STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jamie T. Keeton,

Petitioner,

vs. NO. 00 WC 66233

American Freightways,

Respondent.

ORDER

This matter coming to be heard on Petitioner's Motions pursuant to Sections 8(a), 19(k), and 16 of the Act and Respondent's Motion for Request for Hearing due notice having been given and the Commission fully advised in the premises; IT IS HEREBY ORDERED:

1) Petitioner's oral Motion made on July 25, 2017 to Withdraw her Petitions is granted with leave to re-file at a later date;

2) Given Petitioner's Motion to Withdraw is granted, Respondent's Motion for Request for Hearing is moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's oral Motion to Withdraw her Petitions pursuant to Sections 8(a), 19(k), and 16 of the Act is hereby granted with leave to re-file.

DATED: JUL 28 2017
LEC
r07/25/17
43

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELIAS URENA,

Petitioner,

vs.

NO: 01 WC 50469

17IWCC0434

EAGLE CONCRETE CONTRACTORS, INC.,

Respondent,

DECISION AND OPINION ON REMAND

Procedural History

This matter proceeded to an initial arbitration hearing on March 22, 2006 after which time a decision was issued awarding Petitioner temporary total disability benefits of 37 2/7 weeks with a credit for an overpayment of $2465.33 as well as permanent partial disability benefits of 75 weeks representing 50% loss of use of the right eye under Section 8(e) of the Act. On April 28, 2008, the Commission affirmed the arbitrator's decision, and neither party sought judicial review.

On December 11, 2008 Petitioner filed Petitions pursuant to Sections 19(h) and 8(a) of the Act requesting additional benefits due to a material change in his disability as well as associated medical expenses incurred. Further hearings were undertaken on August 13, 2012 and February 4, 2013 with a decision issuing on August 15, 2014 wherein the Commission awarded additional permanent partial disability benefits of 37½ weeks representing 25% loss use of the right eye pursuant to Section 8(e) of the Act and denying penalties pursuant to Sections 19(k) and (l) and fees pursuant to Section 16 of the Act. On May 14, 2015 the circuit court of Cook County confirmed the decision of the Commission.

Petitioner timely filed an appeal to the Appellate Court, First District, Workers' Compensation Commission Division which entered its Order pursuant to Supreme Court Rule 23

17IWCC0434

on June 24, 2016. The Court vacated the portion of the circuit court order which confirmed the Commission's permanent partial disability award of an additional 25% loss use of the right eye finding the Commission failed to provide adequate factual findings in support of its determination of the additional permanent partial disability benefits. The Court affirmed all other aspects of the decision including the Commission's denial of penalties and fees. As such this remand decision addresses an award of permanent partial disability benefits pursuant to Section 19(h) of the Act.

Statement of Facts

Petitioner testified during the August 13, 2012 hearing as to the current state of his vision specifically "I can't see anything. It's bad." 08/13/12-T. 14. Petitioner testified he was able to drive. Id. Petitioner testified he was not working. *Id.*

The medical records evidence Petitioner continued treatment with Dr. Mack and Dr. Olivier, and while under their treatment, Petitioner underwent four additional procedures: 1) March 9, 2009- Trabeculectomy; 2) January 14, 2010- Corneal Transplant; 3) January 26, 2011 and March 25, 2011- Cyropreserved Amniotic Membrane Procedure. PX12, pp. 10-11, 16- 19(h) Hearing.

In the 19(h) hearing Dr. Robert Mack provided his testimony pursuant to an evidence deposition taken on March 1, 2012. Dr. Mack testified as to Petitioner's treatment as to the above four referenced procedures. Dr. Mack testified Petitioner underwent the Trabeculectomy in order to reduce pressure of fluid in eye due to glaucoma. PX12, p. 8- 19(h) Hearing. Dr. Mack testified following the [second] corneal transplant performed on January 14, 2010 by April of 2010, Petitioner's visual acuity was 20/70 with use of a contact lens. PX12, p. 12- 19(h) Hearing. Dr. Mack testified Petitioner underwent the cryopreserved amniotic membrane procedure on March 25, 2011 in an attempt to reduce inflammation and preserve the transplant. PX12, p. 16-17-19(h) Hearing. Dr. Mack testified as to the existence of objective findings which correlated to the decrease in Petitioner's visual acuity. Specifically Dr. Mack testified Petitioner's [first] corneal transplant began to fail in 2009 as the cornea was no longer clear which was visualized by Dr. Mack. PX12, p.23- 19(h) Hearing. Dr. Mack testified Petitioner likely may need further treatment but no additional surgeries were prescribed at that time. PX12, p. 19- 19(h) Hearing. Dr. Mack testified he did not recall providing any restrictions on Petitioner's work abilities during his treatment. PX12, p. 21- 19(h) Hearing. As for the Petitioner's vision, Dr. Mack testified as follows: "I suppose his vision now is very similar to what it was at the time [2003], but it is certainly not a stable situation even today." PX12, p.6- 19(h) Hearing. Dr. Mack testified the loss of an eye occurs slow and over decades. PX12, p. 22- 19(h) Hearing. The medical records from Dr. Mack note a visual acuity of 20/400 on March 18, 2003 and 20/200 on June 24, 2003. PX12- Original Hearing.

In the 19(h) hearing Dr. Anna Park provided her testimony pursuant to an evidence deposition taken on January 12, 2012. Dr. Park testified she evaluated Petitioner on two occasions, August 14, 2009 and June 13, 2011 at the Employer's request. PX13, p. 5-6- 19(h) Hearing. Dr. Park testified when she initially evaluated Petitioner, he suffered from corneal edema of the corneal transplant. PX13, p.9- 19(h) Hearing. Dr. Park diagnosed Petitioner with a

failed corneal transplant and recommended a further transplant. PX13, p. 11- 19(h) Hearing. Dr. Park testified upon re-evaluation of Petitioner on May 17, 2011, his corneal transplant was swollen. PX13, p. 14- 19(h) Hearing. Dr. Park testified to recommending increasing the steroids in an attempt to reduce the swelling. PX13, p. 15- 19(h) Hearing. Dr. Park testified Petitioner's vision was now worse than when he was evaluated by Dr. Gieser due to swelling, and if the swelling improved so too would Petitioner's vision. PX13, p. 31-19(h) Hearing. Dr. Park testified Petitioner advised her that he had no vision since the initial injury, and her testing revealed visual acuity of hand motions at one foot. PX13, pp. 13, 18- 19(h) Hearing. Dr. Park testified Petitioner is more than legally blind in the right eye. PX13, p. 19- 19(h) Hearing.

Petitioner testified at the initial hearing on March 22, 2006. Petitioner provided varying testimony as it related to his vision in his right eye. "When I'm looking at a person I can see darkness and blurry. And to this day I still see like that." 03/22/06- T. 34. "Sometimes I see black spots and it bothers my left eye." 03/22/06- T. 40. "Q. Today how is your vision in the right eye? A. The Same. Q. What do you notice? What is your vision in the right eye? What can you see? A. I can't see anything?" 03/22/06- T. 41. "Q. With regards to your vision now, you testified that you can't see anything in your right eye? A. No, I see everything blurry." 03/22/06- T. 73. Petitioner testified he was not working. 03/22/06- T. 47. Petitioner testified he would not return to work for the Respondent as he was in process of applying for Social Security Disability Benefits and did not want to jeopardize his receipt of the same as well as his fear of being fired. 03/22/06- T. 84.

Dr. Gieser testified via evidence deposition taken on May 24, 2005 at the initial hearing of March 22, 2006. Dr. Gieser testified Petitioner's visual acuity ranged between 20/20 and 20/400. RX6, p.18- Original Hearing. Dr. Gieser explained such was a subjective finding as the patient needed to report what he could see. RX6, p. 10- Original Hearing. Dr. Gieser testified 20/400 acuity is worse than legal blindness. *Id.*

Conclusions of Law

Material Increase under Section 19(h) of the Act

The Commission notes in its decision of August 15, 2014 no specific finding was made as to whether Petitioner proved a material increase in his disability pursuant to Section 19(h) of the Act. Given the Commission awarded additional permanent partial disability benefits under Section 8(e) of the Act, such finding of a material increase in disability can be inferred. Additionally the Commission is cognizant of the Appellate Court's ruling in *Urena v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151613WC-U, ¶40 wherein the Court held "the evidence in the record clearly established that the claimant suffered an increase in disability since the Commission's original award of benefits." The Commission is bound by this holding. *Aardvark Art, Inc. v. Lehigh/Steck-Warlick*, Inc., 284 Ill. App. 3d 627, 633 (1996). The Commission notes such change in disability stems from Petitioner's failed corneal transplant.

"On review under section 19(h), the Industrial Commission is required to consider the evidence offered and the findings made at the first inquiry, together with such additional evidence as may be offered touching on whether the disability has changed. [citations]." *United*

States Steel Corporation v. The Industrial Commission, 133 Ill. App. 3d 811, 817, 478 N.E.2d 1108 (1985). In the original hearing, the Commission found Petitioner was at MMI as of April 11, 2003 relying on Petitioner's treating physician, Dr. Mack. The Commission further found Dr. Gieser's opinions persuasive finding Petitioner obtained a good surgical result. Commission's Decision and Opinion of Review dated 4/28/08. The Commission did not make a specific finding as to Petitioner's visual acuity but noted subjective reports of acuity by Petitioner of 20/200 to 20/400. *Id* . The Commission further found Petitioner returned to work full duty as of May 21, 2002 and worked in such capacity until an unrelated knee injury of 2005. *Id.*

In the 19(h) hearing the medical records and testimony clearly evidence Petitioner's corneal transplants failed following the original hearing. Dr. Park testified she diagnosed Petitioner with a failed corneal transplant and recommended a further transplant. PX13, p. 11- 19(h) Hearing. Dr. Mark testified such transplant was undertaken on January 14, 2010 and by April 1, 2010, Petitioner's visual acuity was 20/70 with a contact lens. PX12, p. 12- 19(h) Hearing. Dr. Mark provided no testimony as to the ultimate failure or success of Petitioner's corneal transplant performed on January 14, 2010. Dr. Mark's medical records indicate on September 25, 2010 he advised Petitioner that different contact lens may work to improve his visual acuity, but Petitioner refused to try the same. PX4- 19(h) Hearing. Dr. Mark's medical records evidence a diagnosis of graft rejection as of June 15, 2011. During his June 6, 2012 evaluation, Dr. Mark noted the graft looked clearer, and by the final evaluation of July 6, 2012, the graft failure was stable. *Id.*

Dr. Park testified as of her re-evaluation of Petitioner on May 17, 2011, Petitioner's corneal transplant was swollen. PX13, p. 14- 19(h) Hearing. Dr. Park testified to recommending increasing the steroids in an attempt to reduce the swelling. PX13, p. 15- 19(h) Hearing. Dr. Park testified Petitioner's vision was now worse than when he was evaluated by Dr. Gieser due to swelling, and if the swelling improved so too would Petitioner's vision. PX13, p. 31- 19(h) Hearing.

Based upon the above medical evidence, the Commission finds Petitioner previous corneal transplant performed on February 2, 2002 failed requiring four additional procedures including a further corneal transplant performed on January 14, 2010. The January 14, 2010 corneal transplant also began to fail but eventually stabilized by July 6, 2012. Therefore, Petitioner has proven by a preponderance of credible medical evidence his disability has increased, and such increase in disability has been material pursuant to Section 19(h) of the Act.

PPD Award

As Petitioner proved a material increase in his disability, the question presented is how such disability translates into the loss of visual acuity and/or vision loss.

> This Court has noted previously that our workmen's compensation act contains no standards for determining the percentage of loss of use of an eye, and does not specify whether corrected or uncorrected vision shall be used in determining the extent of eye injuries compensable under the Act. In this State it has been uniformly held that the loss of use of an eye is a question of fact and is not one to be determined by mechanical

measurement as to corrected or uncorrected vision. *Pridgeon v. The Industrial Commission*, 89 Ill. 2d 477, 479 (1982).

Further, a determination of disability is dictated by the particular facts of each case. *Gilbert & Shughart Painting Contractors v. The Industrial Commission*, 136 Ill. App. 3d 163, 169 (1985).

In the present matter, Petitioner underwent a corneal transplant on February 22, 2002 which subsequently failed. Due to this failure, Petitioner underwent a second corneal transplant on January 10, 2010. (Prior to this procedure, Petitioner underwent a Trabeculectomy to treat his condition of glaucoma). Following the second corneal transplant, Petitioner underwent a Cypropreserved Amniotic Membrane procedure on two occasions, January 26, 2011 and March 25, 2011. Dr. Mack testified these procedures were undertaken to reduce inflammation in the eye in order to help the [second] transplant from failing. PX12, p. 16-17- 19(h) Hearing. Although Dr. Mack did not provide testimony on March 1, 2012 as to the ultimate success or failure of the second corneal transplant, Dr. Mack testified additional graft procedures would not help to improve Petitioner's visual acuity. PX12, p. 19- 19(h) Hearing. Dr. Mack testified Petitioner's current vision is very similar to his vision at the initial assessment of MMI in April of 2003. PX12, p. 5-6- 19(h) Hearing.

Following Dr. Mack's evidence deposition he continued to treat Petitioner. Dr. Mack's medical records evidence as of June 6, 2012 Petitioner suffered from a failed graft (corneal transplant), and such graft looked clearer. On July 6, 2012 Dr. Mack's final evaluation of Petitioner, he diagnosed a stable graft failure. PX4- 19(h) Hearing.

Dr. Mack testified when initially treating Petitioner there existed a lack of objective evidence to justify Petitioner's claimed decrease in visual acuity. PX12, p. 22-19(h) Hearing. The Commission noted the same in its decision of April 28, 2008 finding "Petitioner's own treating physician [Dr. Mack] was suspicious of malingering and was unable to find an objective reason for the reported loss of visual acuity. In addition, Dr. Mack repeatedly notes in his medical records that Petitioner was non-compliant with his medical care."

Dr. Mack testified Petitioner currently exhibited objective findings which correlated to a decreased visual acuity. PX12, p. 22- 19(h) Hearing. Dr. Mark testified given the failure of the transplant, it was no longer clear. PX12, p. 23- 19(h) Hearing. Dr. Park's testimony is consistent with a failure of the graft at the time of her evaluation of May 17, 2011. Dr. Park testified upon re-evaluation of Petitioner on May 17, 2011, his corneal transplant was swollen. PX13, p. 14-19(h) Hearing. Dr. Park testified to recommending increasing the steroids in an attempt to reduce the swelling. PX13, p. 15- 19(h) Hearing.

As previously indicated, Petitioner continued to treat with Dr. Mack following his testimony as well as following the testimony of Dr. Park. The Commission finds Petitioner's graft failure improved and stabilized as of July 6, 2012. This is supported by Dr. Park's testimony that if Petitioner's swelling improved so too would Petitioner's vision. PX13, p. 31-19(h) Hearing. More importantly, Dr. Mack testified Petitioner's visual acuity as of 2012 was very similar to his acuity in 2003. PX12, p. 6- 19(h) Hearing. It is noted Petitioner's visual acuity in 2003 at and around his MMI date ranged between 20/200 and 20/400. PX12- Original

17IWCC0434

Hearing.

Petitioner's testimony on August 13, 2012 that he is unable to see anything is consistent with his prior testimony on March 22, 2006 at which time he asserted he was also unable to see anything. Such testimony is also consistent with Dr. Park's testimony that Petitioner reported he was unable to see anything since the date of accident. PX13, p. 13- 19(h) Hearing. Petitioner has been consistent regarding his alleged inability to see since the date of accident. Petitioner is not credible given objective findings which belie his testimony.

The objective medical evidence and opinions of Dr. Mack and Dr. Park support a finding Petitioner does have vision. Both Dr. Park and Dr. Gieser testified the visual acuity test is a subjective measure as the patient must report what he can see. According to Dr. Mack, Petitioner has the same visual acuity presently as he did in 2003. The Commission affords great weight to Dr. Mack's opinion. The Commission finds Petitioner's failed corneal transplants did affect his vision causing it to be less clear as testified to by Dr. Mack. Given this objective finding despite Petitioner's stability in visual acuity since 2003, the Commission finds Petitioner suffered an increase of disability in the amount of 25% loss use of the right eye for an additional period of 37.5 weeks pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission filed August 15, 2014, is hereby affirmed and adopted with the modifications and explanations outlined above.

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: JUL 13 2017

Charles J. DeVriendt

L. Elizabeth Coppoletti

LEC/
O: 4/4/17
49

L. Elizabeth Coppoletti

Joshua D. Luskin

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

George Ryczek,
Petitioner,
vs.

NO: 05 WC 35758

D & P Chicago Inc.,
Respondent,

17IWCC0467

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 31, 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 $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.

JUL 21 2017

DATED:
o062917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RYCZEK, GEORGE
Employee/Petitioner

Case# **05WC035758**

D&P CHICAGO INC
Employer/Respondent

17IWCC0467

On 5/31/2016, 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:

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
LINDSEY V BEUKEMA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

George Ryczek
Employee/Petitioner
v.
D&P Chicago, Inc.
Employer/Respondent

Case # **05 WC 35758**

17IWCC0467

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **September 3, 2015** and **September 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 **February 12, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

ORDER

Because petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment, benefits are denied.

The remaining issues are moot.

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

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

Signature of Arbitrator

May 31, 2016
Date

MAY 31 2016

FACTS

Petitioner testified that he was president of D&P Chicago, a construction company, which was incorporated on January 1, 2005. Petitioner testified that D&P Chicago contracted with Cambridge Homes to perform drywall and painting on a condominium building being built in or near Northbrook, Illinois. Petitioner testified that as president, his job duties were supervisory and that he typically worked eight hours per day, five to six days per week. (T.10)

Per Arbitrator's Exhibit 1, petitioner alleges that he earned $78,000.00 the year prior to the accident. He testified that he had a salary of $1,500.00 per week. (T.11) Petitioner submitted into evidence a check in the amount of $5,491.25, issued to George Ryczek, signed by George Ryczek, dated January 4, 2005. (Pet. Ex. 1) Petitioner testified that this was a payroll check which covered the period of December of 2004.Petitioner also presented his 2005 W-2 Wage and Tax Statement. This statement listed $21,400.00 in wages, tips, or other compensation. (Pet. Ex. 2) Respondent submitted petitioner's 2004 1040 US Individual Tax Return which listed zero "wages, salaries, tips, etc." (R. Ex. 4)

Petitioner testified that on February 12, 2005, he was on the Cambridge Homes job site "walking the job to see what progress was made by the workers." (T.18) On direct examination petitioner testified that he was walking down stairs at the jobsite, that there was a loose stair, and that he fell onto his knees. (T.19) He testified that there were no railings along the stairs. (T.19) Petitioner also testified that the stairs were made of concrete,

but there was wood on top of the concrete stair. (T.37) On cross examination, petitioner testified that he had nothing in his hands at the time of the fall. (T.37) Additionally petitioner testified that it was daytime and the stairway was not dark. (T. 38) No witnesses observed the petitioner fall. (T.41-42) Petitioner testified that he continued working that day but experienced pain in his knees and back. (T.19) He did not go to the emergency room or seek any medical treatment that day. (T. 42)

Petitioner testified that he first sought medical treatment on March 9, 2005 with Dr. Joyce Tarbet at Great Lakes Orthopedics. Dr. Tarbet's medical records show that petitioner reported falling onto the anterior aspect of both knees about three weeks prior. Petitioner had no specific treatment to date, other than rest and medications. Petitioner reported some bruising and complained of persistent ongoing bilateral anterior knee pain. (Pet. Ex. 3)

On physical examination of both knees, Dr. Tarbet noted no abrasions or contusions, and no effusion. In addition, range of motion of both knees demonstrated zero degrees of extension and 120 degrees of flexion. There was no medial or lateral joint line tenderness to either knee. The meniscal rotation sign was negative, and petitioner was non-tender throughout the patellar tendons. There was minimal tenderness to the medial facets bilaterally, and he was non-tender over the lateral facet bilaterally. The patellar tilt was neutral bilaterally. Medial and lateral patellar glides measured 2/4 and 2/4, respectively, on both sides. The Lachman's and pivot shift were negative bilaterally, and the quads active test was negative. There was no significant crepitus with full flexions. In addition, X-rays of both knees were unremarkable. (Pet. Ex. 3)

Dr. Tarbet's impression was that petitioner sustained a contusion to both knees and may also have sustained a chondral injury. She recommended that, if his discomfort persisted, an MRI would be required to evaluate the patellar articular cartilage. However, as petitioner's symptoms were minimal and he had no swelling, Dr. Tarbet did not feel that further treatment was necessary at that time. Dr. Tarbet encouraged him to return to all activities. Dr. Tarbet recommended that if his pain persisted, he could return in four to six weeks for re-evaluation. (Pet. Ex. 3)

A March 18, 2005 note from Dr. Tarbet's office indicates that petitioner called for pain medication, and reported he had been taking his mother's Vicodin for pain. Dr. Tarbet advised that petitioner should try Advil or Aleve for his knee pain. (Pet. Ex. 3)

Petitioner testified that he next sought treatment with Dr. Cheryl Ascher, a napropath, at the facility HealthCher. Medical records reflect that petitioner was under Dr. Ascher's care from March 28, 2005 to April 18, 2005 and again from January 11, 2007 through August 28, 2008. Petitioner testified that Dr. Ascher provided manipulation, mobilization of the soft tissue, and various modalities to his knees and back. A March 28, 2005 record indicates that petitioner's symptoms first appeared on February 12, 2005. On evaluation, petitioner complained of pain in the shoulder, pain in the pelvic region and thigh, pain in the thoracic spine, low back pain, muscle spasm, and headaches. Dr. Ascher ordered lateral lumbosacral X-rays, as well as X-rays of both knees and potentially an MRI depending on the results. Petitioner saw Dr. Ascher approximately every two to three days through April 18, 2005. Eventually it was noted that that workers' compensation was not paying, and petitioner was given a referral to a practitioner closer to home. (Pet. Ex. 4)

On April 13, 2005, petitioner presented to Dr. William Sarantos and Dr. Demetrios Patos at Alpha Pain Treatment Center. Petitioner testified that Dr. Sarantos is an M.D. and Dr. Patos is a chiropractor. The intake form of April 13, 2005 notes right and left knee pain with an onset on February 12, 2005 after a sudden fall at work on knees. Records also reflect that petitioner had a moderately severe new complaint of constant pain

bilaterally in the region of the low back. The assessment was internal derangement of the knee, knee effusion, lumbar pain, decreased range of motion. Lumbar spine X-rays were taken. (Pet. Ex. 5)

On April 22, 2005, Dr. Patos ordered bilateral knee and lumbar MRIs. The May 17, 2005 lumbar spine MRI showed multi-level degenerative disc disease without evidence of a focal disc herniation. There was no significant central spinal canal or neuroforaminal narrowing detected. The May 17, 2005 MRI of the right knee was somewhat limited due to motion. The radiologist's impression was moderate increased signal intensity within the posterior medial meniscus. The presence of a tear could not be definitely excluded. The MRI of the left knee showed moderate increased signal intensity within the posterior horn of the medial meniscus, as was seen on the right knee. The presence of a tear could not be definitely excluded. There was low to mid-grade chondromalacia of the patellofemoral joint with evidence of a medial plica. (Pet. Ex. 5) Therapy continued through August 26, 2005. (Pet. Ex. 5)

Petitioner testified that he sought an evaluation with Dr. Tonino at Loyola University Medical Center. (T. 22) Per the medical records, petitioner first presented to Dr. Tonino on May 25, 2006. Petitioner reported falling in February of 2004 on both of his knees. He complained of bilateral knee pain, worse on the left than the right. He reported having difficulty with stairs, occasional giving way, but no locking. Dr. Tonino noted that petitioner had MRIs about a year prior, which were essentially unremarkable. On examination, petitioner had tenderness over the medial joint lines on both knees, but McMurray and Lachman tests were negative. Dr. Tonino recommended obtaining repeat MRIs. (Pet. Ex. 6)

Petitioner returned to Dr. Tonino on July 20, 2006 after undergoing right and left knee MRI's. Dr. Tonino's review of the MRIs showed probable degeneration of the medial meniscus without evidence of tear, and mild tendinopathy of the patellar tendon on the right. On the left, Dr. Tonino saw possible tear of the inferior surface of the medial meniscus with medial facet patellar chondropathy. Dr. Tonino opined that petitioner most likely had patellofemoral chondromalacia bilaterally. As petitioner had not improved with conservative treatment, an arthroscopic evaluation of the left knee was offered with possible chondroplasty. Petitioner testified that he decided not to have the surgery because he doesn't really believe in operations. (T. 22)

Petitioner returned to Dr. Ascher on January 11, 2007, presenting with pain in the left shoulder and low back pain radiating through the testicle and down the left leg. Petitioner also described experiencing sporadic periods of extreme pain and loss of control of legs. Dr. Ascher recommended that petitioner carry a cane, and when anticipating prolonged periods on his feet, have a wheelchair available. It was also suggested that petitioner consider diet changes for weight loss. Petitioner indicated that was not something he would do. Petitioner treated with Dr. Ascher through August 28, 2008. (Pet. Ex. 4).

Petitioner testified that he further sought treatment with Dr. Mikroulis, a chiropractor, at Multi Care Health Center from April 22, 2009 through July 31, 2013. Petitioner testified that Dr. Mikroulis used to work for Alpha Pain Center and opened up his own facility. Upon initial evaluation, petitioner presented with low back at 10/10 and bilateral knee pain at 8/10. The diagnoses were lumbar pain, lumbar radiculitis, lumbar spasm, restricted lumbar motion, and knee pain. Under Disability Status/Work Restrictions, it was noted that "the patient is not working . . . and has trouble getting around and doing his activities of daily living." Records reflect that an April 23, 2009 lumbar MRI revealed bulging discs at various levels, along with stenosis and early signs of arthritis. (Pet. Ex. 7)

Dr. Mikroulis referred petitioner to Dr. Sarantopoulos for a lower extremity EMG and nerve conduction studies. The May 28, 2009 EMG showed needle EMG evidence that there may be seen with bilateral L5-S1

nerve root irritation. Clinical correlation with an MRI was recommended. Dr. Sarantopoulos recommended that petitioner continue with therapy three times a week for the next four weeks. (Pet. Ex. 7)

Petitioner underwent a lumbar spine MRI on July 21, 2009. Dr. Sarantopoulos opined that the MRI showed no substantial change since the MRI of April 23, 2009. On July 30, 2009, Dr. Sarantopoulos administered four trigger point injections to the lumbar spine and recommended ongoing physical therapy. (Pet. Ex. 8)

Dr. Sarantopoulos' November 19, 2009 records indicate that petitioner was seeking an evaluation with a neurosurgeon, Dr. Richardson and was still undergoing therapy. On December 10, 2009 petitioner complained of neck and cervical pain radiating to the upper extremities since a fall on October 6, 2009. Petitioner reported no similar neck or shoulder pain symptoms for two years prior to the fall. Dr. Sarantopoulos ordered cervical and right shoulder MRI's, which petitioner underwent on December 11, 2009. (Pet. Ex. 8)

Petitioner testified that he was involved in a motor vehicle accident on December 23, 2009 (T. 48). The medical records of Dr. Sarantopoulos reflect that petitioner was rear-ended by another vehicle, but did not go to the emergency room. Dr. Sarantopoulos later noted that petitioner re-injured his cervical spine in the automobile accident. At petitioner's request on March 25, 2010, Dr. Sarantopoulos provided a referral to Dr. Zelby, a neurosurgeon, to evaluate petitioner's cervical and lumbar spine. (Pet. Ex. 8)

Dr. Zelby evaluated petitioner on April 14, 2010. Petitioner complained of "pain from his head to his toes." He reported neck pain for a few years, but could not recall a specific inciting event. He also reported pain in his low back without radiation into the legs. He felt he was unsteady when he walked, and had some clumsiness in the hands. It was noted that he was able to drive a car and put on shoes and socks. A cervical MRI from December 11, 2009 showed a prior anterior cervical fusion at C6-7, as well as degenerative disc disease throughout the cervical spine. An MRI of the lumbar spine from October 19, 2009 showed no acute findings. The disc space heights and signal intensities were all well-preserved. (Pet. Ex. 9)

Dr. Zelby explained to petitioner that the cervical spine MRI showed spinal cord compression and that the only way to decompress the spinal cord would be with surgery. Dr. Zelby recommended an anterior cervical decompression and fusion at C4-5. Dr. Zelby opined that no surgery was needed to lumbar spine. Instead, petitioner's best chance to find sustained relief from his low back pain was through significant weight loss. (Pet. Ex. 9)

At the request of Respondent, Dr. Gleason performed a medical records review and issued a report of his findings on May 29, 2011. Dr. Gleason opined that petitioner's complaints, physical findings, and imaging studies suggested at most a soft tissue-type strain, and/or a temporary aggravation of his pre-existing condition related to his knees, and possibly the spine, which would have been anticipated to have resolved within a relatively brief two to three month period of time. Dr. Gleason pointed out that records suggest that by sometime prior to at least May 4, 2006, petitioner's physical examination was negative, range of motion was normal, strength was intact and gait was also normal. Any additional further complaints or associated treatment would be unrelated to February 12, 2005. (R. Ex. 2).

On July 26, 2011, Dr. Gleason examined petitioner and found no objective positive findings on physical exam relative to the low back or lower extremities. He opined that petitioner was capable of working full time without restrictions relative to the low back and knees. Dr. Gleason recommended a neurosurgical follow up with respect to the cervical spine and myelopathy but stated that this was unrelated to the February 12, 2005

work accident. In addition, Dr. Gleason stated that petitioner's gap in treatment to the low back gave him pause to question whether or not the low back condition was even temporarily aggravated. (R. Ex. 3)

Petitioner subsequently underwent an independent medical examination with Dr. Ghanayem relative to the lumbar spine on June 21, 2012. Dr. Ghanayem opined that petitioner may have sustained a back sprain from the mechanism of injury described. However, he found no evidence of any structural or traumatic injury occurring from this fall nor did he find any neurologic deficits. Dr. Ghanayem noted that petitioner was morbidly obese and may have difficulty walking because of his obesity and/or possibly his knees. It was noted that petitioner told Dr. Ghanayem that he was retired and was not going back to work. (R. Ex. 1).

Petitioner testified that he was admitted to Northwestern University Medical Center in July of 2014 because of a fall. (T. 25) Emergency room records from July 16, 2014 note that petitioner was first brought to MacNeal Hospital where he had a brain CT and CT of the cervical spine. Petitioner requested transfer to a facility with an open MRI. The history provided in the initial trauma evaluation at Northwestern was that petitioner reported a mechanical fall—he got a new pair of shoes and tripped. It was further noted that petitioner reported having been unable to use his arms for two to three minutes after the fall but then regained use of his hands and dialed 911. Imaging revealed a left C6 transverse process fracture. Petitioner was discharged on July 16, 2014. (Pet. Ex. 10)

At petitioner's attorney's request, Dr. Sarantopoulos issued a report on September 3, 2014 stating that petitioner had reached maximum medical improvement with regard to his lumbar injury but that he continued to require pain medication. (Pet. Ex. 17) Dr. Sarantopoulos issued another report on January 14, 2015 opining that there was a causal connection between petitioner's low back pain symptomatology and the injury that he reported occurred on February 12, 2005. (Pet. Ex. 18)

Petitioner testified that currently, his pain prevents him from staying in one position too long and also interrupts his sleep. (T. 27) Petitioner testified that he never knows when he is going to fall. Petitioner testified that while driving he has to get out of the car and stretch his legs because his back hurts. (T. 28) Petitioner testified to taking daily pain bills, anti-inflammatories, anxiety medication, as well as using cold packs on his back and knees. (T. 28)

ACCIDENT

The Arbitrator finds that petitioner was not credible.

The Arbitrator further finds that the evidence at trial does not support petitioner's claim of accident.

The Arbitrator notes the multiple inconsistencies and discrepancies in petitioner's testimony and the evidence submitted. Petitioner testified that on the day of the accident, he was walking down stairs on the job site and there was a loose stair on which he fell. (T.19) However, on cross examination, petitioner testified that the stairs were made of concrete. (T. 37) He then testified that there was wood on top of the concrete stair. (T.37) Petitioner later testified that he had no idea how or why there was wood on top of a step. (T.58)

The Arbitrator notes other examples of petitioner's inconsistent testimony. At one point he testified that the building was a commercial building, and subsequently he testified that there were three condominium buildings being built. (T.55) Petitioner at one point could not recall whether D&P Chicago was contracted to perform drywall and painting for the entire development or just a portion of it and yet later, he clearly testified

that D&P Chicago was hired to perform drywall and painting on one entire condominium building, in every unit. (T. 36, 40) He could not, however, recall how many units were involved. (T. 40)

Petitioner also could not recall the address or general location of the jobsite where he alleges the accident occurred. (T.56) Petitioner could not recall when D&P Chicago started working on this construction site. (T.36) Petitioner could not recall how many employees he had at the time of the accident. (T.35) He could only say that he had an unlimited supply of workers. (T.35) Petitioner was not specific as to whether or not D&P Chicago completed the Cambridge Homes project or performed another job after this project. He testified "I believe so", "I believe just one. I'm guessing one". (T.39 41) Petitioner at first denied, then could not recall, then answered affirmatively to still being the president of the company. (T.41)

The Arbitrator finds that petitioner's testimony, taken as a whole, is inconsistent and unreliable.

Based upon the foregoing, the Arbitrator finds that petitioner did not prove by a preponderance of the credible evidence that he sustained an accident arising out of and in the course of his employment.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Pena,

Petitioner,

vs.

NO. 05 WC 53638

Wells Manufacturing

17IWCC0451

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, causal connection, prospective medical care, 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 3, 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.

17IWCC0451

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,700.00. 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: JUL 18 2017
SJM/sj
o-6/29/17
44

Stephen J. Mathis

Kevin W. Lamborn

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

PENA, JOSE
Employee/Petitioner

Case# **05WC053638**

WELLS MANUFACTURING
Employer/Respondent

17IWCC0451

On 6/3/2016, 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 0.47% 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:

5181 CANDIANO LAW OFFICE
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CHICAGO, IL 60604

0481 MACIOROWSKI SACKMANN & ULRICH
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105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

17IWCC0451

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
CORRECTED ARBITRATION DECISION

Jose Pena
Employee/Petitioner

v.

Wells Manufacturing
Employer/Respondent

Case # **05** WC **53638**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **December 22, 2015 and in the city of Rockford, on January 11, 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 **October 16, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,404.28**; the average weekly wage was **$642.39**.

On the date of accident, Petitioner was **45** years of age, *married* with **2** dependent children.

Petitioner *has not* received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$6,729.80** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$4,069.72** for other benefits, for a total credit of **$10,799.52**.

Respondent is entitled to a credit under Section 8(j) of the Act for medical benefits paid under a qualifying plan.

ORDER

Respondent shall pay reasonable and necessary medical services for treatment of the condition of ill being in the Petitioners right knee only, pursuant to the medical fee schedule to Centegra Hospital, Woodstock Imaging and Mercy Woodstock Medical Center, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for any payments made under Workers' Compensation or a group plan pursuant to Section 8(j) of the Act. All other medical bills are denied.

Respondent shall pay Petitioner temporary total disability benefits of $428.26/week for 31 2/7 weeks, commencing November 25, 2005 through March 29, 2006 and February 20, 2009 through May 23, 2009 as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$6,729.80** for TTD and **$4,069.72** for other benefits, for a total credit of **$10,799.52**.

Respondent shall pay Petitioner permanent partial disability benefits of $385.43/week for 75.25 weeks, because the injuries sustained caused the 35% loss 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

June 2, 2016
Date

JUN 3 - 2016

Statement of Facts

Petitioner Jose Pena testified that in October, 2005, he was employed by Respondent Wells Manufacturing as an iron transporter. He was hired by Respondent on May 12, 2004. His responsibility was to transport iron from the furnace to other parts of the plant. He also did chemistry. On October 16, 2005, he was cleaning the dust collectors when another employee driving a forklift ran into his right leg. Petitioner testified that the forklift impacted his right hip, leg and knee and bent his leg. The forklift pushed him about two feet. Petitioner testified that he put his hand on the roof support of the forklift to stay away from the forklift. He was dragging his right foot. He lifted it up a little bit. He felt a popping in his knee.

Petitioner reported the injury to Respondent. The Employee Accident Report signed by Petitioner on October 19, 2005 was admitted as Respondent's Exhibit 1. Petitioner reported that he was moving a big fan when Rafael Ortiz pulled back and hit his right leg. The Supervisor's Accident Report, admitted as Respondent's Exhibit 2, records that a co-worker backed into Petitioner's right leg or right knee.

Petitioner testified that he sought medical treatment at Centegra Hospital in Woodstock on the day of the accident. The Admission Assessment records a history of Petitioner being hit in the right thigh by a forklift. Right knee twisted. He complained of pain with movement. The pain diagram showed pain across the right leg from mid thigh to mid calf. Pain was 7-8/10. Petitioner was diagnosed with a contusion to the right knee. He was advised to take Advil, use ice and elevate. He was taken off work for one day (PX 1, 55-63). The Physician's Record contains a history of a direct blow when Petitioner was hit by a forklift. The pain diagram documents tenderness on the outside of the right knee. Petitioner advised he has diabetes and has had prior left knee surgery. The examination of the entire right lower extremity from the foot to the hip reveals only soft tissue tenderness in the knee. X-rays were taken of the right knee and the diagnosis was a contusion to the right knee (PX 1, 37-38).

Petitioner testified that he sought treatment with Dr. Dana Tarandy. The records of Dr. Tarandy and Mercy Medical Center were admitted as Petitioner's Exhibit 10. The records document Petitioner's prior left knee treatment beginning December 8, 2004 after a work related accident on October 27, 2004. Petitioner had arthroscopic surgery on the left knee on March 7, 2005. He was released from care on May 31, 2005 with an MMI date of June 7, 2005. He reported medial sided knee pain and difficulty kneeling.

He saw Dr. Tarandy on November 16, 2005, giving a history of injuring his right knee and ankle at work. He notes treatment at the emergency room and Dr. Vlahos who ordered an MRI. Petitioner complained of swelling and pain in his knee. He noted clicking in his ankle and knee. The physical examination notes swelling and tenderness in the ankle with an area of ecchymosis on the dorsum of the foot and a 1 cm. abrasion. The right knee exam noted moderate effusion, medial joint line tenderness with loss of motion and positive McMurray sign and drawer test. Dr. Tarandy read the MRI as showing a posterior horn medial meniscus tear as well as effusion. He diagnosed Petitioner with right knee posterior horn medial meniscal tear, and right ankle sprain.

On November 25, 2005, Petitioner underwent a right knee arthroscopy, partial medial meniscectomy and excision of medial synovial plica for a pre-operative diagnosis of right knee medial meniscal tear and post-operative diagnosis of right knee, medial meniscal tear and medial synovial plica. The operative report documents a tear of the anterior horn of the medical meniscus. The posterior horn was intact. There was some mild chondromalacia of the medial femoral condyle. The ACL and PCL were noted to be intact. A mild amount of synovitis around the ACL and medial compartment was debrided. Some mild Grade 2

chondromalacia was noted in the lateral compartment (PX 10, 146-147). Petitioner remained under the care of Dr. Tarandy after the surgery for his right knee. He was released to return work on March 29, 2006 to light duty with up to 20 pound lifting and limit ladder and stair climbing.

Post operatively, Petitioner continued to complain of pain and swelling in his right ankle. Dr. Tarandy ordered an MRI of the ankle which was performed on January 19, 2006. The impression was no diagnostic abnormalities but subtle signal alterations in the sinus tarsi and a small degenerative cyst in the talus. Dr. Tarandy read the MRI as showing only minor degenerative changes.

Petitioner was evaluated at Respondent's request by Dr. Charles Mercier on February 23, 2006. Dr. Mercier's report was admitted as Respondent's Exhibit 3. Dr. Mercier took a history from the petitioner, solicited his complaints and performed a physical examination of Petitioner's knees and ankles. As to the right knee, the doctor found a negative Lachman, no anterior or posterior instability, decreased sensation to pinprick and a stocking glove distribution. As to the right ankle, Dr. Mercier reports no swelling. There was generalized pain to palpation about the entire ankle area. There was subjective mild decreased range of motion of the ankle and subtalar joint. There was no gross ligament instability. Ankle flexion and extension, inversion and eversion were normal. Dr. Mercier felt that Petitioner could have returned to work with restrictions a long time ago from the knee surgery. He wanted to review the operative report and the ankle MRI but felt that Petitioner could, at this point in time, returned to work, no lifting over 15 to 20 pounds for two weeks.

Petitioner was re-evaluated by Dr. Mercier on April 11, 2006. The report was admitted as Respondent's Exhibit 4. Dr. Mercier had reviewed the November 25, 2005 operative report and the January 19, 2006 MRI of the right ankle which, he opined revealed a pre-existing talar cyst and findings of questionable significance in the sinus tarsi. He stated that Petitioner demonstrated some non-anatomical motor and sensory loss in the right lower extremity. Dr. Mercier felt that this represented false reporting to clinical testing. He opined that Petitioner did not need a functional capacity evaluation and could return to his regular work at maximum medical improvement.

Petitioner returned to work as a transporter until 2007 when he became a Notcher. That job required him to be on his feet, bend and lift, and operate the forklift truck. He continued work for Respondent until a burn injury on January 25, 2008. The petitioner returned to his job as a Notcher on March 30, 2008 after the burn injury. The petitioner did that job until he was taken off work by Dr. Tarandy for the second knee surgery on February 20, 2009.

Petitioner's visit with Dr. Mundozie for diabetic follow up on March 1, 2006 notes Petitioner's weight gain and poor control of his blood sugar. He notes his diabetic neuropathy is the same with pain and tingling numbness in the right side. He was referred to Dr. Staskus for diabetic management. The March 28, 2006 note states that Petitioner was diagnosed with diabetes in November, 2004. He complained of numbness and tingling in his feet with burning at night. Petitioner was referred to Dr. Hyderi, a podiatrist. Dr. Hyderi diagnosed diabetic neuropathy, bilateral ganglion cysts and bilateral foot pain. He recommended surgical removal of the cysts, right foot first. The Petitioner had the right foot surgery on April 20, 2006. Follow up with Dr. Staskus on May 9, 2006 notes Petitioner is still having pain in the right foot. He reports Dr. Hyderi told him there was some inflammation in the surgical incision area. Petitioner stated the pain has gotten works over the last week, probably because he did not follow the aftercare instructions. He reported pain of 6/10 and a burning sensation (PX 10, 116-126).

Petitioner continued treatment for his right knee for complaints of knee pain and swelling. A repeat MRI performed July 12, 2006 was read as showing no evidence of a recurrent meniscal tear. Increased signal was present within the body and posterior horn of the medial meniscus. The impression included changes consistent with the operative report, new onset low grade injury to the collateral ligament and new onset of mild chondromalacia medial joint compartment. Petitioner underwent and injection on July 19, 2006. Petitioner continued to complain of pain and swelling. Physical examinations document full range of motion without instability, mild crepitus and minimal effusion. Dr. Tarandy stated the symptoms may be related to some post traumatic arthritis. On September 21, 2006 he states that Petitioner is at maximum medical improvement. He does not believe some type of arthroplasty should be considered.

At the request of Dr. Tarandy, Petitioner was seen by Dr. Samuelson on November 21, 2006 for his ankle. Petitioner reported that he injured both his knee and right ankle at the time of the injury. Examination revealed an antalgic gait, mild tenderness about the right ankle, and a well-healed incision noted about the sinus tarsi area. Dr. Samuelson reviewed the MRI of the ankle and indicated that there were no significant abnormalities present outside of the benign-appearing cyst in the mid portion of the talus towards the subtalar joint. He indicated that there were no abnormalities in the area where Petitioner experienced tenderness on examination. His impression was possible right ankle synovial impingement. Petitioner was given an injection.

On December 19, 2006, Petitioner reported the injection not helping his pain. Dr. Samuelson recommended a repeat MRI since the last one was done almost a year ago. The doctor indicated that Petitioner may require surgery. Petitioner returned to Dr. Samuelson on February 7, 2007 with right ankle pain. The MRI had not been done. Dr. Samuelson diagnosed a synovial impingement and stated Petitioner may require arthroscopy. Petitioner testified that he did not return to Dr. Samuelson because Dr. Samuelson's office refused to see him due to unpaid invoices.

On January 18, 2007, Petitioner reported no improvement to his right knee with surgery. Dr. Tarandy noted that Petitioner had developed some degenerative changes with respect to the medial side of the knee. He stated Petitioner had failed conservative treatment and recommended a unicompartmental arthroplasty. Petitioner was released to light duty with no repetitive bending, squatting or climbing. Dr. Tarandy authored correspondence to Petitioner's attorney on February 7, 2007 indicating that he was not convinced that any surgery will improve Petitioner's symptoms. On April 19, 2007, Dr. Tarandy states Petitioner has failed conservative management and recommends surgery. He states Petitioner may have a re-tear of the meniscus as the previous MRI was inconclusive (PX 10, 129). Surgical authorization was denied. On May 29, 2007, Dr. Tarandy assessed right knee pain and post traumatic arthritis. He states that Petitioner requires arthroscopy and likely arthroplasty. Since surgery was denied, he finds Petitioner at maximum medical improvement and makes the restrictions permanent (PX 10, 128).

At the request of the Respondent, Petitioner was seen by Dr. Troy Karlsson on September 6, 2007, with respect to the right knee. He found full range of motion, mild tenderness on the medial and lateral joint line as well as the lateral patellar facet. There was no ligamentous instability. X-rays of both knees revealed slight loss of medial clear space, slight tricompartmental spurring, no severe arthritic changes. MRI's were reviewed from November 4, 2005 and July 12, 2006. The November 4, 2005 MRI revealed high signal in the posterior horn of the medial meniscus consistent with a tear and some slight degenerative changes. The July 12, 2006 MRI showed slight degenerative changes with mild post-operative changes in the medial meniscus. Dr. Karlsson reviewed the treating records including the operative report of November 25, 2005. His assessment was mild osteoarthritis, right knee, and chondromalacia patella, right knee. He diagnosed a traumatic meniscal

tear which was appropriately treated arthroscopically and underlining osteoarthritis unrelated to the work injury.

He opined that Petitioner had adequate treatment for the work-related meniscal tear. He felt that there was a chance Petitioner may eventually require total knee arthroscopy but given his age and changes on x-rays, any recommendation for unicompartmental arthroplasty or total knee replacement was contraindicated at the present time. He opined that this was in no way related to the accident (RX 5).

At the request of his attorney, Petitioner was examined by Dr. Scott Rubenstein on October 15, 2007. His reports were admitted as Petitioner's Exhibit 12. Physical examination of the knee revealed full range of motion without instability, swelling or effusion. He had tenderness a little bit of patellofemoral crepitus. Ankle examination showed mild persistent swelling over the lateral ankle ligaments, some loss of motion in terms of inversion and eversion. With respect to the knee, Dr. Rubenstein commented that his experience with a direct blow to the knee, repeat arthroscopy a year or two later finds significant progression of chondral changes. He recommends a series of hyaluronic acid injections and a repeat arthroscopy if that is unsuccessful. With respect to the ankle, he felt that Petitioner may have some chronic ligamentous instability and/or impingement syndrome. The plan was to get an MRI and evaluate his ligamentous structures. He suggested a possible injection of anesthetic and if successful ankle arthroscopy may be in order. Dr. Rubenstein opined that the condition of the right knee and right ankle is related to the original injury (PX 12, 14-15).

On January 25, 2008, Petitioner sustained a burn injury while employed by Respondent. He was disabled from January 26, 2008 through March 30, 2008. The matter was filed as case 08 WC 14133. The matter was tried on September 3, 2010. The Arbitrator's award of 15% loss of use of a man as a whole was affirmed by the Commission on July 22, 2011. The Arbitrator found that Petitioner's employment opportunities were significantly limited, supported by the fact that he has been unable to secure work since the Respondent laid him off nearly 18 months ago (RX 10).

Dr. Karlsson performed a medical records review addressing Petitioner's right ankle. The February 19, 2008 report was admitted as Respondent's Exhibit 6. Based upon his review of the records, he found no need for further care of the ankle and opined that there was an apparent pre-existing problem in the area of the sinus tarsi. He did not find any reason to restrict Petitioner from working because of his right ankle.
Dr. Karlsson subsequently performed a Section 12 examination of Petitioner's right ankle on April 21, 2008 (RX 7). Petitioner gave a history of having continued problems with his ankle and of the condition getting worse. Petitioner stated his ankle swelled up at times. Petitioner described the surgery for a lump on the right ankle in 2006. He stated that this surgery was unrelated to his work injury. He was told that it was because of his diabetes. Dr. Karlsson's diagnosis was mild osteoarthritis of the right ankle. Dr. Karlsson opined that this is unrelated to any work injury. He opined that Petitioner could work without restrictions or additional care.

Petitioner continued treatment with Dr. Tarandy. A repeat MRI of the right knee was performed on December 31, 2008 (PX 1, 101). The MRI was interpreted as demonstrating effusion, thinning of the cartilage on the medial femoral condyle, a complex medial meniscus tear and degenerative spur formation. Dr. Tarandy performed arthroscopic surgery on February 20, 2009 (PX 1, 151). The post operative diagnosis was a medial meniscal tear, Grade 3 chondromalacia of the medial compartment, and a partial tear of the ACL. The operative report documents a large posterior horn medial meniscal tear.

Dr. Tarandy ordered a repeat MRI of the right ankle which was performed on March 17, 2009. The MRI noted a lesion within the medial talar dome probably representing a subchondral cyst (PX 8, 68). Dr. Tarandy released Petitioner to return to work with the same light duty restrictions on May 20, 2009 (PX 10, 5-6).

Petitioner received short term disability during his period of lost time (RX 13). Lon Hollis testified for Respondent. He has worked for Respondent in Human Resources since 1998. He is familiar with the group benefit plans in place for employees. The medical coverage was with Blue Cross/Blue Shield. The employer contributes to this plan. There was a short term disability plan in place. It would begin after a seven day waiting period. It paid 60% of earning or a $400 per week maximum.

Petitioner testified he took the restrictions to his employer and was told that they did not have light duty for him. He was told this by Silvia Perez, the secretary to Mr. Hinderlider in Human Resources. Petitioner went to unemployment and applied for benefits in May, 2009. He was approved for unemployment benefits. He received them for about two years. During this time, he testified that was actively looking for work. He completed forms for unemployment showing where he applied. He was assigned someone from Workforce Development to assist him in his job search.

Petitioner continued regular follow up visits with Dr. Tarandy for right knee and ankle complaints. On August 12, 2010, Dr. Tarandy recommended a total knee arthroplasty for a diagnosis of post traumatic arthritis (PX 10, 10). The surgery was not authorized. Petitioner underwent a series of Synvisc injections as well as cortisone injections (PX 10).

Petitioner had surgery on his left foot to excise a mass on September 23, 2010 by Dr. Lisowsky. Petitioner also had a cortisone injection for left heel pain (PX 8, 26).

Petitioner testified that he found a job around April 1, 2011 doing welding. This was with a temporary agency. He took a physical for that job. The job required bending, twisting, lifting heavy things, a lot of physical work. He worked 10 hours a day. He quit after a week and a half because he could not do the job. His knee was swollen. Dr. Tarandy's records include a March 16, 2011 telephone encounter stating Petitioner recently started a new job and is working 10 hours. He reported pain and asked what Dr. Tarandy thought he should do. He was advised that he was cleared for work as tolerated. On March 17, 2011, Petitioner saw Dr. Tarandy reporting pain at the end of the day of 9/10. He reported he had just gone back to work but feels he cannot do it because of his pain. Petitioner received a cortisone injection into the right knee. The examination notes full pain free range of motion without tenderness in the right ankle (PX 10, 18-19). Petitioner reported to Dr. Tarandy on May 2, 2011 that he was unable to stand for 10 hours per day and quit his welding job. The diagnosis was posttraumatic arthritis on top of osteoarthritis. The recommendation was for total knee replacement (PX 10, 20-21).

Petitioner testified he found a job at Wisconsin Miniature Precision Components at the end of April or beginning of May, 2012. He is still employed there. He earns $11.96 per hour. Petitioner is a molding injection machine operator. He works five days per week, eight hours per day. He stands on his feet all day. He does some light lifting.

Petitioner testified he has been offered other work doing drywall, construction. He has skill to do drywall, but is not able to climb, twist or lift anything heavy because of his knee. He was offered drywall work three years ago and again last week by Rafael Mora. He has also been offered work with a guy that paints floors.

Petitioner testified that he had an injury at MPC in June, 2012. He caught his foot on a pallet on June 4, 2012, and injured his shoulder when he tried to catch himself (PX 10, 39-40). Petitioner treated for shoulder pain as well as headaches, dizziness and neck pain. Petitioner had a left shoulder and cervical MRI on November 20, 2012. An EMG found cervical radiculopathy. He treated with Dr. Panchal for his cervical problem with a recommendation for surgery. He had conservative treatment for his shoulder and had a rotator cuff repair on March 3, 2014 (PX 10). Petitioner was on light duty for these complaints. He testified that he was off work about three months and then went back to work.

Petitioner continues to treat with Dr. Tarandy for his right knee and ankle. Dr. Tarandy's records document ongoing visits through April, 2015 (PX 10). Petitioner testified that he saw Dr. Tarandy last week. He sees Dr. Tarandy every month to six weeks. Petitioner testified he gets injections and is prescribed pain medication. Dr. Tarandy continues to recommend a knee replacement. Petitioner testified that he still has pain in his knee and ankle. He cannot move his ankle from side to side. It hurts when he walks. Driving hurts.

Petitioner was seen by Dr. Rubenstein again on February 24, 2012. Examination of the knee showed significant palpable osteophytes along the medial ridge of the femur. He had full range of motion of the knee. There was no instability but a significant medial spacer loss and tenderness along the medial joint line. As far as his ankle was concerned, he had pain laterally over the ligaments but no instability. Dr. Rubenstein felt the petitioner should undergo a knee arthroplasty to try to resolve the post traumatic knee arthritis and that he have an arthroscopic procedure to his ankle. He opined that both injuries are directly related to the work accident (PX 12).

The evidence deposition of Dr. Tarandy was taken on December 16, 2009 (PX 15, RX 11). He testified that he initially saw Petitioner for the injury in question November 16, 2005. He testified that Petitioner gave him a history of injuring his knee and ankle when he was run over by the forklift. He initially diagnosed a meniscal tear and a sprain of the right ankle. He testified that an MRI was done that revealed a meniscal tear and that he performed surgery on November 25, 2005, a right knee arthroscopy, partial meniscectomy and incision of medial synovial plica. He testified that he initially released the petitioner to full duty on December 14, 2005. Petitioner's right knee became symptomatic again. On March 29, 2006, he put Petitioner on restricted duty. The restrictions have not been altered since that date. He testified that after the release to return to work, Petitioner continued to be symptomatic with complaints of ankle and knee pain. He testified that an MRI of the right ankle on January 19, 2006 revealed no diagnostic abnormalities other than degenerative changes. A second MRI of the ankle was performed on March 27, 2009 and was no more helpful. He opined that Petitioner's diagnosis was lateral ankle impingement. He referred Petitioner to Dr. Samuelson for treatment of the right ankle. He testified that because of ongoing symptomology, a repeat MRI of the right knee was done December 31, 2008 that showed cartilage thinning of the medial femur condyle with swelling, complex tear of the medial meniscus and degenerative spur formation medially. He recommended a repeat knee arthroscopy. He performed a right knee arthroscopy and a partial medial meniscectomy on February 20, 2009. He testified that Petitioner continued to be symptomatic in the right ankle and knee. He opined that Petitioner has failed conservative treatment and that the only definitive management would be a knee replacement. He opined that the injury was in part responsible for the need for a knee replacement related.

On cross examination, Dr. Tarandy admitted that Petitioner did not give him a history of his ankle actually being struck. He testified that he did not review the accident report or records from the emergency room. The only finding on the ankle was a 1 cm. abrasion over the lateral aspect of the ankle. He admitted that the

findings on the January 19, 2006 MRI of the ankle were degenerative in nature. He testified that there was no way to date those findings to the injury in question. He testified in terms of the knee surgery performed in November, 2005, the tear was at the anterior horn. In November, 2005 operative report the posterior horn was noted to be intact as was the anterior cruciate ligament. He testified that when he did the surgery in November, 2005, there was no way for him to determine what caused the tear and there was no way for him to determine how long the tear was there. There was already evidence of arthritis in the knee on November 25, 2005. It is a progressive condition. He testified that the restrictions he put on Petitioner in March of 2006 were based on his subjective complaints. Dr. Tarandy testified that the surgery on February 20, 2009 revealed a tear to the posterior horn of the medial meniscus. He testified that the February 20, 2009 surgery found a tear to the anterior cruciate ligament. He testified that there was no way to determine the cause of the tears found during the 2009 surgery. He testified that there was no way to document based upon the operative reports that the injury played a part in the need for his knee replacement. He admitted that Petitioner never gave him a history of a twisting injury to his ankle.

The evidence deposition of Dr. Troy Karlsson was taken on January 11, 2010 (RX 8). Dr. Karlsson testified to his examinations and physical findings. He testified that he reviewed x-rays of the right and left knees, and both knees revealed some slight spur formation throughout, basically some mild arthritic changes without any severe changes being seen. He testified that he did review the MRI's of the knee from November, 2005 and July, 2006. They revealed some signal in the posterior horn which would be consistent with a tear. He testified that at the time of his initial examination, he diagnosed mild osteoarthritis of the right knee and chondromalacia patella of the right knee. He opined that as a result of Petitioner's work injury, he did have a meniscal tear for which he had adequate treatment. He opined that Petitioner may at some time require a total knee replacement but did not feel that Petitioner was a candidate for the procedure at the time of his examination and that the need for a total knee replacement would not be in any way related to the injury. He opined that at the time that he initially saw him, Petitioner could do regular duty without any restrictions.

With respect to the ankle, he initially did a records review and then had an opportunity to evaluate Petitioner. He testified that the MRI of the ankle revealed some slight alterations in the sinus tarsi, mild degenerative cyst in the adjacent talus and no other diagnostic abnormalities. He testified that he did not see any tendon deficiency damage to the ulnar cartilage or major abnormalities on the MRI. He noted the surgery of the sinus tarsi area which is the lateral aspect of the foot and ankle. He testified that Petitioner did not need any further medical care or treatment for the ankle. He testified that there was evidence of a pre-existing problem in the area of the sinus tarsi which is really the only area that anything abnormal was found. He did not see a reason why Petitioner could not return to regular work because of the ankle problem. He did not find any bony abnormality in his foot or ankle and noted the circumference of both ankles were the same. He found only a slight loss of motion of the right ankle when compared to the left. He testified that all of the tendons around the ankle seem to be working fine. He diagnosed Petitioner with mild osteoarthritis of the ankle. He testified that the findings on the MRI of the ankle were not related to the alleged injury.

As to the operative report of February 20, 2009, he noted that there was a tear to the posterior horn of the medial meniscus. In reviewing the operative report from 2005, he noted that the posterior horn was intact. He testified that the tear found in 2009 was not related to the injury of October, 2005 or the surgery that was performed November 25, 2005. He noted that in 2005, the anterior cruciate ligament was evaluated and found to be intact; and that in his opinion there was no relationship between the tear of the anterior cruciate ligament in 2009 and the injury of October 4, 2005. He found no relationship between the injury of October 16, 2005 and the need for a knee replacement. He admitted that Petitioner never gave him a history of a twisting injury

to his ankle. He testified that his understanding was that there was a twisting component to the injury. The injury could have caused a temporary exacerbation of the preexisting condition. Synovial impingement symptoms usually include a clicking in the lateral aspect of the ankle.

The evidence deposition of Dr. Rubenstein was taken January 9, 2013 (PX 16). Dr. Rubenstein testified that Petitioner gave him a history of injuring his knee and ankle when he was run over or knocked over by a forklift. Petitioner was complaining of persistent pain in his ankle and knee. He testified to surgery in November, 2005 and to a second surgery. Grade III chondromalacia of the patellar joint could cause pain and discomfort. Dr. Rubenstein testified that when he last saw Petitioner in 2012, he was having significant discomfort in his knee and difficulty with prolonged standing and walking. He testified that he did not think there was a mandatory need to restrict him completely, but as tolerated. If Petitioner was having a lot of pain, he should back off those activities that would cause him pain. He testified that Petitioner was complaining of symptoms that sound like either ankle impingement or a chronic ligamentous injury around the lateral ankle ligaments. He opined that Petitioner would need a knee replacement and ankle arthroscopy in the future. He testified that the need for a knee replacement is based on the patient's subjective complaints and adequate objective findings. He testified that when he reviewed the operative report from November 25, 2005, the surface of the posterior horn of the medial meniscus was intact. He testified that at the time of surgery the anterior horn of the medial meniscus was found to be torn. At the time of surgery on November 25, 2005, the surgeon did have an opportunity to observe the anterior cruciate ligament. It was not torn. He testified that in February, 2009, the posterior horn of the medial meniscus was torn. This could be a contradictory or progressive finding. It is hard to know.

He testified that in 2007, Petitioner had a full range of motion of the knee without any instability, swelling or effusion. He testified that he did not note any altered gait. He testified that in 2012, Petitioner had full range of motion of the knee with no instability. He agreed with the findings of the radiologist of the January 19, 2006 MRI of the ankle.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner sustained an undisputed accident on October 16, 2005 when he was struck on the right leg by a forklift. Petitioner is claiming ongoing complaints, treatment and additional treatment sought for the right knee and ankle. Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury.

Petitioner's initial emergency treatment documents immediate complaints in the right knee. An MRI was performed in November, 2005 and Dr. Tarandy performed arthroscopic surgery on November 25, 2005 finding a tear of the anterior horn of the medial meniscus. Respondent has not disputed this initial diagnosis, treatment and lost time. Respondent does dispute subsequent treatment and surgery to the right knee and all claims with respect to the right ankle. Respondent submits the opinions of Dr. Mercier and Dr. Karlsson as well as the cross examination of Dr. Tarandy during his deposition to support these denials.

Right Knee: Although Petitioner has a prior surgery to the left knee as a result of an earlier workplace injury, there is no evidence of prior treatment or complaints to the right knee before the accident on October 16, 2005. Following the accident, Petitioner advance immediate complaints in the right knee. An MRI on

November 4, 2005 revealed high signal intensity in the posterior horn of the medial meniscus. Dr. Tarandy read the MRI as showing a posterior horn medial meniscus tear. He recommended surgery. Dr. Karlsson also stated that the MRI revealed high signal in the posterior horn of the medial meniscus consistent with a tear and some slight degenerative changes. Dr. Tarandy's November 25, 2005 operative report reflected a resection of the anterior horn of the medial meniscus and a notation that the posterior horn was intact.

Thereafter, Petitioner continued to advance complaints in the right knee. Dr. Tarandy placed Petitioner on work restrictions. A repeat MRI performed in July, 2006 noted changes consistent with the operative report, new onset low grade injury to the collateral ligament and new onset of mild chondromalacia medial joint compartment. Dr. Tarandy noted that Petitioner had developed some degenerative changes with respect to the medial side of the knee. He diagnosed post traumatic arthritis. On April 19, 2007, Dr. Tarandy states Petitioner has failed conservative management and recommends surgery. He states Petitioner may have a re-tear of the meniscus. Surgical authorization was denied. On May 29, 2007, Dr. Tarandy assessed right knee pain and post traumatic arthritis. He stated that Petitioner requires arthroscopy and likely arthroplasty. Since surgery was denied, he finds Petitioner at maximum medical improvement and makes the restrictions permanent.

Thereafter, Petitioner continued with regular treatment with Dr. Tarandy for his right knee complaints through his second surgery on February 20, 2009. A repeat MRI of the right knee was performed on December 31, 2008 demonstrated effusion, thinning of the cartilage on the medial femoral condyle, a complex medial meniscus tear and degenerative spur formation. Dr. Tarandy's post operative diagnosis was a medial meniscal tear, Grade 3 chondromalacia of the medial compartment, and a partial tear of the ACL. The operative report documents a large posterior horn medial meniscal tear.

Petitioner has continued to advance complaints in his right knee and continues with ongoing care with Dr. Tarandy including viscosupplementation and periodic cortisone injections. The diagnosis remains posttraumatic arthritis on top of osteoarthritis. Dr. Tarandy continues to recommend a total knee replacement. Dr. Tarandy testified that Petitioner's condition of ill being in the right knee including the need for the February 20, 2009 surgery and his continued treatment, diagnosis and recommendation for a knee replacement are in part related to the accidental injury sustained on October 16, 2005. Dr. Rubenstein felt Petitioner should undergo a knee arthroplasty to try to resolve the post traumatic knee arthritis. He opined that this is directly related to the work accident.

Dr. Mercier saw Petitioner February 3, 2006 and April 11, 2006. He initially suggested return to work with restrictions pending his review of additional records. In April, 2006, Dr. Mercier notes non-anatomical complaints. He finds no objective evidence of disability, only subjective complaints and releases Petitioner to regular duty at maximum medical improvement.

Dr. Karlsson examined Petitioner on September 6, 2007, with respect to the right knee. He stated that the November 4, 2005 MRI revealed high signal in the posterior horn of the medial meniscus consistent with a tear and some slight degenerative changes. He diagnosed a traumatic meniscal tear which was appropriately treated arthroscopically and underlining osteoarthritis unrelated to the work injury. As to the operative report of February 20, 2009, he noted a tear to the posterior horn of the medial meniscus. He opines it is not related to the injury of October, 2005. It was also his opinion there was no relationship between the tear of the anterior cruciate ligament in 2009 and the injury of October 4, 2005. He found no relationship between the injury of October 16, 2005 and the need for a knee replacement.

It is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. Petitioner had no prior complaints or treatment to the right knee before the October 16, 2005 accident. He has had ongoing and consistent treatment thereafter. Review of the treating medical records and evaluation reports reveals subjective complaints that are greater than the objective findings documented. Petitioner's level of pain reported seems disproportionately high compared with the physical capacity he demonstrates. Nevertheless, there are sufficient objective findings documented by Dr. Tarandy to support the treatment rendered and a documented level of subjective pain. The Arbitrator finds Dr. Rubenstein's statement that the tear to the posterior horn of the medial meniscus could be a progressive finding supported by the MRI findings which consistently found damage at the posterior horn as noted by the radiologist, Dr. Tarandy and Dr. Karlsson.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Reviewing the totality of the medical evidence, the Arbitrator finds the opinions of Dr. Tarandy and Dr. Rubenstein, coupled with Petitioner's prior good health in the right knee and subsequent continuous symptoms persuasive that Petitioner's ongoing condition of ill being in the right knee is causally connected to the accidental injuries sustained on October 16, 2005.

Right Ankle: The Centegra emergency room records do not include any complaints in the right ankle. The examination of the entire right lower extremity from the foot to the hip reveals only soft tissue tenderness in the knee. X-rays were taken of the right knee and the diagnosis was a contusion to the right knee. The accident reports prepared do not include any mention of the right ankle.

Petitioner complained of injuring his ankle to Dr. Tarandy on November 16, 2005. Dr. Tarandy testified that the only finding on the ankle was a 1 cm. abrasion over the lateral aspect of the ankle. There is no mention of this finding in the emergency room examination. He initially diagnosed a sprain. The January 19, 2006 MRI of the ankle showed no diagnostic abnormalities but subtle signal alterations in the sinus tarsi and a small degenerative cyst in the talus. Dr. Tarandy read the MRI as showing only minor degenerative changes. Dr. Mercier examined Petitioner's ankle in February and April, 2006 and found little objectively, with non-anatomical subjective complaints. He also found the MRI did not reveal any disabling pathology. He also initially diagnosed an ankle sprain.

Petitioner also has documented unrelated conditions in both feet. Petitioner was diagnosed with diabetes in 2004. The records note that this is poorly controlled. On March 1, 2006, Dr. Mundozie notes Petitioner's diabetic neuropathy is the same with pain and tingling numbness in the right side. On March 28, 2006, Petitioner complained of numbness and tingling in his feet with burning at night. Petitioner was referred to Dr. Hyderi, a podiatrist. Dr. Hyderi diagnosed diabetic neuropathy, bilateral ganglion cysts and bilateral foot pain. He recommended surgical removal of the cysts, right foot first. The Petitioner had the right foot surgery on April 20, 2006. Follow up with Dr. Staskus on May 9, 2006 notes Petitioner is still having pain in the right foot. He reported pain of 6/10 and a burning sensation. Petitioner had surgery on his left foot to excise a mass on September 23, 2010 by Dr. Lisowsky. Petitioner also had a cortisone injection for left heel pain.

Petitioner has degenerative changes in his foot and an unrelated diabetic neuropathy. If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting 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. Dr. Samuelson diagnosed a possible right ankle synovial impingement and recommends a diagnostic arthroscopy of the ankle. Dr. Rubenstein and Dr. Tarandy echo this diagnosis.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Petitioner's medical opinions are based upon Petitioner's statements that he initially injured his ankle at the time of the accident, a fact not supported by the initial treating records. The Arbitrator also notes that there are few objective findings with respect to the ankle examinations. The MRI studies showed only degenerative changes with no diagnostic pathology. Although Petitioner, on some occasions complains of clicking in the ankle, there is no such finding on examination. There are also examinations noting full pain free range of motion and no swelling. Dr. Mercier notes non-anatomic subjective complaints.

Based upon the totality of the evidence, the Arbitrator finds the opinions of Dr. Mercier and Dr. Karlsson's diagnosis of mild osteoarthritis of the right ankle and his opinion that this is unrelated to any work injury persuasive.

Based upon the record as a whole, the Arbitrator finds that the Petitioner has proved by a preponderance of the evidence that his condition of ill being in the right knee consisting of a tear of the anterior horn of the medial meniscus and post traumatic arthritis including a the subsequent repair of tear of the posterior horn of the medial meniscus, chondromalacia and an ACL repair is causally connected to the accidental injuries sustained on October 16, 2005. The Arbitrator further finds that Petitioner has failed to prove by a preponderance of the evidence that he suffered any condition of ill being to the right ankle as a result of the accidental injuries sustained on October 16, 2005.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Petitioner is seeking payment of medical bills for treatment rendered. Petitioner has submitted billing from Centegra Hospital (PX 2), Town Square Anesthesia (PX 3), Woodstock Imaging (PX 4), McHenry County Orthopedics (PX 7), Mercy Harvard Hospital (PX 9), Mercy Woodstock Medical Center (PX 11), and Illinois Bone & Joint Institute (PX 14). Respondent offered the Payment History (RX 9). The parties further stipulated that if the Arbitrator finds the bills causally related and reasonable, that Respondent shall receive credit for whatever payments made under Workers' Compensation or under Section 8(j). Respondent will reimburse Petitioner for out of pocket and co pay. If providers accepted Blue Cross/Blue Shield, Respondent will be liable for the lesser of the fee schedule or what the providers accepted (Tr., 74-75).

Based upon the Arbitrator's finding with respect to Causal Connection, any bills related to treatment of the right ankle are not causally connected to the accidental injuries sustained on October 16, 2005. Dr. Samuelson's treatment and the related bill (PX 7) would therefore not be related to the accident.

The Arbitrator finds that Dr. Rubenstein did not provide treatment, but rather was an evaluator at the request of Petitioner's attorney. The bill from Illinois Bone & Joint Institute is therefore not awarded.

The remaining bills are for providers who, at least in part, treated the condition of ill being in the right knee. Based upon the Arbitrator's finding with respect to Causal Connection, any such treatment for the right knee is causally connected to the accidental injuries on October 16, 2005. Consistent with the Arbitrators finding with respect to causal connection and supported by the medical records admitted, the Arbitrator finds that such treatment to the right knee was reasonable and necessary. Based upon this finding, the Arbitrator has reviewed bills submitted and the payments and stipulations entered, and finds as follows with respect to the remaining claimed medical bills:

Centegra Hospital (PX 2): The Exhibit includes billing for related and unrelated admissions. The outstanding balance of $7.979.00 for the February 20, 2009 admission is reasonable, necessary and causally connected to the October 16, 2005 accident.
Town Square Anesthesia (PX 3): The Exhibit is a December, 2005 billing for the November 25, 2005 surgery which is not disputed by Respondent. The Payment log confirms that this bill was paid by Respondent on March 9, 2006 and therefore is not awarded.
Woodstock Imaging (PX 4): The Exhibit is a November 7, 2005 billing for an x-ray to the knee on October 17, 2005 which is not disputed by Respondent. The $42.00 bill is reasonable, necessary and causally connected to the October 16, 2005 accident.
Mercy Harvard Hospital (PX 9): The Exhibit includes multiple admissions and treatment, most of which is not addressing the condition of ill being in the knee and therefore is not causally related to the accident on October 16, 2005. Any causally connected treatment has been paid by either Workers' Compensation or Blue Cross/Blue Shield. Pursuant to the stipulation of the parties, no bills to this provider are awarded.
Mercy Woodstock Medical Center (PX 11): The Exhibit is 104 pages of Account Charge Activity Detail and Account Summaries from October 16, 2005 though August 5, 2015. The detail does not contain the exact services rendered or specifics on payments made. The dates of service rendered and the doctors providing service indicate that a portion of the bill would be for services unrelated to the right knee. Despite extensive review of the document, the Arbitrator cannot determine the exact amounts which are related and may be outstanding. Therefore, pursuant to the stipulation of the parties, the Arbitrator finds that to the extent there are unpaid bills for services related to the condition of ill being of the right knee; said billing is reasonable, necessary and causally related to the accident.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services for treatment of the condition of ill being in the Petitioners right knee, pursuant to the medical fee schedule to Centegra Hospital, Woodstock Imaging and Mercy Woodstock Medical Center, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for any payments made under Workers' Compensation or a group plan pursuant to Section 8(j) of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation and (N) Credit, the Arbitrator finds as follows:

It is undisputed that Petitioner was temporarily disabled beginning with his knee surgery on November 25, 2005. Petitioner was seen postoperatively by Dr. Tarandy. On January 3, 2006, Dr. Tarandy discussed a tentative return to work on February 13, 2006. On February 7, 2006, Dr. Tarandy continued Petitioner off work

for one more month. On February 23, 2006, Dr. Mercier felt that Petitioner could, at this point in time, return to work, no lifting over 15 to 20 pounds for two weeks. Dr. Tarandy released Petitioner to return to work with restrictions on March 30, 2006. Petitioner returned to his pre-injury job as a transporter for Respondent on that date. The Arbitrator finds that Dr. Tarandy's records support Petitioner's entitlement to temporary total disability from November 25, 2005 through March 29, 2006, a period of 18 weeks.

Petitioner has alleged eligibility for TTD benefits on the 6th, 7th, 11th, and 31st of July 2006 as well as the 1st, 2nd, 7th, and 8th of August 2006. The Arbitrator finds that Petitioner failed to prove his eligibility for benefits during that time. With the exception of July 6, 2006 and July 7, 2006 there is no medical record authorizing Petitioner to be off of work. As to July 6, 2006 and July 7, 2006, Dr. Tarandy's chart note of July 19, 2006 records that Petitioner reported "2 bad days" but Dr. Tarandy allowed Petitioner to continue to work with the same restrictions. No medical justification for lost time for these two days was given other that Petitioner's claim of increased subjective complaints. Accordingly, the Arbitrator finds that Petitioner has failed to prove entitlement to temporary compensation for any of these periods.

Petitioner underwent a second surgery on his right knee on February 20, 2009. Petitioner was disabled until Dr. Tarandy released him to return to work on May 24, 2009. Petitioner was given the same restrictions he had worked under since March, 30, 2006. Pursuant to the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that this period of total disability is causally connected to the accidental injuries sustained on October 16, 2005. The Arbitrator finds that Petitioner is entitled to TTD benefits for the period from February 20, 2009 through May 23, 2009, a period of 13 2/7 weeks.

Petitioner seeks additional temporary compensation thereafter for the period Petitioner was unemployed through his obtaining his current job. The Petitioner testified that when he tendered his restrictions to Respondent on May 24, 2009, he was advised that Respondent "had no work for him." Petitioner testified that he immediately applied for and began to receive unemployment benefits. Petitioner provided only minimal testimony as to his job search without documentation as to the nature of the search or the number or type of positions applied for.

Dr. Tarandy testified that Petitioner had been under the same restrictions since his original release on March 30. 2006. At that time, Petitioner testified that he returned to his regular job as a transporter for Respondent and continued in that position through 2007. Petitioner testified he then became a Notcher. There is no evidence that this job change was caused by his restrictions. Petitioner testified that in this position, he continued to be on his feet most of the day and did lifting, bending and twisting. Petitioner's release in May, 2009 returned his to the same physical capacity that he had previously performed his regular job duties for Respondent. Petitioner testified he obtained a welding job in 2011, but quit because he was on his feet all day. The Arbitrator notes that his restrictions were not changes in 2011 and that he had worked all day on his feet from March 2006 through February, 2009. The Arbitrator also notes Dr. Tarandy's statement in 2011 that Petitioner could work as tolerated, not specifically stating he could not do heavier work. Petitioner's current job, which he has performed since 2012, also requires him to be on his feet for 40 hours per week.

On September 21, 2006 Dr. Tarandy stated that Petitioner was at maximum medical improvement. Dr. Tarandy first raised the option of a knee replacement surgery in 2007. When this was not authorized by Respondent he stated that since surgery was denied, he finds Petitioner at maximum medical improvement. Since 2009, Petitioner is in that same position with Dr. Tarandy continuing to recommend a knee replacement, denied by Respondent, and providing symptomatic relief.

During the disputed period from 2009 to Petitioner's 2012 current employment, Petitioner's work capacity is also intertwined with multiple unrelated conditions. Petitioner has unrelated conditions with respect to both feet resulting in surgery in 2006 and 2010. He also has been treated for additional right foot complaints which the Arbitrator has found not causally connected to the accident. Further, he suffered a burn injury in 2008 which resulted in work restrictions as to high temperature environments and exposure to caustics. He is also on ongoing pain management from that injury.

Based on the evidence submitted, the Arbitrator finds that Petitioner has failed to prove that, as a result of the accidental injuries sustained on October 16, 2005, he was unable to return to the duties of his regular job with Respondent, and that any lost time after his release to return to work with the same restrictions on May 23, 2009 precluded him from returning to his regular job. The Arbitrator also finds that Petitioner has failed to prove that he conducted a sufficient job search and that his inability to find work was related to the condition of ill being in his left knee. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he was entitled to temporary total disability after his release to return to work on May 23, 2009.

The parties stipulated that Petitioner received temporary compensation of 6,729.80. Petitioner testified he received short term disability benefits following the February 20, 2009 surgery. Mr. Hollis testified that this program was paid for by Respondent and therefore would qualify as a benefit under Section 8(j) if the Act. Respondent's exhibit 13 documents STD payments, net of taxes withheld, of $4069.72 for which Respondent is entitled to credit.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to 31 2/7 weeks of compensation for the period of November 25, 2005 through March 29, 2006 and February 20, 2009 though May 23, 2009. Respondent shall be given a credit of $6,729.80 for TTD and $4,069.72 for other benefits, for a total credit of $10,799.52.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's date of accident is before September 1, 2011 and therefore the provisions of Section 8.1b of the Act are not applicable to the assessment of partial permanent disability in this matter.

Petitioner suffered accidental injuries arising out of his employment on October 16, 2005 when he was struck on the right leg by a forklift. Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner suffered injury to his right knee resulting in the initial surgery on November 25, 2005 for a medial meniscus tear and medial synovial plica and continuing care included the second surgery on February 20, 2009 for a medial meniscus tear and ACL repair. Petitioner continues to be diagnosed with posttraumatic arthritis and chondromalacia. Dr. Tarandy continues to recommend a total knee arthroplasty.

Petitioner has continued to advance complaints of significant pain in his knee. Dr. Rubenstein's examination on February 24, 2012 showed significant palpable osteophytes along the medial ridge of the femur with full range of motion of the knee. There was no instability but a significant medial spacer loss and tenderness along the medial joint line. Recent physical examinations by Dr. Tarandy note a varus alignment with moderate crepitus and mild effusion. There is no instability.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that, as a result of the accidental injuries sustained on October 16, 2005, Petitioner has sustained a loss of use of the Right Leg to the extent of 35%.

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ 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

Donise Brown,
Petitioner,

vs.

No. 06 WC 19311,
08 WC 38611

State of Illinois,
Illinois State University,
Respondent.

17IWCC0431

DECISION AND OPINION ON REVIEW PURSUANT TO §19(h) and §8(a)

This matter comes before the Commission on Petitioner's §19(h) and §8(a) Petition, which alleges material increases in her disabilities and seeks additional medical, temporary total disability and permanent partial disability benefits since Arbitrator White's two February 11, 2011 decisions. The Arbitrator awarded Petitioner, for her February 3, 2004 accident (06 WC 19311), 10% loss of use of her left leg for an aggravation of knee arthritis and a possible meniscus tear. The Arbitrator awarded Petitioner, for her July 8, 2008 accident (08 WC 38611), 8% loss of use of her right hand and 5% loss of use of her left, for unoperated carpal tunnel syndrome. No review was filed by either party in either case. Petitioner timely filed the instant §19(h)/§8(a) Petition on December 6, 2011. Following numerous continuances, a hearing was held before Commissioner Luskin on December 12, 2016.

Left Knee Claim (06 WC 19311):

At the December 16, 2010 arbitration hearing, Petitioner testified that while employed by Respondent as a janitor on February 3, 2004, her left knee gave out while she was pushing a floor scrubber. She treated conservatively with Dr. Mark Hanson, and missed no time from work as a result of that accident.

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At the §19(h)/§8(a) hearing, Petitioner testified that she continued receiving treatment from Dr. Hanson after the arbitration hearing, and eventually underwent left knee replacement surgery in March 2014. She was off work from March 17, 2014 until July 7, 2014. Since the surgery, she still experiences aching in her left knee after walking.

Dr. Mark Hanson testified at a 2013 deposition that he first saw Petitioner as a patient on June 28, 2004. X-rays taken then showed mild valgus alignment and lateral and patellofemoral arthritis. He treated Petitioner with therapy, medication and a patellar sleeve. After October 28, 2004, Dr. Hanson did not see Petitioner for her left knee for almost seven years, until August 13, 2011. Then, she presented with a history of a new injury, stating she aggravated her knee while moving furniture on August 19, 2011. Dr. Hanson informed Petitioner that a knee replacement would be appropriate. He provided opinions that Petitioner has severe left knee osteoarthritis, and her February 2004 and August 2011 work accidents could or might have aggravated and accelerated this condition. On cross-examination, Dr. Hanson admitted he was wrong in 2004 to have reported that Petitioner had left knee arthritis; he did not have independent knowledge of Petitioner's job duties, and he did not know when Petitioner tore her meniscus, though he "guessed" it was when she used the scrubber.

Dr. Timothy Farley performed a Section 12 examination at Respondent's request. He testified at an April 2014 deposition that he examined Petitioner's left knee on March 5, 2013. Then, Petitioner described two workers' compensation claims involving her left knee, on February 3, 2004 and on August 19, 2011. Both occurred while she was using a floor scrubber. Petitioner also admitted moving furniture on August 19, 2011. Following her February 2004 injury, she was treated without surgery and was returned to full duty work, though with some episodic pain and discomfort. Dr. Farley noted Petitioner's X-rays showed lateral femoral condyle hypoplasia, a condition and risk factor for developing osteoarthritis in the lateral compartment of her knee. He opined Petitioner had a pre-existing genetic condition of her knees which predisposed her to the advanced arthritis. He further opined her current left knee condition was neither causally related to her February 3, 2004 or August 19, 2011 work accidents, nor aggravated or accelerated by her work duties.

Dr. Hanson's records of Petitioner admitted into evidence at the §19(h)/§8(a) hearing showed he performed a total left knee arthroplasty on March 17, 2014 and that post-operatively, Petitioner did well. He released Petitioner with permanent work restrictions of no kneeling and no ladders on October 7, 2014. He last saw her for left knee pain of a few months' duration in August 2016.

The Commission concurs with and finds more credible the opinions of Dr. Farley and therefore affords greater weight to his opinion that Petitioner's current left knee condition is not causally related to her February 3, 2004 injury, and that her need for a knee replacement was not caused nor accelerated by that injury. Both Drs. Hanson and Farley acknowledged Petitioner had a pre-existing condition, congenital lateral femoral condyle hypoplasia, which predisposed her to developing arthritis. The Commission finds significant the fact that Petitioner missed no time from work because of her February 3, 2004 work injury, which Dr. Hanson diagnosed then as only medial knee pain. Following Petitioner's October 2004 visit with Dr. Hanson, she did not return to see him for almost 7 years. When she finally did in August 2011, she reported having had a new traumatic injury. Based upon this, the Commission finds that Petitioner has not proven as causally related any recurrence of or material increase in her left leg disability, pursuant to §19(h) of the Act. The Commission further finds Petitioner has not proven entitlement to any post-arbitration benefits relating to her left leg condition, pursuant to §8(a) of the Act.

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Carpal Tunnel Claim (08 WC 38611):

At the December 16, 2010 arbitration hearing, Petitioner testified she began noticing numbness, tingling and stiffness in her hands around July 2008. At that time, she used her hands in her job to mop, sweep, vacuum, wax, clean, dust, pick up trash and place items in recycle bins. She treated with Dr. Jerome Oakey, who provided injections to her hands. She wore wrist braces for a while but stopped because her hands got better.

At the §19(h)/§8(a) hearing, Petitioner testified that since the arbitration hearing, she has noticed a lot of numbness and tingling in both hands into her arms after doing a lot of mopping or dusting. She has difficulty sleeping and has less strength in her hands. In 2008, Dr. Oakey recommended hand surgery. She would now like to proceed with those surgeries. On cross-examination, Petitioner admitted she noticed carpal tunnel symptoms in 2003; those became progressively worse through 2008. She admitted that the therapy and medications she received improved her symptoms a little.

Dr. Jerome Oakey testified at a May 2014 deposition that on October 8, 2008, he saw Petitioner who was then complaining of bilateral hand pain and numbness of 4 months' duration. She described her job as requiring repetitive grasping and twisting. His diagnosis then was carpal tunnel syndrome. He discussed the possibility of carpal tunnel surgery with Petitioner, but at that time Petitioner opted for conservative treatment. In 2009, Dr. Oakey administered carpal tunnel steroid injections; those provided only temporary relief. Petitioner's hand symptoms continued into 2010. On August 31, 2011, Petitioner reported the return of aching and tingling in her hands after doing a lot of waxing and moved furniture at work. In October 2011 Petitioner underwent a second EMG test; it was consistent with carpal tunnel syndrome. Dr. Oakey provided his opinion that Petitioner's carpal tunnel condition was a continuation of her original problem because she had never gotten better. He further opined Petitioner's carpal tunnel syndrome was related to her job duties because she used vibratory tools and did repetitive gripping; her work activities irritated her medial nerve. Dr. Oakey testified Petitioner has exhausted conservative treatment and now requires carpal tunnel releases.

Dr. James Williams performed a Section 12 examination at Respondent's request. He testified at a June 2014 deposition that he examined Petitioner's hands and wrists on March 13, 2013. Then, Petitioner reported injuring her arm due to repetitive motions on July 10, 2008. Dr. Williams provided the following opinions: Petitioner suffered from bilateral carpal tunnel syndrome, but her work activities didn't appear to involve sustained repetitive forceful gripping or pinching, significant impact or exposure to vibration. Her carpal tunnel syndrome was not aggravated by her work activities. Dr. Williams believed Petitioner's carpal tunnel was either idiopathic, or related to: her hypertension, her post-menopausal status, her early development of CMC joint arthritis or her 36.6 body mass index. On cross-examination, Dr. Williams admitted he had not seen Petitioner since March 2013 and did not know her current condition. He agreed that performing the same duties for 11 years could be sufficient time to cause carpal tunnel syndrome, and that picking up trash and using an auto-scrubber could cause carpal tunnel syndrome if performed long enough.

The Commission concurs with the analyses of Dr. Oakey that Petitioner's current carpal tunnel syndrome is a continuation of her July 8, 2008 work injury, which never completely resolved, even after

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her March 2010 release from care. Prior to that time, Dr. Oakey had recommended Petitioner undergo carpal tunnel surgeries. Contrary to Dr. Williams' opinion, the Commission finds Petitioner was exposed to vibrations in her use of the floor scrubbing machine. Her mopping duties required forceful gripping. While Petitioner preferred to first try conservative treatment, that has been unsuccessful.

The Commission finds Petitioner has proven entitlement to further benefits relating to her bilateral carpal tunnel condition pursuant to §8(a) of the Act. Those benefits include reasonable and necessary medical expenses for that condition since the December 16, 2010 Arbitration hearing, as well as carpal tunnel surgery recommended by Dr. Oakey. Because further permanent partial disability relating to this condition is not yet determinable, the Commission defers any modification of the Arbitrator's award pursuant to §19(h), at this time.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h) and §8(a) Petition in 06 WC 19311, relating to her left knee, is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's §8(a) Petition in 08 WC 38611, relating to her bilateral carpal tunnel syndrome, is granted to the extent discussed in the above Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's §19(h) Petition in 08 WC 38611, relating to her bilateral carpal tunnel syndrome, is deferred.

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

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

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

DATED: JUL 5 – 2017

o-06/07/17
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID A. CLARKE,

Petitioner,

vs.

NO: 08 WC 12057

CITY OF PEORIA,

17IWCC0475

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, occupational disease, TTD, and PPD, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, and reduces the PPD award to 20% loss of use of person-as-a-whole, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FACTS

Petitioner was employed by the Respondent as a firefighter for 30 years. During his tenure, he rose in the ranks from firefighter to engineer to fire captain. (T. pp. 11, 18) His work activities for the City of Peoria were primarily those of firefighter, and Petitioner testified in detail regarding his extensive history of exposure to fire, smoke, toxins, high-stress situations, and noise. (T. pp. 15, 24-27, 33-37) The last 10 years of his career, he worked as Captain or Acting Captain. Even in those capacities, he continued to answer calls for home and industrial fires and would enter locations while the fire was actively engaged, in addition to having supervisory duties. (T. pp. 18-21)

Petitioner had last worked on December 26, 2007.On December 29, 2007, he was off-duty, and had not worked for 2.5-3 days. (T. p. 62) On December 29, 2007, Petitioner went to the ER after suffering upper chest pain. He was admitted to the hospital and on December 30, 2007, was diagnosed with a heart attack. (T. pp. 38-39) On December 30, 2007, Petitioner underwent left heart cardiac catheterization and 2 overlapping stents were placed. (T. pp. 54-55) Petitioner

did not return to work for the City of Peoria after this time. (T. p. 56)

Petitioner did not have a family history of cardiovascular disease. (T.p. 42) At the time of the heart attack, Petitioner was on mild blood pressure medication and medication for acid reflux. (T. pp. 45,47)

As a result of his heart attack, Petitioner applied for a disability pension and that was granted. (T. p. 56) Since that time, a third stent was placed, and Petitioner continues to see Dr. Malik on an annual basis. (T. p. 57)

Petitioner testified as to the traumatic experiences he went through as a firefighter. (T. pp. 26-27, 32-35) He additionally testified to the lack of sleep. (T. pp. 23-24)

The evidence deposition of Dr. Francesca Litow was admitted into evidence on behalf of Petitioner. Dr. Litow testified she prepared a report, and that in preparation of that report, she conducted an hour long telephone interview with Petitioner, reviewed his medical records, and reviewed literature regarding risk factors for cardiovascular disease in firefighters. She concluded that Petitioner's 30 years of exposure would have contributed to his cardiovascular disease and Petitioner's myocardial infarction.

The evidence deposition of Dr. Dan Fintel was admitted into evidence on behalf of Respondent. Dr. Fintel also prepared a report. He based his report on his review of Petitioner's medical records, but did not meet nor speak with Petitioner. Dr. Fintel concluded that Petitioner's heart attack and coronary artery disease were a direct consequence of Petitioner's multiple risk factors for coronary artery disease, including high blood pressure, hyperlipidemia, Petitioner's age and gender and Petitioner's family history, rather than Petitioner's work as a firefighter.

On January 1, 2008, the following changes to the Illinois Workers' Compensation Act and Illinois Occupational Diseases Act as it pertains to firefighters became effective:

> ...any condition or impairment of health of an employee employed as a firefighter... which results directly or indirectly from any...heart or vascular disease or condition, hypertension... 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... and shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. ... However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, or paramedic for less than 5 years at the time he or she files and Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission. *820 ILCS 305/6(f)* and *820 ILCS 310/1(d)*

On December 17, 2015, Arbitrator Dollison issued a decision awarding Petitioner PPD benefits of 25% person as a whole, pursuant to 820 ILCS 305/8(d)2, as well as 8 weeks of TTD, and medical benefits. Arbitrator Dollison additionally found that the changed statutory language to 820 ILCS 305/6(f) and 820 ILCS 310/1(d) could be retroactively applied. The City of Peoria sought the instant review.

CONCLUSIONS OF LAW

Retroactive application of 820 ILCS 305/6(f) and 820 ILCS 310/1(d)

The Arbitrator correctly found the application of the statute should be retroactive. 5 ILCS 70/4 authorizes the retroactive application of amendments or repeals only if such changes are

procedural. Conversely, it forbids retroactive application of substantive changes to statutes. Procedural law has been defined as the mode of proceeding by which a legal right is enforced, as distinguished from the law which gives or defines the right. Rules of procedure, including rebuttable presumptions, may be changed by the legislature and applied retroactively, unless there is a savings clause as to existing litigation, without offending any constitutional prohibition. *The First Nat'l Bank of Chicago v. Narcissa Swift King, et al.*, 165 Ill. 2d 533, 542-43 (1995) *citing Maiter v. Chicago Board of Education*, 82 Ill.2d 373, 390 (1980); *Illinois Public Aid Comm'n v. Brauer*, 11 Ill. 2d 416, 419 (1957).

Since the statutory changes to the Acts simply create a rebuttable presumption, and not a conclusive rule of law, the change is only procedural and therefore can be retroactively applied. 820 ILCS 305/6(f) and 820 ILCS 3110/1(d) do not raise a presumption that Petitioner suffered from hypertension and/or heart disease, but only that once it is shown that Petitioner suffers from these ailments, the statutes raise a rebuttable presumption that such condition is causally related to his employment. A rebuttable presumption is one that may be overcome by the introduction of contrary evidence.

Standard of Proof

The changes in the Act create a "rebuttable" presumption in the favor of the firefighter, EMT or paramedic. The presumption of compensability is not conclusive. It is only rebuttable. In all workers' compensation claims, the claimant has the burden of proof to prove the claim is compensable. The Arbitrator erred in stating that the Respondent would need to introduce clear and convincing evidence to establish the nonexistence of the presumed fact. The standard is only to introduce evidence that is sufficient to support a finding of the nonexistence of the presumed fact. *Simpson v. Ill. Workers' Comp. Comm'n*, 2017 IL App (3d) 160024WC, ¶30.

Petitioner met his burden of proof regarding whether his heart condition was work-related. Respondent introduced evidence to rebut the presumption created by the statute, but Petitioner was able to prove by a preponderance of the evidence that his condition was work-related.

Causal Connection

The evidence is undisputed that Petitioner suffered a heart attack. Based on the retroactive application of the statute, Petitioner's condition is rebuttably presumed to arise out of and in the course of his firefighting, and to be causally connected to the hazards or exposures of firefighting. 820 ILCS 305/6(f) and 820 ILCS 310/1(d).

The Illinois Supreme Court has weighed in on the effect of rebuttable presumptions in *Diederich v. Walters*, 65 Ill.2d 95, 100-01 (1976). The Court states, in pertinent part:

> With regard to the procedural effect of presumptions, most jurisdictions in this country follow the rule that a rebuttable presumption may create a *prima facie* case as to the particular issue in question and thus has the practical effect of requiring the party against whom it operates to come forward with evidence to meet the presumption. However, once evidence opposing the presumption comes into the case, the presumption ceases to operate, and the issue is determined on the basis of the evidence adduced at trial as if no presumption had ever existed.

The prevailing view that a presumption ceases to operate in the face of contrary evidence has generally been followed in Illinois. A presumption is not evidence and cannot be treated as

evidence. It cannot be weighed in the scale against evidence. Presumptions are never indulged in against established facts. They are indulged in only to supply the place of facts. As soon as evidence is produced contrary to the presumption which arose before the contrary proof was offered, the presumption vanishes entirely. *Johnston v. Illinois Workers' Compensation Comm'n*, 2017 IL App. (2d) 160010WC, ¶37, *Franciscan Sisters Health Care Corp. v. Dean*, 95 Ill. 2d 452, 461 (1983)

In order to establish causation under the Act, Petitioner need only prove that some act or phase of his employment was *a* causative factor in his ensuing injuries. *Sisbro, In. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003), *Land and Lakes Co. v. Industrial Comm'n*, 359 Ill.App. 3d 582, 592 (2005). Thus, the causation presumption in the revised portion of 820 ILCS 305/6(f) and/or 820 ILCS 310/1(d) only required that the Arbitrator presume that Petitioner's employment as a firefighter was a *contributing cause* of Petitioner's coronary artery disease. In order to rebut this presumption, Respondent had to burst the bubble of the presumption by introducing evidence sufficient to support a contrary finding. Respondent was able to do so through the expert testimony of Dr. Fintel. However, Dr. Fintel testified that he had no knowledge of Petitioner's specific duties as a firefighter, nor did Dr. Fintel speak or meet with Petitioner prior to the issuance of his report. Petitioner's expert, Dr. Litow, testified she prepared a report, and that in preparation of that report, she conducted an hour long telephone interview with Petitioner, reviewed his medical records, and reviewed literature regarding risk factors for cardiovascular disease in firefighters. She concluded that Petitioner's 30 years of exposure would have contributed to his cardiovascular disease and Petitioner's myocardial infarction. Petitioner's expert's opinion that Petitioner's disease was work-related, was more persuasive than that of Respondent's expert's opinion that it was not. The Commission affords greater weight to the opinion of Dr. Litow. Thus, Petitioner was able to prove causal connection.

Permanency

The Commission, having weighed the evidence, finds that the Award should be reduced to 20% person-as-a-whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is covered under the Occupational Diseases Act, 820 ILCS 310/1 *et seq*, and that 820 ILCS 310/1(d) be retroactively applied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,114.84 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 to Petitioner the sum of $636.15 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 20% person as a whole.

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

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

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

DATED: JUL 27 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 6/6/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

CLARKE, DAVID A
Employee/Petitioner

Case# **08WC012057**

CITY OF PEORIA
Employer/Respondent

17IWCC0475

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:

1004 BACH LAW OFFICE
ROBERT W BACH
110 S W JEFFERSON SUITE 410
PEORIA, IL 61602

0980 HASSELBERG GREBE ET AL
BOYD O ROBERTS III
410 MAIN ST SUITE 1400
PEORIA, IL 61602

17IWCC0475

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
CORRECTED

David A. Clarke
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **08** WC **12057**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, IL**, 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 17IWCC0475

On **12/29/07**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner was last exposed to an occupational disease that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$86,957.52**; the average weekly wage was **$1,672.26**.

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

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

ORDER

The Arbitrator finds that Petitioner was temporarily totally disabled due to his occupational disease from December 29, 2007 until February 22, 2008, when he began receiving a statutory duty disability pension, or a total of eight (8) weeks. Petitioner is awarded 8 weeks of TTD at the rate of $1,114.84 per week. In addition, the Arbitrator finds the Petitioner has suffered a permanent partial disability loss of 25% person as a whole at the maximum rate of $636.15/week.

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

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

Signature of Arbitrator

12/15/15
Date

ICArbDec p 2

DEC 17 2015

17IWCC0475

I. FINDINGS OF FACT:

A. Petitioner's Testimony

Petitioner, at the time was a 56 year old firefighter with 30 years on the job, testified that he suffered chest pains while off duty on December 29, 2007. He last worked on December 26, 2007. He suffered a heart attack while hospitalized at Proctor Hospital on December 30, 2007. Cardiac catheterization revealed two areas of significant stenosis of the right coronary artery which were treated with the insertion of two stents. Petitioner testified that he was later readmitted to the hospital on June 11, 2008 for the insertion of a third stent into his right coronary artery.

Petitioner testified that in the course of his career as a firefighter he had worked as both a firefighter and an EMT at some of the busiest fire stations in the City of Peoria, working a 24 hours on 48 hours off shift. His duties included responding to home, grass, and industrial fires at which he wore a self-contained breathing apparatus (SCBA). During the overhaul phase, when the fire had been knocked down, he frequently would not. He stated the department policy did not mandate SCBA use during overhaul and that on some occasions he ran out of air bottles.

While on duty, alarms would go off in the firehouse at all hours. Petitioner stated that if an alarm went off anywhere in the city it rang into all of the firehouses. He reported difficulty sleeping and sleep interruption due to the loud bell tones of the alarm. He admitted to being nervous in anticipation of the next call as well.

Petitioner stated that he had been exposed to many stressful situations and witnessed many gruesome injuries and deaths at accident scenes. He described being called to a scene where a knife wielding man attacked police officers and was shot to death less than 20 feet from him. On another occasion he and a fellow firefighter crawled through upstairs bedrooms at a house fire in an unsuccessful attempt to rescue two young children. Petitioner found one child burned to death and another dead from smoke inhalation. He recalled that he responded to the scene of a gruesome daytime accident where he futilely attempted to save the life of an injured motorcyclist. These experiences cause him to lose sleep, experience nightmares and suffer anxiety.

Petitioner testified that his prior medical history included treatment for high blood pressure (hypertension) and gastro-esophageal reflux disorder, both of which were controlled with oral medication. He stated he was diagnosed with hypertension in 2000 and had never treated for hyperlipidima prior to his heart attack. He testified that he had never smoked and had no family history of heart disease. He was 5'10" tall and had weighed between 180 and 190 lbs for twenty years prior to his heart attack. He had annual department physicals required by the Fire Department.

B. Medical Evidence

1. Heartcare Midwest Records of Treatment.

Petitioner was a patient at Heartcare Midwest during and after his hospitalization in December 2007. The records of his treatment substantiate that he suffered a heart attack due to right coronary artery blockage which was addressed initially by the placement of two stents with a third being implanted in June 2008. Petitioner's prior medical history is notable for never having been a smoker, and high blood pressure which was controlled by the oral medication, Norvasc.

2. Report and Testimony of Dr. Francesca Litow

Petitioner introduced the report and evidence deposition of Dr. Francesca Litow, a board certified physician in Occupational Environmental Medicine on the faculty of Johns Hopkins School of Medicine and Director of the residency program in Occupational Medicine at the University. She interviewed Petitioner, reviewed his medical records and drafted a report focusing on the causal connection between Petitioner's employment as a firefighter and his cardiovascular disease.

Dr. Litow's interview with Petitioner concerned his exposure to various job related situations during his 30 year career which included toxic fumes at fire scenes during overhaul, alarms at his firehouse during shifts which resulted in sleep disturbance/deprivation, stressful fire and accident scenes involving death and gruesome injury causing him anxiety.

Dr. Litow also described the impact of the "demand control" model of psychological stress in Petitioner's job experience. She stated that firefighters are an example of workers who are at increased risk for occupational stress because their jobs have very high demands yet very low control over how busy their shifts will be, resulting in stress to the individual firefighter such as Petitioner.

Dr. Litow expressed the opinion that these occupational exposures were a cause of Petitioner's hypertension and coronary artery disease as well as his subsequent myocardial infarction. Dr. Litow noted exposures at fire scenes, to a wide variety of toxicants, loud noise exposure, sleep deprivation, stress, anxiety, and shift work each increased the risk of cardiovascular disease in firefighters such as Petitioner.

Specifically, she testified to a positive correlation between sleep deprivation and occupational stress and the development of hypertension, which in turn contributed to the development of Petitioner's coronary artery disease.

On cross examination, Dr. Litow acknowledged that she has testified on three occasions in behalf of the International Association of Fire Fighters (IAFF) with respect to the causal relationship between firefighting and disease. She also stated that the IAFF contributed $90,000 per year to the Johns Hopkins School of Medicine for travel expenses for residents in the Occupational Medicine program and partial salary support. She has not lobbied for the IAFF.

Dr. Litow does not treat patients with cardiovascular disease but has training and education in heart disease. She acknowledged Petitioner's non-occupational risk factors for developing heart disease such as age, obesity, hyperlipidemia, hypertension and gender but maintained her opinion that his occupational exposures were a cause for coronary artery disease, hypertension and heart attack. This was the first case involving cardiovascular disease in which she had testified.

3. Report and Testimony of Dr. Dan J. Fintel

Dr. Fintel performed a record review at the request of the Respondent. He is a board certified internal medicine and cardiovascular disease doctor who is on the faculty of the Northwestern University School of Medicine. Dr. Fintel opined that the cause of Petitioner's heart attack was his multiple non-occupational risk factors for coronary artery disease including high blood pressure or hypertension, hyperlipidemia, age, male gender, and possibly family history. These risk factors dramatically increased his risk for having a coronary event and were the cause of his accelerated atherosclerosis.

On cross examination, Dr. Fintel admitted that his testimony regarding causation did not exclude other risk factors which might have been present. He also admitted that Petitioner's age of 56 was not a strong risk factor and that at 5'9", 200 lbs, he may not have been obese.

Dr. Fintel stated that Petitioner's hyperlipidemia and hypertension were both important risk factors for the development of coronary artery disease. He admitted that he did not know how long Petitioner had been suffering from hyperlipidemia and that that information would be necessary to know the importance of hyperlipidemia in the development of Petitioner's heart disease. He also admitted that he did not know the cause for Petitioners hypertension and stated it could be related to "emotional or physical stress". Dr. Fintel opined that hypertension was a cause of Petitioner's coronary artery disease, but did not express an opinion as the cause of Petitioner's hypertension.

Dr. Fintel admitted that the presence of one cardiovascular risk factor does not preclude other causes. Dr. Fintel had no information with respect to any potential occupational disease exposures to which Petitioner might have been subjected in his work as a firefighter. He admitted he had no experience or training in occupational medicine, and that he had no evidence concerning Petitioner's work activities.

4. Report of Dr. Keith Mankowitz to the Peoria Fireman's Pension Fund dated 3/12/08

Dr. Mankowitz, a member of the faculty at Washington University School of Medicine in St. Louis in the cardiovascular division. He performed an examination of Petitioner at the request of the Peoria Fireman's Pension Fund. Dr. Mankowitz noted Petitioner was suffering from hypertension but otherwise in good health until his myocardial infarction of December 30, 2007.

Dr. Mankowitz noted that Petitioner's hypertension was diagnosed at age 52 and that he had no family history of cardiovascular disease and had never been a smoker. He went on to state that Petitioner's coronary artery disease was due to his abnormal lipids and hypertension which predisposed him to that disease. The doctor mentioned age as a further cause. He did not address the causation of Petitioner's hypertension. He concluded that "disability is not caused by an on-the-job-incident" but rather related to coronary artery disease due to coronary risk factors.

5. Report of Dr. William S. Scott to the Peoria Fireman's Pension Fund dated 3/12/08

Dr. Scott of OSF Occupational Medicine performed an examination of Petitioner for the Fireman's Pension Board. He noted that Petitioner's hypertension and hyperlipidemia were fairly well controlled prior to his heart attack. He made no mention of any other history including any family history or smoking. His focus seemed primarily on whether Petitioner could return to work as a firefighter. He concluded his report by stating that based upon Petitioner's personal risk factors, non-work location and activities at the time of the cardiac event, he did not see this as an on-the-job incident.

With respect to (C.) Was Petitioner last exposed to an occupational disease on December 26, 2007 in the course his employment by Respondent and? (F) Is Petitioner's current condition of ill-being causally related to the said occupational disease, the Arbitrator finds as follows:

1. <u>Presumption under §1(d) – retroactivity</u>

The Illinois legislature passed an amendment to the Illinois Worker's Occupational Disease Act which which created the presumption contained in 820 ILCS 31-1(d) and became effective January 1, 2008. It states: "...Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), emergency medical technician-intermediate (EMT-I), advanced emergency medical technician (A-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, EMT-I, A-EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, EMT-I, A-EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission. The rebuttable presumption established under this subsection, however, does not apply to an emergency medical technician (EMT), emergency medical technician-intermediate (EMT-I), advanced emergency medical technician (A-EMT), or paramedic employed by a private employer if the employee spends the preponderance of his or her work time for that employer engaged in medical transfers between medical care facilities or non-emergency medical transfers to or from medical care facilities. The changes made to this subsection by this amendatory Act of the 98th General Assembly shall be narrowly construed. The Finding and Decision of the Illinois Workers' Compensation Commission under only the rebuttable presumption provision of this paragraph shall not be admissible or be deemed res judicata in any disability claim under the Illinois Pension Code arising out of the same medical condition; however, this sentence makes no change to the law set forth in Krohe v. City of Bloomington, 204 Ill.2d 392."

Petitioner last worked on December 26 and his coronary artery disease manifested itself on December 29, 2007 leading to a heart attack the next day. Respondent argues that §1(d)) should not be applied to Petitioner's claim for Occupational Disease benefits in this case because it was not in effect when he last worked or his coronary artery disease manifested itself, citing 5 ILCS 75/1 in support. That section addresses the effective dates of laws passed in the Illinois legislature.

However, when a change of law merely affects the law of procedure, all rights of action are enforceable under the new procedure, without regard to whether they accrued before or after such change of law. (*Maiter v. Chicago Board of Education*, 82 Ill.2d 373, 415 NE 2d, 1034, (1980), *Orlick v. McCarthy*, 4 Ill.2d 342, 122 NE 2d 513 (1954).

A presumption, such as the one in §1(d) is a procedural rule that dictates the effect of the absence of evidence (*Franciscan Sisters Health Care Corp .v Dean*, 95 Ill.2d 452 at 460, 448 NE 2d 872, (1983); *Diederich v. Walters*, 68 Ill.2d 95, 357 NE 2d 1128, (1976)). A presumption does not shift the burden of proof but rather shifts only the burden of production (*Franciscan Sisters, supra* at 460-62). Thus, a statutory presumption is a rule of evidence. No one has a right in any particular procedure (*Maiter, supra*). Therefore, the Arbitrator finds that the statutory amendment contained in §1(d) applies to Petitioner's claim because it constituted a change in a procedural rule.

2. **Presumption under §1(d) – effect**

Since Petitioner's coronary artery disease, hypertension and heart attack are presumed to be causally connected to and arising out of the hazards or exposures of his employment, it is necessary to analyze the effect of the presumption in light of the evidence introduced at arbitration.

Presumptions can be refuted by evidence which attacks or tends to disprove the "basic facts" which are those facts which must be proven in order for the presumption to arise. In this case, the basic facts required for the presumption are not in dispute. Petitioner, a firefighter, was employed in that capacity for more than 30 years. The presumption applies to any firefighter employed in excess of 5 years. Thus, it applies in this case.

A presumption can also be rebutted by proof that the presumed fact is not true. This would be proof relating to the nature or subject matter of the presumption. In this case it would be evidence that Petitioner's occupation as a firefighter was not a cause of his cardiovascular disease. Respondent did not attempt to "establish the nonexistence" of the presumed relationship between Petitioner's firefighting and cardiovascular disease. In fact, it did not introduce any medical testimony to the effect that firefighting did not cause cardiovascular disease. Instead it proffered evidence directed toward showing that other non-occupational causes existed, which might have caused Petitioner's heart disease, hypertension and heart attack.

Petitioner is not required to prove that his employment was the sole or even the primary cause of his condition, but only a cause (*Old Ben Coal Co. v. Industrial Commission*, 217 Ill.App. 3d 70, 576 NE 2d 890 at 899). Thus, in the absence of evidence that firefighting does not cause cardiovascular disease or that there cannot be more than one cause for the development of cardiovascular disease, the evidence proving the existence of other non-occupational factors does not exclude the presumed relationship between Petitioner's work and illnesses.

The Illinois Supreme Court has held that statutory presumptions require strong evidence to overcome, and has stated that under certain circumstances clear and convincing evidence must be introduced to counter such a presumption (*Franciscan Sisters, supra*). In this case the presumption requires the Arbitrator to accept the presumed fact that Petitioner's cardiovascular disease, hypertension and heart attack are work related unless the evidence introduced by Respondent constitutes clear and convincing evidence establishing the nonexistence of the presumed fact. (*Franciscan Sisters, supra (emphasis added)).*

Respondent introduced evidence that Petitioner had other personal lifestyle risks for the development of cardiovascular problems; that he was male, overweight, had high blood pressure and high cholesterol, and was over 45 years old. No testimony was offered to the effect that the presence of these factors excluded the occupational exposures of noise, shift work, toxic fume exposure, psychological stress and sleep disturbance/deprivation as additional causes for Petitioner's cardiovascular disease. In fact, Dr. Fintel admitted that the presence of these factors did not exclude other factors in Petitioner's illness. Respondent's experts did not discuss, much less exclude occupational factors in their reports or testimony. None of them opined that Petitioner did not experience these exposures or that they were not a cause, directly or indirectly, for his cardiovascular conditions. While the doctors stated that they did not find that Petitioner's cardiovascular disease to be related to his activities as a firefighter, these general opinions are insufficient to overcome the presumption.

The Arbitrator further finds that the evidence regarding Petitioner's hypertension supports a finding of a causal connection between Petitioner's employment and his cardiovascular disease. First, pursuant to §1(d), hypertension is presumed to be a result of Petitioner's employment as a firefighter. Respondent did not offer evidence regarding the cause of Petitioner's hypertension and in particular no doctor opined that his hypertension was not related to his employment. The only doctor to address the causation of this condition was Dr. Litow who expressed the opinion that Petitioner's hypertension was a result of exposure to various occupational risks including noise exposure, shift work and stressful on-the-job situations. Therefore, even if the presumption of §1(d) did not to apply in this case, Dr. Litow's opinion that Petitioner's hypertension is work-related stands unrefuted.

Secondly, all doctors expressed the opinion that hypertension was a cause for Petitioner's coronary artery disease. On this point, all of the medical evidence is consistent. Drs. Litow, Fintel, Scott and Mankowitz concur that Petitioner was suffering from hypertension and that this lead to the development of his coronary artery disease.

Thus, with or without the presumption, the evidence supports a finding that Petitioner's coronary artery disease and heart attack were related to his employment.

With respect to (K) What benefits are in dispute (TTD), the Arbitrator finds as follows:

Petitioner testified that he did not return to work following his heart attack. He was granted a duty disability pension effective February 22, 2008. The Arbitrator finds that Petitioner was temporarily totally disabled due to his occupational disease from December 29, 2007, and February 22, 2008, when he began receiving a statutory duty disability pension, or a total of eight (8) weeks.

With respect to (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's occupation is a heavy duty job from which he was permanently disabled due to his coronary artery disease and which, given his age of 56, prevented him from continuing in his chosen profession for a number of years. This has substantially impaired his earning capacity. In addition, Petitioner's disability is corroborated by the medical evidence. He testified that he did not have the same energy or stamina following his heart attack and that he had voluntarily restricted his activities for this reason. His coronary artery disease has required two surgical procedures to place a total of three stents. In combination with the above factors, the Arbitrator awards 25% loss of the person as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Griffiths,
Petitioner,

17IWCC0457

vs.

NO: 08 WC 43519

Freeman United Coal Mining Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent disability, average weekly wage, evidentiary error 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.

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

DATED: JUL 19 2017
o7/13/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0457

GRIFFITHS, LARRY
Employee/Petitioner

Case# **08WC043519**

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

17IWCC0457

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

LARRY GRIFFITHS
Employee/Petitioner

v.

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

Case # **08** WC **43519**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **October 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 **Disease, Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

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

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

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

Timely notice of 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 **$76,088.48**; the average weekly wage was **$1,463.24**.

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

Petitioner claims no medical.

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

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

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

ORDER

Petitioner failed to prove that he suffers from any occupational disease, including coal workers' pneumoconiosis, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, or asthma that arose out of or in the course of the exposure of his coal mine employment. Petitioner failed to prove that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusion as to those issues.

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

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

Signature of Arbitrator

January 7, 2016
Date

JAN 11 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LARRY GRIFFITHS
Employee/Petitioner

v.

Case #: 08 WC 43519

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his work accident, Petitioner was 54 years of age and employed by Respondent as a coal miner in the Crown II mine. He worked in coal mines for a little over 34 years, with 24 to 25 of those years being underground. Petitioner testified that he was regularly exposed to and breathed coal dust, silica dust, roof bolting glue fumes, diesel fumes, and periodically smoke from coal fires. He graduated from Girard High School and is married.

Petitioner last worked in a coal mine on August 28, 2007. On that day he worked for Respondent at its mine in Virden, Illinois. His job classification was underground supply man. He testified that he was exposed to and breathed coal dust on that day. He testified that was the last day he worked at the mine because the mine closed. He testified that he did have the opportunity to work at Respondent's Crown III mine, but he chose not to. Signing up for the panel would have allowed him to be hired at another of Respondent's mines if his job classification was needed, but he chose not to do so. Petitioner decided to end his coal mining career on that date because he was having too many problems with his breathing and other medical issues.

Petitioner testified that in 2008 he began working part-time as a warehouse attendant for Cabinet Land, a cabinet company in Springfield, Illinois. On the date of Arbitration he was still so employed, but had not worked for a while because of some medical problems. He testified that he started out earning $10.00 per hour and currently makes $12.00 per hour. He works 28-32 hours per week. He testified this is the only job he has had since leaving the coal mine.

Petitioner began his coal mining career in August 1973, with Monterey Coal Company. He worked there for a little over three years. He began as an underground laborer, which he described as doing any job that needed to be performed. This included working as an inby at the working section of the mine, as well as an outby. Outby duties included shoveling beltlines and building stoppings, and anything that did not actually involve production of coal. He also worked as a utility man and supply tractor operator. In that position he would get supplies for the roof bolters and clean up. He would also do rock dusting, which was silica material ground with limestone, sprayed on the top of the ribs to keep the coal dust down. Petitioner testified this

generated a lot of rock dust, which he was exposed to. He also worked as a shuttle car operator, where he would haul the coal from the face of the mine where it was cut, to the belts be taken out of the mine. He testified that as a shuttle car operator he was exposed to the same coal and rock dust as the person who was digging the coal out of the mine. Petitioner also filled in sometimes as a roof bolter. In that job he drilled into the roof, which caused rock dust to fall directly on top of him as he was drilling. He would insert the roof bolt and then take the roof bolting glue pin and spin it in to seal the bolt. Petitioner testified that when the glue pin spins and breaks up it produces a lot of strong fumes.

Petitioner began working for Respondent in 1976 and worked there the rest of his mining career, until the mine closure in 2007. He worked as a shuttle car operator and also as a continuous mine operator, which is the person who operates the piece of equipment that actually cuts the coal out of the face. He testified this job generates a lot of coal dust. He was in this position about a year and a half. He then worked on the surface for eight or nine years as a mobile equipment/surface laborer, which involved loading supplies with a forklift onto an elevator to be sent underground.

Petitioner testified he first noticed breathing problems in the last four or five years before the mine closed. He noticed his energy level and his endurance were low. He could not perform the tasks he normally performed at 100% and it slowed him down quite a bit. He testified that from the time he first noticed breathing problems until he left the mine he did not think the problems increased a whole lot, but that since leaving the mine he has noticed his breathing has been labored. Petitioner testified that he could probably walk two to three blocks on level ground at normal pace before becoming short winded. He testified he could climb 15 or 20 stairs before stopping to rest. Petitioner testified that he previously had taken Albuterol but does not take it a lot now, only periodically when he has breathing episodes and cannot get air. Petitioner testified he has slowed down quite a bit in his daily activities. He used to ride his bicycle 20 to 25 miles a day and has not done that in the last four years. He walks his dog twice a day and is limited to a half mile to a mile. He testified he does not have a lot of extracurricular activities.

Petitioner testified his current treating doctor is Dr. Cramer. Prior to Dr. Cramer he treated with Dr. Smelter, who retired. He testified that he mentioned his breathing problems to them a couple of times and that they were aware he worked in a coal mine. Petitioner testified he has never smoked. He takes medication for coronary artery disease. He has had six stents placed in three different surgeries. He also has hypertension and is prediabetic.

Petitioner testified that if he were offered a job in a coal mine today, he would not take it. He testified he can hardly get around dust at all any more. Petitioner testified that under the Bituminous Wage Agreement he was a grade 3 at the time of the mine closure. As of January 1, 2015, the wage he would have been earning was $28.64 per hour. He testified that the Bituminous Wage Agreement was between the United Mine Workers and Freeman Coal. He testified that the other coal mine owned by Respondent is no longer in operation. He was not aware of any job available with Respondent at a grade 3 classification.

Petitioner testified that he found out about the mine closure in August 2007 when he went to work and there was a padlock on the gate and security was present. He testified he would

have worked his shift if the mine had not closed, and that it was his intention to keep working. After he was laid off he applied for his pension and resigned his employment with Respondent, which severed all his rights to recall at the mine. Petitioner received a 30 and out pension which meant that if he had 30 years of employment he could retire without repercussions as far as pension payments, regardless of his age. Petitioner received a full retirement pension.

Petitioner testified that he had his kitchen done by Cabinet Land, and they offered him a job because they were in need of help. He has always worked part-time for them. He last worked for them about six weeks prior to the date of arbitration.

Petitioner testified that from time to time while he was a coal miner he underwent screening by NIOSH in the form of a chest x-ray. He testified that after he underwent the screening, NIOSH would write a letter to tell him what his films revealed. He testified he did not bring any of the letters with him to arbitration. Petitioner testified that he presented to Dr. Smelter on December 3, 2012, at which time he requested a methacholine challenge, which was completed. Petitioner testified that he has recently had some difficulty with his heart. He testified that he had a treadmill test in September 2015, and that he was scheduled for an angioplasty on the Monday after arbitration. He testified this would be the fourth time he has gone in for stenting. He testified he has been off work recently related to his heart problems.

Petitioner testified he saw Dr. Clapp in Chicago at the request of his attorney. He gave Dr. Clapp a history about his complaints, as well as a full and complete history of the medications he was taking. Albuterol was not one of the medications mentioned to Dr. Clapp. Petitioner testified that he started taking same within the last couple of years.

Dr. William Clapp examined Petitioner on April 23, 2010, at the request of his counsel. He testified by way of evidence deposition on April 17, 2015. PX1. Dr. Clapp is a pulmonary physician at Stroger Hospital in Chicago. He is the Medical Director of the Pulmonary Physiology Laboratory. The lab is used for Department of Labor examinations, but Dr. Clapp does not perform such examinations. In the lab they do pulmonary function studies such as spirometry, diffusion capacity, lung volumes, blood gases, and exercise studies including cardiopulmonary exercise testing. Dr. Clapp has been a B-reader for four and a half years and was recertified in December 2014. In his practice he has had occasion to treat former coal miners. PX1.

Petitioner reported to Dr. Clapp that he had episodic dyspnea and a non-productive cough for several years. He reported he had episodes of difficulty breathing, particularly with exertion. He would sometimes have to stop when he was walking his dog, and sometimes had shortness of breath if he climbed three or four flights of stairs. Sometimes if he took a deep breath it would cause him to cough. He reported his cough was raspy and dry, without sputum. Petitioner further reported a history of heart problems. In 2004 he was found to have coronary arteriosclerosis and had five stents put in. He was restented in 2009. He reported to Dr. Clapp that his shortness of breath and dyspnea improved after the cardiac procedures, but did not completely go away. Dr. Clapp testified that Petitioner's shortness of breath and dyspnea on exertion were multifactorial in etiology and that Petitioner had a component of pulmonary related dyspnea and cardiac related dyspnea. PX1.

Petitioner reported he wore a paper mask about 25 percent of the time while working in the coal mine. Dr. Clapp testified that a mask such as that generally does not keep a person from having exposure to silica dust, coal mine dust, roof bolting glue fumes, and diesel fumes. PX1.

Dr. Clapp testified that on physical examination Petitioner's chest was clear. Dr. Clapp testified that in conjunction with his examination of Petitioner, Dr. Cohen read Petitioner's chest x-ray of July 24, 2008, and found opacities of pneumoconiosis. He testified that Petitioner's exercise test was an interesting study, in that he exceeded the expected work capacity both by watts and by oxygen consumption. He used his entire respiratory capacity to do so. Dr. Clapp testified that generally one uses only 70% to 80% of respiratory capacity to get to maximal workload, whereas Petitioner used 100%. He achieved maximal work capacity and was not impaired, but he did so at the cost of his entire respiratory capability. This implied Petitioner did not have as much reserve as most people do at maximal capacity. Dr. Clapp testified that Petitioner was not disabled from his last coal mining job based strictly on the measurable pulmonary function test and exercise test. He further testified that Petitioner could not return to work in a coal mine without risking his health, due to an increased risk of worsening his coal workers' pneumoconiosis. PX1.

Dr. Clapp testified that he believed Petitioner's chest x-ray indicates he has coal workers' pneumoconiosis because he has had extensive exposure to coal dust, and there is no other reasonable explanation for the small rounded opacities on the chest film. PX1.

Dr. Clapp testified that dyspnea can be associated with heart disease. He testified there are many causes for dyspnea on exertion and that deconditioning is one of them. Dr. Clapp noted Petitioner had a spot on his lung which had been reported as stable in the past. Petitioner did not give a past history of pneumoconiosis. Dr. Clapp testified that Petitioner's history was not consistent with chronic bronchitis. Dr. Clapp testified as to the various medications Petitioner was taking, and what they were used for. He testified that Petitioner was not taking any breathing medication at the time of his examination and he did not get a history from Petitioner of ever having taken a breathing medication. There were no obvious signs of pulmonary disease on chest exam. Dr. Clapp testified he did not read Petitioner's chest x-ray dated July 24, 2008, but rather he relied upon Dr. Cohen's interpretation of the x-ray. He also saw no other chest x-ray interpretations. PX1.

Dr. Clapp testified that in 2012 he testified that the classic presentation for simple coal workers' pneumoconiosis was lesions in the lung, nodular opacities predominately in the upper lung zones. He testified that since then there has been good evidence showing that the opacities can at any point be in the upper, lower or middle lung zones. Dr. Clapp could not recall whether the study with that finding looked at chest x-rays with a profusion lower than 1/0. He testified that if the study did not look at profusions lower than 1/0, then the common sense conclusion would be that the earliest signs of opacities in the lung were not included in the study. PX1.

Dr. Clapp did not review any treatment records. He testified that when treatment records are available they are valuable in the evaluation of an individual for the presence of, and when present the significance of, an occupational disease. He testified this is even more true where an

individual also suffers from another significant systemic disease such as arteriosclerotic heart disease. Dr. Clapp testified that he has evaluated coal miners, but that he does not treat coal miners. PX1.

Dr. Clapp testified that the spirometry he performed on Petitioner was normal and his lung volumes were normal. There was no evidence of obstruction or restriction. His blood gases were normal at rest and at peak exercise. His diffusion capacity was normal. The exercise testing was maximal. Dr. Clapp testified there was no evidence of respiratory insufficiency in terms of Petitioner's ability to move air or his gas exchange. Dr. Clapp testified that the testing allowed him to conclude that Petitioner was physically capable of performing the requirements of his last coal mining job. His exercise testing was stopped primarily due to leg fatigue and general fatigue, but he did have some shortness of breath as well. PX1.

Dr. Clapp did not recall if Petitioner told him why he left mining, did not recall if Petitioner told him he left due to breathing problems, and did not recall if Petitioner told him he left on the advice of a physician due to lung disease. The only occupational related diagnosis that Dr. Clapp made for Petitioner was pneumoconiosis, based on Dr. Cohen's interpretation of the chest x-ray. PX1.

Dr. Clapp testified that there is no cure for coal workers' pneumoconiosis. Pneumoconiosis requires a tissue reaction to the coal dust trapped in the lungs, called scarring or fibrosis. The damaged area of lung is a macule or nodule, referred to as opacities on x-ray. He testified that coal workers' pneumoconiosis is likely to progress because the lungs cannot remove the coal dust and the exposure continues. PX1.

Dr. Clapp testified it is possible to have coal workers' pneumoconiosis radiographically, yet have no symptoms, and have normal pulmonary function testing, normal blood gases, and normal physical chest exam. PX1.

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted grade 1 chest x-ray dated November 21, 2003, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. He made identical interpretation of grade 1 chest x-ray dated March 15, 2005. He interpreted grade 1 chest x-ray dated July 24, 2008, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in middle and lower lung zones. He interpreted grade 1 chest x-ray dated August 23, 2010, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. PX2.

Dr. Robert Cohen, B-reader, interpreted grade 2 chest x-ray dated July 24, 2008, as positive for pneumoconiosis, profusion 1/0 with P/Q opacities in all lung zones. PX3.

Dr. Akshay Sood, B-reader, interpreted grade 2 chest x-ray dated November 21, 2003, as positive for pneumoconiosis, profusion 1/0 with S/T opacities in right lower and left middle and lower lung zones. PX4.

Records of NIOSH were admitted into evidence. Petitioner's chest x-ray dated March 14, 1977, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. Chest

x-ray dated July 6, 1979, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. Chest x-ray dated July 17, 1984, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. Chest x-ray dated October 11, 1993, was interpreted by two B-readers as negative for pneumoconiosis. Chest x-ray dated April 2, 1998, was interpreted by two B-readers as negative for pneumoconiosis. Chest x-ray dated June 7, 2002, was interpreted by two B-readers as negative for pneumoconiosis. RX3.

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed chest x-rays of Petitioner and testified by way of deposition on May 17, 2013. Dr. Meyer has been board certified in radiology since 1992 and has been a B-reader since 1999. One of the training courses for the B-reader exam is conducted by the American College of Radiology. Dr. Meyer was recently asked to have an active academic role in helping with the course in the future. The faculty is typically experienced senior level B-readers. Dr. Meyer testified that radiologists have about a 10% higher pass rate on the B-reading exam than other specialties. He opined this is because radiologists are more practiced at reading x-rays and have a better sense of what the variation in normal is. RX1.

Dr. Meyer reviewed Petitioner's chest x-rays dated November 21, 2003, July 24, 2008, and August 23, 2010. He also reviewed Petitioner's CT scan dated March 15, 2005. Dr. Meyer testified that the chest x-rays of November 2003 and July 2008 were quality 2. The chest x-ray of August 2010 was quality 1. Dr. Meyer testified there were no findings of coal workers' pneumoconiosis on any of the chest x-rays. He noted that the July 2008 x-ray showed degenerative changes of the thoracic spine. The August 2010 x-ray showed the same degeneration, as well as the placement of a coronary artery stent. Dr. Meyer testified that he saw no findings of coal workers' pneumoconiosis on the CT scan. He noted the lung parenchyma was normal. He testified that there was an inter-pulmonary lymph node in the minor fissure on the right side, between the right upper and right middle lobe, which is a normal finding. Dr. Meyer testified that the lungs are covered on the outside by a layer called the pleura, and the separation between the lobes of the lung are fissures, which is where the two pleura or coverings of the lung of each lobe abut one another. He testified that the inter-pulmonary lymph nodes associated with a minor fissure was of no clinical significance. He testified this was a normal finding and not a manifestation of dust exposure. RX1.

Dr. Meyer testified that B-reading is an epidemiologic evaluation of chest x-rays to decide whether there are any small nodular opacities or any linear opacities present. Based on the size and appearance of the small opacities, they are given a score. Nodular opacities are P, Q, R and linear opacities are S, T, U. As the size of the opacities goes up, the letter score goes up, with P and S being the smallest and R and U being the largest. Dr. Meyer testified it is important to identify the opacity type as being round or irregular, as specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Dr. Meyer testified the next component of evaluating the chest x-rays is the distribution of the opacities. Different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Dr. Meyer testified the last component of evaluating chest x-rays is determining the extent of the lung involvement, the so-called profusion. Profusion defines the

density of the small opacities in the lung. The classification system varies from 0/0, which is normal, to 3/+, which is the most abnormal in terms of profusion. RX1.

Dr. Meyer testified that it is possible for two qualified and competent B-readers to reasonably disagree on whether they are seeing small opacities or not. It is important that the individuals interpreting the examinations have ample experience reading chest x-rays, to be able to sort out what is normal. He testified that part of trying to figure out whether or not there is an abnormality in the lung is recognizing the large spectrum of normal. RX1.

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and films regarding Petitioner. He testified by way of deposition on July 31, 2015. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. He has been a B-reader since 1985. RX2.

Dr. Castle testified that Petitioner's chest x-ray dated November 21, 2003, revealed no parenchymal abnormalities consistent with pneumoconiosis, and the lungs were entirely clear. He testified that Petitioner's chest x-ray dated July 24, 2008, revealed no parenchymal abnormalities consistent with pneumoconiosis. There was evidence of calcified granulomas in the hilum. Dr. Castle testified that Petitioner's chest x-ray dated August 23, 2010, revealed no parenchymal abnormalities consistent with pneumoconiosis, and the lungs were entirely clear. Dr. Castle testified that next to pathology, a CT scan is the best diagnostic tool for detection of lung disease. RX2.

Dr. Castle agreed with Dr. Clapp that Petitioner did not suffer from chronic bronchitis. He testified chronic bronchitis is defined as a chronic cough productive of sputum for at least three months out of the year for two consecutive years. He testified that a person may have a chronic cough related to multiple things, but medical records simply containing entries of cough do not support a diagnosis of chronic bronchitis. Dr. Castle testified there was no objective evidence of pulmonary impairment in the medical records he reviewed. Dr. Castle noted that Petitioner exceeded his predicted exercise capability by 11% in exercise testing that was performed on April 30, 2010. At the time of the testing Petitioner was taking Metropolol. Dr. Castle testified that Metroprolol is a beta blocker used to treat hypertension as well as cardiac disease. It will reduce the heart rate and will not allow the heart to reach a maximum rate. The fact that Petitioner managed to hit his predicted maximum heart rate while taking medication that would reduce his heart rate, and that he exceeded his predicted exercise capability by 11%, explains his use of respiratory reserve in his testing. RX2.

Dr. Castle agreed with Dr. Clapp that Petitioner had the respiratory capacity to perform the duties of his last coal mining job. From an objective standpoint, based upon the testing he reviewed, Dr. Castle saw no limit from a ventilatory standpoint in regard to Petitioner's ability to work. Dr. Castle noted that Petitioner suffered from heart disease and had interventional therapy on two occasions for angina. Dr. Castle agreed with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. In his review of the medical in this case, Dr. Castle did not see any pathologic evidence of

pneumoconiosis. Dr. Castle testified that the significance of sub-radiographic pneumoconiosis is generally none, from an impairment perspective. RX2.

Dr. Castle testified that based upon a thorough review of all the data he had available to him, Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure. He testified that Petitioner worked in or around the underground mining industry for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. RX2.

Dr. Castle testified that another risk factor for the development of pulmonary symptoms is cardiac disease. Petitioner had a documented history of significant coronary artery disease. He was noted to have chest pain as well as dyspnea on exertion related to his cardiac disease. Dr. Castle noted that Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He testified that the physiologic studies that he reviewed were entirely normal in terms of spirometry. They did not demonstrate any evidence of obstruction or restriction. He testified that Petitioner did not demonstrate any abnormality of ventilatory function from any cause including coal mine dust exposure. The arterial blood gas studies were entirely normal at rest, and he had a normal response to exercise. Dr. Castle testified that Petitioner retained the respiratory capacity to perform his previous coal mining employment duties. RX2.

Dr. Castle testified that coal workers' pneumoconiosis is a permanent condition and that there is no cure for it. He further testified that the scar tissue does not cure and does not return to normal healthy lung tissue. RX2.

The treatment records of Dr. Paul Smelter, Prairie Cardiovascular Consultants, Multispecialty Care Old Jacksonville Road, and Physicians Group Associates were admitted into evidence. PX5, RX4, RX5, RX6, RX7, RX8.

On April 4, 1996, Petitioner complained of a cough on and off for past three months. He also complained of shortness of breath. It was noted that he had exertional asthma as a child. The assessment included acute bronchitis. On November 14, 1996, Petitioner was seen regarding an issue related to his finger, sore throat, an ear problem and coughing up yellow sputum. The assessment was acute pharyngitis/tonsillitis. On March 24, 1997, Petitioner complained of cough for past three weeks and fluid in the left ear. The assessment was acute bronchitis. On April 4, 1997, Petitioner was having cough with a little bit of phlegm coming up. On December 4, 1997, Petitioner complained of continued cough. His lungs were clear on examination. The assessment was chronic bronchitis. On February 6, 1998, Petitioner complained of continued cough and shortness of breath. Assessment was acute bronchitis. Petitioner was seen on December 15, 1999, with fever, aches and shortness of breath with cough. It was charted that he had acute viral syndrome. RX4.

Petitioner underwent a chest x-ray on June 7, 2002, for coal mine screening. NIOSH letter dated December 10, 2002, advises there was no evidence of pneumoconiosis on this film. Petitioner underwent a CT of the chest on November 22, 2003. No pericardial or pleural effusion was seen. The lungs were well expanded and clear of infiltrate. On March 2, 2004, it

was charted that Petitioner had acute pharyngitis and bronchitis. Petitioner underwent a CT of the chest on April 10, 2004. There was an approximately 5mm indeterminate pulmonary nodule abutting the minor fissure in the middle lobe. No pleural effusions or pulmonary infiltrates were seen on either side. Petitioner underwent pulmonary function tests on April 23, 2004. The test was noted to be reproducible and adequate for interpretation. It was a normal spirometry. On July 27, 2004, Petitioner underwent an angioplasty of a right coronary artery occlusion. On August 4, 2004, Petitioner had an angioplasty of the left anterior ascending coronary artery. Petitioner was seen by Dr. Lam for follow up on August 31, 2004. At that point he was back to work without problems. He had no shortness of breath. Petitioner was very satisfactory from a clinical viewpoint with marked improvement of angina. On October 12, 2004, Petitioner complained of a dry cough and was found to have mild bronchitis. RX4.

Petitioner was admitted to the hospital in inpatient cardiology on March 15, 2005, with complaints of chest discomfort. He reported that he began to notice an increase in exertional dyspnea approximately one week prior. Petitioner was seen on September 7, 2007, with complaints of wheezing, cough and green sputum. His lungs were charted to be normal. He was found to have acute bronchitis. Petitioner was seen by Dr. Lam in follow up on August 22, 2008. On that date he was having some chest discomfort which was not exertional. He reported that when he exerted himself with riding a bike uphill he would get some shortness of breath. Petitioner underwent a cardiolite scan on September 8, 2008. On exercise testing he achieved an estimated work load of 13.4 METS. Petitioner was found to have good exercise capacity. Petitioner was seen on December 29, 2008, for follow up regarding his blood pressure and coronary artery disease. At that time he had a cold which was accompanied by a dry cough. No breathing problems were noted. RX4.

Petitioner saw Dr. Lam on January 27, 2009. At that time he had minimal shortness of breath. His chest was clear to auscultation. No cough or breathing problems were noted at Petitioner's medical visits on April 28, 2009, and August 25, 2009. RX4.

Petitioner was seen on October 5, 2009, with complaint of chest discomfort for one week. He also related that he was tired and more short of breath. He had taken two Nitro with some relief. No cough was noted. In the "Review of Systems" section it was noted "he has black lung disease secondary to being a coal miner". RX4, p. 96. On that same date Petitioner underwent chest x-ray. Same was compared to those taken on August 4, 2004. The interpretation was that the pulmonary vasculature looked normal. The lungs were expanded and clear. There was a small rounded soft tissue nodule within the mid left lung unchanged from 2004, compatible with a benign process. Petitioner was seen by Dr. Lam on November 10, 2009. On that date the doctor charted that Petitioner had no particular shortness of breath and could do pretty much normal activity. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed it to be clear to auscultation. RX4.

Petitioner was seen by Dr. Smelter in follow up on January 26, 2010. There was no indication of cough or breathing problems. Petitioner saw Dr. Smelter on April 3, 2010. It was charted that Petitioner had no breathing problem but did have allergy symptoms when he mowed his grass with slight cough attributable to dust and grass. Petitioner was seen on August 23, 2010, by Dr. Lam. He reported he had some dyspnea on exertion if he overworked, especially

walking his dog in hot weather. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs to be clear to auscultation. Petitioner underwent a chest x-ray on August 23, 2010. The film was interpreted as revealing a stable round radiopacity in the mid left lung zone. There was a normal pulmonary vascular pattern. There was no significant change in this film from the one taken October 5, 2009. Petitioner was seen on May 9, 2011. He related that he suffered a cold a couple weeks prior and the sequela of same was still lingering with a cough, which was non-productive. No breathing problems were noted. Petitioner was seen by Dr. Lam on August 1, 2011. On that date the doctor charted that Petitioner had minimal shortness of breath. He could walk a mile and a half without stopping. Physical examination of the chest revealed the lungs to be clear. Petitioner was seen on November 7, 2011. He denied cough or exercise limitation. Review of systems respiratory revealed no chronic cough or shortness of breath. His lungs were clear to auscultation. Petitioner was seen on February 6, 2012. Review of systems respiratory revealed no chronic cough or dyspnea. The lungs were clear to auscultation. RX4.

Petitioner was seen by Dr. Lam on March 9, 2012. On that date he had minimal shortness of breath and walked over a mile or two without stopping. His chest was clear to auscultation. Petitioner was seen on April 8, 2012, for cough and sinus drainage. He reported the cough was productive of clear phlegm. He did not report any shortness of breath. The lungs did show wheezing. The assessment was bronchitis. Petitioner was seen by Dr. Ray Nawoor on December 10, 2012, for methacholine study because of a history of dyspnea. Petitioner had a negative methacholine test and normal pulmonary function. Petitioner was seen on December 17, 2012, for cold symptoms. He was aching all over and coughing up phlegm. Physical examination respiratory showed diffuse expiratory wheezes. The assessment was acute upper respiratory infection and bronchitis. Petitioner was seen on April 6, 2015, for follow up of his cardiovascular status. His chief complaint was precordial chest pain, dyspnea and coronary artery disease. Review of systems respiratory showed Petitioner denied chronic cough. His chest was clear to auscultation. Petitioner was seen by Dr. Cramer on May 11, 2015, for his coronary artery disease. He denied chronic cough. The chest was clear to auscultation. RX7.

Petitioner was seen by Dr. Cramer on September 21, 2015, for episodes of chest pain radiating to his left arm. This was in follow up from an emergency room visit for chest pain. He did not have shortness of breath or cough. Review of systems respiratory was negative. Physical examination showed no increased work of breathing or signs of respiratory distress. RX6.

Petitioner was seen on June 4, 2012. It was noted that he had minimal shortness of breath and was only short of breath with extraordinary activity. He could walk over a mile a day with no symptoms. He was able to walk up numerous flights of stairs with no symptoms. He also indicated that in addition to walking he biked for exercise. On exam his chest was clear to auscultation. Petitioner saw Dr. Lam on January 21, 2013. It was noted that he worked in a warehouse loading trucks and did heavy work with no chest pain or increased shortness of breath. He did have some mild dyspnea on exertion with overexertion that was strenuous. RX5.

Petitioner was seen on April 6, 2015, with complaint of some chest tightness and shortness of breath. On examination his chest was clear to auscultation. Petitioner was seen on May 11, 2015. On review of systems respiratory Petitioner denied any chronic cough. His chest

was clear to auscultation. Petitioner was seen on September 18, 2015, regarding chest and arm pain. Review of systems respiratory was positive for sleep apnea and otherwise negative. Chest was clear to auscultation. Petitioner underwent a myocardial profusion study on September 28, 2015. It revealed moderate sized regions of reversible ischemia of moderate severity involving the mid and distal inferior wall. Stress test on the same date was positive for the conduction of chest pain. Petitioner underwent cardiac catheterization on October 9, 2015. Discharge summary for that visit stated that Petitioner was noted to have very rapid progression of disease in the right pulmonary artery with severe in-stent restenosis resulting in complete occlusion of the RCA with a long segment occlusion. Cardiac rehabilitation was scheduled. RX8.

CONCLUSIONS OF LAW

In regard to disputed issues of disease (c) and causal connection (f), to recover compensation under the Workers' Occupational Diseases Act a claimant must prove that he suffers from an occupational disease, and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it is a causative factor in the condition of ill being. *Bernardoni v. Indus. Comm'n*, 362 Ill. App. 3d 582, 596 (2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator relies, in part, upon the findings of the two NIOSH B-readers that Petitioner's x-ray of June 7, 2002, did not reveal any evidence of coal workers' pneumoconiosis. The Arbitrator further notes that all of the NIOSH B-readers and A-readers found Petitioner's x-rays of March 14, 1977, July 6, 1979, July 17, 1984, October 11, 1993, and April 1, 1998, to be negative for coal workers' pneumoconiosis. However, the Arbitrator does not rely upon these interpretations, due to the temporal remoteness of those x-rays to Petitioner's date of accident and last date of exposure. RX3. The Arbitrator relies upon the opinions of the NIOSH physicians, as NIOSH is the governmental agency responsible for administering the health surveillance program for the benefit of coal miners, NIOSH is not a party to this action, and the x-rays were taken and reviewed for reasons independent of litigation.

Further, the Arbitrator finds the B-reading interpretations and opinions of Drs. Meyer and Castle to be more persuasive than the B-reading interpretations of Drs. Sood, Smith, and Cohen.

Dr. Sood interpreted only one x-ray dated November 21, 2003, and found it to be positive for pneumoconiosis, profusion 1/0 with S/T opacities in the right lower zone and the left middle and lower zones. This is inconsistent with the typical progression of coal workers' pneumoconiosis. It is also inconsistent with all of the other B-readers, including Petitioner's experts, and the Arbitrator assigns it no weight.

The Arbitrator does not find the x-ray interpretations of Dr. Smith persuasive. Dr. Smith interpreted x-rays of November 21, 2003, and March 15, 2005, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. He next interpreted x-ray of July 24, 2008, as positive for pneumoconiosis, profusion 1/0 with P/P opacities; however, he found opacities in only the middle and lower zones. He then interpreted x-ray of August 23, 2010, as positive for

pneumoconiosis, profusion 1/0 with P/P, and again found opacities in all lung zones. His interpretations would demonstrate that Petitioner's opacities found in the upper lung zone in 2003 and 2005 resolved, regressed, or were otherwise not present on July 24, 2008, and then reappeared on August 23, 2010. This is inconsistent with the permanent nature of the scarring and opacities of pneumoconiosis, as testified to by all experts for both Petitioner and Respondent.

Drs. Meyer and Castle interpreted x-rays dated November 21, 2003, July 24, 2008, and August 23, 2010. Both doctors found all x-rays to be negative for any abnormalities consistent with pneumoconiosis. This is consistent with the negative interpretations performed at the behest of NIOSH, discussed above, and the Arbitrator finds them persuasive.

Dr. Cohen interpreted only one x-ray dated July 24, 2008, and found it to be positive for pneumoconiosis, profusion 1/0 with P/Q opacities in all lung zones. Drs. Meyer and Castle interpreted the same x-ray as negative for any abnormalities consistent with pneumoconiosis. As such, the Arbitrator does not find the x-ray interpretation of Dr. Cohen to be persuasive.

Dr. Clapp testified that his only occupational diagnosis for Petitioner was pneumoconiosis. He based that diagnosis upon Dr. Cohen's interpretation of the chest x-ray dated July 24, 2008. In that the Arbitrator has found this x-ray interpretation to not be persuasive, the Arbitrator also finds Dr. Clapp's diagnosis of pneumoconiosis, based on that interpretation, to not be persuasive.

The Arbitrator takes note of the fact that various treatment records for Petitioner list "black lung disease and fibrosis" as one of several diagnoses. However, the record is void as to what doctor actually made that diagnosis, upon what basis the diagnosis was made, and when the diagnosis was made. The notation first appears in October 2009, without explanation. The notation is then carried through on some subsequent treatment records, but not all. Dr. Castle was asked about this on cross-examination, and whether these notations would alter his opinion. Dr. Castle testified that many people do not render accurate diagnoses and once something gets in the record it tends to be carried on and on. It is euphemistically called a carryover diagnosis. Its presence in Petitioner's treatment records did not alter Dr. Castle's opinion that Petitioner did not, in fact, have "black lung" (pneumoconiosis). RX2. Its presence also does not alter the Arbitrator's finding.

The Arbitrator finds the reverberation of opinions amongst B-readers Drs. Meyer and Castle, in conjunction with the aforementioned opinions of the two NIOSH B-readers, to be compelling. Based upon the foregoing and the totality of evidence, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis.

The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that he has chronic obstructive pulmonary disease, emphysema or bronchitis causally related to the exposures of his coal mine employment.

Petitioner underwent pulmonary function testing in 2004 and 2012. Treating doctors as well as examining doctors all noted the results were normal in both instances. Cardiopulmonary exercise testing was maximal and exceeded the predicted exercise capacity by 11%. There was no evidence of impairment due to respiratory insufficiency.

The Arbitrator notes Petitioner's treatment records document a long history of episodic shortness of breath, dyspnea, and cough, including acute bronchitis. No physician made a diagnosis of chronic bronchitis. In fact, Petitioner's examining physician Dr. Clapp, as well as Respondent's examining physician Dr. Castle specifically stated Petitioner's history is not consistent with a diagnosis of chronic bronchitis. The treatment records further document Petitioner's extensive history of cardiac disease and treatment for same. Dr. Castle testified that cardiac disease is a risk factor for development of pulmonary symptoms. Petitioner is noted to have had chest pain and dyspnea on exertion, related to his coronary artery disease.

Based on the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, or asthma that arose out of and the course of the exposures of his coal mine employment, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VIRGINIA DIAZ,

Petitioner,

vs. NO: 09 WC 17365

MITSUBISHI ELECTRIC AUTOMOTICE,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to the Respondent's "Motion for Re-Approval of Settlement Contracts with MSA Amount Included" filed June 23, 2017.

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

That by the terms of the Lump Sum Settlement Contract approved by Arbitrator Gregory Dollison on February 5, 2016, the Respondent reserved the right to close benefits under §8(a) of the Act;

That since the approval of the referenced contract, the Respondent has obtained and submitted a Workers' Compensation Medicare Set Aside (WCMSA) to the Centers for Medicare and Medicaid Services (CMS) for consideration;

That the parties have advised the Commissioner of the decision of CMS, approving a WCMSA in the amount of $9,136.00. CMS has determined that $9,136.00 adequately considers

Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs;

That the parties have advised the Commissioner of its decision to fund an MSA in the amount of $9,136.00, which adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs;

That pursuant to the terms of the settlement contract, approved on February 5, 2016, Respondent will fund said WCMSA with a lump sum payment of $9,136.00. Petitioner agrees to self-administer the WCMSA, understanding that said monies are to be placed in an interest-bearing account and agrees to only use the funds towards Medicare Allowable Expenses and in accordance with Medicare guidelines;

And it being duly noted that Section 8(a) benefits have remained open pending the MSA determination, and the Commission having jurisdiction over said claim;

It is the Order of the Commission:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Gregory Dollison on the 5th day of February, 2016, is hereby modified pursuant to the Stipulation of the parties;

2. That it is the further Order of the Commission that pursuant to the terms of the Lump Sum Settlement Contract, Petitioner's continuing rights under Section 8(a) of the Act are hereby closed;

3. That the heretofore approved Lump Sum Settlement Contract, as was approved by Arbitrator Gregory Dollison on the 5th day of February, 2016, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

DATED: JUL 19 2017

Michael J. Brennan

MJB/tdm
7/14/17
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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTONIO de JESUS AYALA,

Petitioner,

17IWCC0454

vs.

NO: 09 WC 8725

JOAQUIN CARRERA and STATE TREASURER as *EX OFFICIO* CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND

Respondents.

DECISION AND OPINION ON REVIEW

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

Petitioner suffered a work-related accident on February 7, 2009. While working on building repair, Petitioner fell from height. Petitioner suffered a severely fractured right femur, fractured right wrist, and testified he struck his face and had some teeth broken. He was hospitalized for 10 days after the accident and eventually had three surgeries to repair his leg fracture. His right arm was casted but did not require any surgery. Petitioner testified that he had temporary teeth put in and was waiting for permanent ones. However, Petitioner did not submit any medical records specifying dental treatment, though he did submit dental bills. Petitioner testified that he has tried to find employment since the accident. However, it is "always in construction" and it is difficult for him because he has hardly any strength in his leg or hand.

17IWCC0454

The Arbitrator awarded Petitioner 161.6 weeks of permanent partial disability benefits, representing loss of 40% of the right leg, 20% of the right arm, and 5% of the person-as-a-whole. The Commission agrees with the Decision of the Arbitrator regarding the issues of causal connection and medical expenses and affirms and adopts those aspects of the decision. Furthermore, the Commission agrees with the permanent partial disability award regarding Petitioner's right leg and right arm. Clearly, Petitioner suffered a devastating fracture to his right leg requiring 10 days of hospitalization and three surgeries. In addition, the record establishes that these injuries had had a negative impact on his ability to earn income because his occupation is in construction and he testified he has difficulty finding work in his field due to weakness in his right leg and arm.

The Arbitrator did not explain the bases for his 5% loss of the person-as-a-whole award. Presumably, it was compensation for the injury Petitioner testified he had to his face and teeth. Respondent argues that the person-as-a-whole award should be vacated in its entirety because Petitioner did not prove any permanent impairment from any injury to his face or teeth. Petitioner justifies the Arbitrator's award arguing the Arbitrator may take several factors into account in determining "disfigurement." However, the Decision of the Arbitrator does not mention anything regarding disfigurement. There was no description of any basis for disfigurement and there was no indication that there was any "viewing" of any area of the body to determine a disfigurement award.

Petitioner testified that he was still having some trouble with his teeth. Even though Petitioner did not provide dental records to support his testimony, there was no evidence rebutting his testimony about his facial injury or continuing difficulty. In looking at the entire record before us, the Commission finds that an award of loss of 2% of the person-as-a-whole is appropriate for the injury Petitioner sustained to his face and teeth and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $400 per week for a period of 54&4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360 per week for a period of 146.6 weeks, as provided in §8(e) and §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 40% of the right leg (86 weeks), the loss of 20% of the right arm (50.6 weeks), and the loss of 2% of the person-as-a-whole (10 weeks).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay the sum of $116,598.80, representing $92,783.80 to Loyola University Health, $22,965.00 to Loyola University Physicians' Foundation, and $850 to Little Village Dental for medical expenses under §8(a) of the Act subject to the applicable medical fee schedule.

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

17IWCC0454

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 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: JUL 18 2017

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

KWL/dw
O-6/29/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0454

AYALA, ANTONIO DE JESUS
Employee/Petitioner

Case# 09WC008725

JOAQUIN CARRERA AND THE STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 5/5/2016, 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 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0243 JAMES ELLIS GUMBINER & ASSOC
EDUARDO SAGADO
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0000 JOAQUIN CARRERA
3512 S 59TH CT
CICERO, IL 60804

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0454

17IWCC0454

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Antonio de Jesus Ayala
Employee/Petitioner

v.

Joaquin Carrera and the State Treasurer, as ex-officio Custodian of the Injured Worker's Benefit Fund,
Employer/Respondent

Case # **09** WC **08725**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **April 20, 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 **Insurance coverage and liability of the IWBF.**

FINDINGS

On **February 7, 2009**, Respondent Employer *was* operating under and subject to the provisions of the Act.

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

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 Employer.

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

In the year preceding the injury, Petitioner earned $**31,200**; the average weekly wage was $**600**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **4** dependent children.

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

Respondent Employer ***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

The Respondents, Joaquin Carrera and the Injured Worker's Benefit Fund, shall pay $850.00 to Little Village Dental, $24,820.00 to Loyola Physician's Foundation, and $92,783.80 to Loyola University Medical Center for reasonable and necessary medical services provided to the Petitioner, and subject to the medical fee schedule of Section 8.2 of the Act.

Respondents, Joaquin Carrera and the Injured Worker's Benefit Fund, shall pay Petitioner temporary total disability benefits of $400/week for 54 4/7 weeks ($21,832.00), commencing February 7, 2009 through January 12, 2010 and for the period of February 27, 2013 through April 11, 2013, as provided in Section 8(b) of the Act.

Respondents, Joaquin Carrera and the Injured Worker's Benefit Fund shall pay Petitioner permanent partial disability benefits of $360/week for 161.6 weeks, because the injuries sustained caused the 40% loss of use of the right leg (86 weeks), 20% loss of the right arm, (50.6 weeks) and 5% MAW (25 weeks) for the face injury as provided in Sections 8(e) and 8(d)2 of the Act.

The Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This 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 the Respondent-Employer to pay the benefits due and owing the Petitioner, the Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of the 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.

David A. Kane
Signature of Arbitrator

MAY 5 - 2016

May 5, 2016
Date

17IWCC0454

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Antonio de Jesus Ayala
Petitioner,

v.

Joaquin Carrera
and the State Treasurer, as
ex-officio Custodian of the Injured
Workers' Benefit Fund,
Respondents.

Case # **09** WC **08725**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Findings of Fact

Petitioner testified that he began working for Respondent-Employer Carrera around the time of January 2009. The Petitioner indicated to the court that he was hired by Carrera to work for him as a general laborer. When asked to describe the type of business the Respondent-Employer was involved in the Petitioner indicated that Carrera would purchase homes in order to remodel and resale the homes for profit. Petitioner was paid $100/day and worked six days a week, Monday through Saturday. Petitioner was paid with both cash and checks.

When asked to describe his work the Petitioner indicated that Carrera would provide all building materials required for each particular job.

Furthermore the Petitioner said his work required him to use power tools and handsaws. Regarding the assignment of work the Petitioner said Carrera would assign each week's schedule and work to Petitioner. Petitioner also indicated that Carrera had exclusive control of his hours. Specifically, Carrera controlled what time Petitioner could arrive on the job site and when he could leave.

On Direct examination the Petitioner testified to working for the Respondent-Employer on February 7, 2009. At that time the Petitioner was right handed, 35-years-old and married with four minor children. On said date, Mr. Ayala was painting while on a ladder`` at one of the homes being remodeled by Respondent-Employer. When asked who ordered him to work at the job site, the Petitioner indicated that Carrera had sent him to the location, provided the ladder, and instructed him to paint the roof canals. When asked if anything out of the ordinary happened on February 7, 2009, the Petitioner stated that he fell 20-23 feet from ladder onto the cement ground below. A neighbor witnessed the fall and called 9-1-1. Police and ambulance arrived shortly thereafter, as did Mr. Carrera. The Petitioner indicated that Mr. Carrera saw the Petitioner moments after the fall as he was being taken away via ambulance to the hospital. According to the evidence presented the Respondent-Employer Joaquin Carrera did not maintain workers' compensation insurance at this time. (Petitioner's Exhibit 4, "Pet. Ex. 4")

When the ambulance arrived at the scene of the accident, Petitioner was severely injured and had an obvious deformity to his right leg. (Pet. Ex. 5A) The Petitioner was immediately transported to Loyola Hospital's emergency room ("Loyola"), with injuries to his right leg, right wrist and a laceration above the upper lip. (Pet. Ex. 5A) X-rays were taken of

Petitioner's right knee, right elbow, right forearm, right femur, right wrist, chest, and pelvis. (Pet. Ex. 5A) Petitioner was diagnosed with a fracture of the right femur, a nondisplaced patellar fracture, a possible tibial plateau fracture, a fracture of the right ulnar in the arm and a minor dislocation of the elbow. (Pet. Ex. 5A and B)

Petitioner's injuries were so severe that they required a lengthy hospitalization at Loyola Hospital from February 7, 2009 until February 16, 2009. (Pet. Ex. 5B) Petitioner required a surgical procedure to repair his right femur fracture on February 9, 2009. (Pet. Ex. 5B) The extent of the damage caused to Petitioner's right femur was so significant that on February 13, 2009, Petitioner had a second surgery to the right femur to revise the hardware installed during the previous surgery. (Pet. Ex. 5B) Both surgeries were performed by Dr. Hobie Summers. (Pet. Ex. 5B) Petitioner was released from Loyola on February 16, 2009.

A review of the Loyola discharge records shows the Petitioner was ambulating with the assistance of a rolling walker. (Pet. Ex. 5B) Petitioner returned, per Dr. Summers' referral, for outpatient physical therapy appointments 21 times between March 13, 2009 and May 28, 2009. (Pet. Ex. 5A and 5B) The medical records of Petitioner's March 24, 2009 physical therapy appointment indicate the Petitioner continued to require the use of a rolling walker because he could not put weight on his right elbow or underarm due to his right elbow injury. (Pet. Ex. 5A) On April 3, 2009, the physical therapy notes further state that Petitioner needed to continue using walker and remain non-weight-bearing on his right leg. (Pet. Ex. 5A)

On March 31, 2009 Dr. Hobie Summers prescribe to the Petitioner that he remain off work for an undetermined amount of time due to a right

femur fracture. (Pet. Ex. 5A) On June 16, 2009, Dr. Summers continued to excuse the Petitioner from work for an undetermined amount of time. (Pet. Ex. 5A) On July 28, 2009, Dr. Summers again wrote a note excusing Petitioner from work for an indefinite amount of time, observing that Petitioner was healing from his right femur fracture. (Pet. Ex. 5A) At the same time Dr. Summers referred the Petitioner to see a sports medicine specialist. Id. On September 22, 2009, Dr. Douglas Evans also provided Petitioner with a "Return to Work" note excusing him from work "activities". Dr. Douglas indicated that a re-evaluation would occur after surgery. (Pet. Ex. 5A) On November 24, 2009, Dr. Summers also wrote a "Return to Work" note excusing Petitioner from work until treatment for his right knee injury concluded. (Pet. Ex. 5A)

On January 12, 2010, Mr. Ayala was told by Dr. Summers that he was able to return to back to work without any formal restrictions. (Pet. Ex. 5A) Despite being released from care by Dr. Summers the Petitioner continued to experience pain and swelling to his right knee. As a result on March 2, 2010 the Petitioner went in for an evaluation with Dr. Summers. At this time Dr. Summers' records indicate that Petitioner was able to return to work, but this time with formal work restrictions. (Pet. Ex. 5A) Petitioner again saw Dr. Summers on July 27, 2010. Dr. Summers provided the Petitioner an off work note during this appointment excusing Petitioner from work as a result of his right knee pain and suspected meniscus tear. (Pet. Ex. 5A)

During January of 2010, the Petitioner visited Stroger Cook County Hospital do to continued pain in his right knee. (Pet. Ex. 7) The medical records indicate that Petitioner had been scheduled for a third arthroscopy at Loyola, but Worker's Compensation refused coverage. (Pet. Ex. 7) As a

result during March of 2010, the Petitioner was placed on the elective wait list for a right knee arthroscopy at Stroger Cook County Hospital. (Pet. Ex. 7) Mr. Ayala was advised that he faced a potential six months to a year wait before he would be operated. From this date forward the Petitioner had multiple imaging studies of his right femur all of which confirmed the existence of irregular callus formation on Mr. Ayala's distal femur's fracture lines.

On February 7, 2013, Jessica Kirkpatrick, Physician's Assistant at Stroger Hospital noted that Petitioner had right knee pain which had been going on for a couple of years and caused him to ambulate with a significant limp. (Pet. Ex. 7) After years of waiting on February 27, 2013 at Stroger Cook County Hospital, the Petitioner underwent a third surgery to his right leg in order to remove hardware that had been placed during the prior two surgeries at Loyola. (Pet. Ex. 7). By April 11, 2013 the Petitioner was using crutches intermittently. (Pet. Ex. 7) Petitioner did not complain of right leg or knee pain again until July 2014, stating that the pain was 5 out of a possible 10. (Pet. Ex. 7) He was again referred to a sports medicine specialist.

After July of 2014 the Petitioner did not treat on a consistent basis for the sustained injuries suffered on February 7, 2009. Instead Petitioner's next appointment was not until November of 2015. During this time the Petitioner complained of pain in both of his knees. This time however, Petitioner's left knee hurt worse than his right. He was again referred to sports medicine specialist and given a lidocaine patch for his pain. (Pet. Ex. 7) Petitioner complained of pain in both knees again in December 2015, stating that he had had minimal symptoms until recent months. (Pet. Ex. 7) January 2016 imaging of his right knee confirmed that there were

degenerative changes in the knee and possible calcifications in the site where the hardware had previously been set. (Pet. Ex. 7) A CT scan was recommended for further clarification, but there is no record of one being taken. (Pet. Ex. 7)

According to the Petitioner he still suffers from localized pain in his right leg. He always has pain in his right wrist and has lost strength in that hand. Petitioner has tried to find a job since this accident, but it is difficult to find a job in construction because he still has weakness in his leg and hand.

Along with the aforementioned treatment to Petitioner's right leg the Petitioner also indicated that he had sustained an injury to his teeth when the ladder struck his face during the fall. As a results the Petitioner underwent treatment and was given temporary teeth. For this treatment the Petitioner paid out of pocket. (Pet. Ex. 8B). Petitioner offered into evidence two pages of payment receipts to 1st Family Dental as Petitioner's Exhibit 8B. According to Petitioner's testimony these were the receipts he was provided at the dentist office after each appointment.

Conclusions of Law

The Arbitrator adopts and incorporates the above findings of fact in support of the following conclusions of law:

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

The Arbitrator finds that Petitioner and Respondent were operating under the Act on February 7, 2009. In so finding, the Arbitrator relies on Petitioner's credible and uncontested testimony that his duties required him

to use power tools, hand saws, as well as perform other general carpentry / remodeling work.

According to the Illinois Workers' Compensation Act Section 3, there is automatic coverage when a Respondent is engaged in certain activities deemed to be "extra hazardous". Given the facts of the case in hand clearly indicate that the Respondent-Employer was involved in the remodeling of homes as a business enterprise as well as the inherent risk of handling sharp saws in a construction setting, the Arbitrator finds that the Respondent was operating under and subject to he Illinois Workers' Compensation Act.

B. Was there an employee-employer relationship?

The Arbitrator finds that prior to and an February 7, 2009, an employee/employer relationship did exist between Mr. Ayala and the Respondent-Employer. In particular the Petitioner's credible testimony and the evidence entered into evidence regarding the circumstances of his hiring.

The Petitioner testified that at the time of the accident he was employed for about a one month period by the Respondent-Employer and had been so hired by Joaquin Carrera, whom Mr. Ayala identified as the business owner. In exchange for the performance of various duties, the Petitioner testified that he was compensated in weekly payments at a rate of $100/day for six days a week or $600.00 a week in checks and cash. According to Petitioner's testimony his work day and work duties were directed and managed exclusively by Joaquin Carrera. He further stated that Joaquin Carrera obtained all projects and customers and provided any specialized tools required for the Petitioner to accomplish his work. Based

on the foregoing evidence and having considered all relevant factors, the Arbitrator concludes that, an employee/employer relationship did exist between the Petitioner and Employer- Respondent.

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

The Arbitrator relies on Petitioner's testimony and the medical records, to find that the Petitioner sustained an accident resulting in injury to his right femur, right knee, right wrist and right elbow which arose out of or in the course of is employment.

It is well settled that an injury is compensable if it arises out of and occurs in the course of employment. An injury "arises out of" the employment if the origin of risk is in some way connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Furthermore, a claimant's accident arises out of his or her employment if, at the time of the injury, the claimant was performing acts he was instructed to perform incidental to their assigned duties.

In the case at hand the Petitioner was performing a task he was instructed to perform by the Respondent-Employer and the task was an employment related risk as it involved painting a house that the company was remodeling for profit. Moreover, there is little doubt that Petitioner's accident occurred in the course of his employment with Joaquin Carrera as he was assigned to work on the day off accident and was performing task assigned to him at the directions of the owner, Joaquin Carrera. Petitioner's medical records also support his testimony of having sustained injuries to

his right leg, arm, and face while under the scope of Joaquin Carrera's employment.

D. Did the accident occur on February 7, 2009?

The Arbitrator finds that the Petitioner proved that the accident occurred on February 7, 2009, by testifying to that date and entering into evidence several medical records that support a finding of February 7, 2009 as the date of injury.

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

The Arbitrator finds that timely notice was given to Respondent-Employer, based on Petitioner's testimony that Respondent-Employer arrived at the worksite and witnessed the Petitioner lying on the ground moments after his fall. Further evidence reveals Joaquin Carrera also witnessed the Petitioner being taken away via ambulance to a local hospital. Given the fact that Petitioner testimony was credible and uncontested the Arbitrator finds that notice was properly provided to the Respondent-Employer on February 7, 2009.

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

The Arbitrator finds that Petitioner established a causal connection between the remodeling / carpentry / painting duties performed for Respondent-Employer and the onset of pain to the right leg, arm, and face, which resulted in the Petitioner being taken to the emergency room at Loyola Hospital. The medical records submitted into evidence confirm that the Petitioner severely fractured his right leg, dislocated right his elbow, sustained a right wrist fracture, as well as an injury to his mouth and teeth.

After a careful review of all the evidence, including Petitioner's testimony, the Arbitrator finds Petitioner's account of the mechanism of injury to be well founded by a preponderance of evidence and given the medical treatment related to said accident, Petitioner's current condition as to the right leg, right arm, and face are causally related to his February 7, 2009 injury.

G. What were Petitioner's earnings?

Based upon the evidence presented at trial and Petitioner's credible testimony, the Arbitrator finds that the Petitioner average weekly wage was $600.00 along with earnings of $31,200.00 in the year preceding his injury. At trial the Petitioner credibly testified that he was paid $600.00 a week in both cash and checks by Joaquin Carrera.

H. I. Petitioner was 35 years old and married with four dependents at the time of the accident.

The Arbitrator finds that Petitioner presented sufficient evidence to establish his age and marital status at the time of the accident. At trial, Petitioner's unrebutted testimony was that on the date of accident, he was 35 years old and single with four minor children at the time of the accident. Petitioner's testimony is supported by copies of his children's birth certificate submitted into evidence. (Pet. Ex. 2)

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

The Arbitrator finds and concludes that Respondent is liable for the medical treatment rendered to Petitioner as a result of the work accident on February 7, 2009. Petitioner's medical records document timely medical care rendered in connection with Petitioner's right leg, right arm, and face injuries sustained as a result of his work accident. After failed attempts at conservative care, Petitioner's providers recommended surgery to Petitioner's right leg on three separate occasions. Petitioner underwent all three surgeries and continues to have medical problems with the use of his right leg. The Arbitrator finds the medical treatment reasonable and necessary.

Petitioner alleged the following medical bills were the liability of the Respondent:

Loyola University Physicians Foundation:	$22,965.00
Loyola University Health:	$92,783.80
Little Village Dental:	$850.00

The fund did not object to these bills in evidence. Respondent shall pay directly to Petitioner the reasonable and necessary medical services of $116,598.80, as provided in sections 8(a) and 8.2 of the Act. All such outstanding medical bills shall be paid pursuant to the medical fee schedule.

K. Is Petitioner owed temporary total disability benefits?

The Arbitrator finds that Petitioner is entitled to temporary total disability (TTD) payments for the claimed period of time from February 7, 2009 through January 12, 2010 and also from February 27, 2013 until April 11, 2013 for a total of 54 4/7 weeks.

Petitioner testified and his medical records support that he was in the hospital for 10 days immediately after his injury on February 7, 2009. His medical records further reflect that he was using a rolling walker to ambulate and that he was not able to put weight on either his right leg or right arm in March 2009. From March 31, 2009 until January 2010, Petitioner's doctor consistently wrote off-work slips for Petitioner. On February 27, 2013 Petitioner had another surgery to repair his fractured femur. The last check-up following the February 2013 surgery was on April 11, 2013 when the doctor noted that Petitioner was still using crutches intermittently.

The Arbitrator finds that Petitioner is entitled to TTD payments for the period of February 7, 2009 through January 12, 2010 and for the period of February 27, 2013 until April 11, 2013 for a total of 54 4/7 weeks.

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

Petitioner testified to continuing to feel pain, discomfort, and suffers from loss of strength to his right leg and right arm. Mr. Ayala testified that since sustaining these injuries he has had trouble maintaining a job given his diminished capabilities. Based on the foregoing, Respondent-Employer shall pay Petitioner permanent partial disability payments of $360.00/week for 161.6 weeks, because the injuries sustained caused the 40% loss of use of the right leg, 20% of the right arm, and 5% MAW as provided in Sections 8(e) and 8(d)2 of the Act.

O. Insurance coverage and liability of the Injured Workers' Benefit Fund.

The Illinois State Treasurer as *ex-officio* custodian of the Injured

Workers' Benefit Fund (the Fund) was named as a party respondent in this matter. Respondent-Employer was properly served with notice of these proceedings. (Pet. Ex. 9) The Arbitrator finds that Respondent-Employer was not properly insured. (Pet. Ex. 4) In the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner this award is hereby also entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act. Respondent-Employer shall reimburse the Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Fund, including but not limited to the full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Respondent-Employer's obligation to reimburse the Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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

Joyce Bievenue,

Petitioner,

vs. NO. 09WC 36151

Menard Correctional Center,

17IWCC0480

Respondent.

DECISION AND OPINION ON REVIEW

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JUL 31 2017
SJM/sj
o-7/13/2017
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BIEVENUE, JOYCE
Employee/Petitioner

Case# **09WC036151**

MENARD CORRECTIONAL CENTER
Employer/Respondent

17IWCC0480

On 7/28/2016, 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 0.42% 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:

0384 NELSON & NELSON
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1350 CENTRAL MANAGEMENT SYSTEMS
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 28 2016

RONALD A. RARDIN, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0480

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

Joyce Bievenue
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # **09** WC **36151**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin, IL**, on **07/16/2015**. 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective Medical**

17IWCC0480

FINDINGS

On **09/29/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$55,807.96**; the average weekly wage was **$1,073.23**.

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

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

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

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

Respondent is entitled to a credit for any medical bills paid under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $31,317.00, as set forth in PX 7, 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 pay Petitioner permanent partial disability benefits of $643.94/week for 129 weeks, because the injuries sustained caused the 35% loss of the left leg (75.25 weeks), and 25% loss of the right leg (53.75 weeks), 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.

Michael K. Nowak, Arbitrator

7/14/16
Date

JUL 28 2016

FINDINGS OF FACT

Petitioner worked for the State of Illinois at Menard Correctional Center as a correctional medical technician for over 13 years until September of 2008 when she took a medical leave. She officially separated from the State in November of 2008. Petitioner filed an application for adjustment of claim which alleges that she sustained injuries to both of her knees as a result of repetitive trauma sustained while working at Menard. Petitioner alleged the date of accident as September 29, 2008.

Petitioner's work required her to be on her feet three-fourths of a normal or overtime shift on either iron or concrete. She walked up and down stairs and through the galleries. She spent two to four hours everyday walking up and down thirty-two flights of iron steps. If she worked overtime, she walked up and down ten to twenty extra flights. Petitioner worked overtime frequently. (*see* PX 12).

Petitioner squatted repeatedly in her work passing out medicine, including insulin on medication rounds. This took two to three hours or longer each day. When Petitioner reached an inmate's cell she squatted to assemble his pills and insulin injections. There was supposed to be a cart to set medicine on but it was not generally available. Petitioner's Exhibit Number 10 includes a photograph of a woman demonstrating the squatting Petitioner was required to do as she passed out medicine. She would generally stay squatting three to four minutes at each cell. Petitioner distributed medicine 90% of the time that she worked.

Petitioner carried frequently in her work. Generally the Petitioner would walk up and down the stairs carrying only her five to eight pound medication bucket. Occasionally, however she and another officer would be required to carry an inmate, a fifty-pound chair "stair chair," used to transport incapacitated inmates from their cells, and an emergency bag weighting fifteen to twenty pounds up and down four flights of stairs. There were no elevators available in most work areas.

Petitioner responded with all nurses to emergencies. The emergency responses, called hot runs, required quick responses usually carrying a stair chair and an emergency response bag. She would drag the stair chair and the emergency response bag up the stairs and then carry the inmate down the stairs on the chair. She carried the stair chair holding the handlebars and an officer carried the foot end. She used the stair chair approximately once per shift.

Petitioner had no similar exposures while off duty. She did exercise on an elliptical which, according to the treating surgeon, was helpful for her knees.

The Respondent called Gail Walls, current Healthcare Unit Administrator at Menard CC. She discussed the current requirements of correctional medical technicians. She noted that the number of inmates getting medication has increased since 1994 and that the inmate population in general has increased greatly. She admitted that Petitioner's job is considered heavy. It requires stair climbing two to four hours a day.

Petitioner testified that she had progressive problems with her knees over the years; and in the several months prior to July of 2008 the condition had worsened. She testified that she did not know the work was a cause of the pain and discomfort until her family doctor on, 09/29/08, advised that her knee problems were related to her work and that she needed to stop doing the work activity. At the time she was a fifty-year-old

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woman, five foot two weighing one hundred and seventy pounds. Petitioner testified that she had notified the employer repeatedly of her ongoing knee problems over the course of her employment, but had not reported that they were job related before 09/29/08 when she was so informed by Dr. Pickett. She had worn a knee brace to work to help her with the stairs. Petitioner further testified that the next business day after Dr. Pickett advised her that her knee problems were work related she called in and asked to amend her repetitive trauma claim she turned in earlier regarding her hands to include a claim for repetitive trauma to her knees. She testified she was told she could not amend the paperwork regarding her upper extremity claim or fill out new paperwork because she was on a leave of absence. Petitioner also turned in her doctor's paperwork dated 09/29/08 regarding her left knee problem. (PX 13)

Petitioner further testified that she started relying on the right knee because the left knee hurt and then began having trouble with the right knee also. On May 11, 2009 Dr. Pickett told Petitioner that her right knee problems were related to her work as well. When Dr. Pickett confirmed the right knee was work related she called at or near that time and spoke with Henry Fields, the charge nurse on midnight shifts to notify the Respondent of the right knee claim.

Respondent called Cindy Cowell, office coordinator at Menard CC. She handles workers' compensation cases at Menard and has been the workers' compensation coordinator for five years, starting after the Petitioner left Menard. Ms. Cowell testified that when medical information from a physician is provided to Menard it is kept in a file. She testified that she found a file for the Petitioner. She did not remember if it included the paperwork from the Petitioner's physician, Dr. Pickett. She did not bring the file to the hearing. When asked whether the Petitioner turned in medical records from Dr. Pickett discussing a particular condition before she began in 2011, she said that it could be in Petitioner's file. She would have to look at the file to know whether the documents were there. She confirmed that Petitioner's Exhibit 13 is a form that is customarily used at Menard. The form may be used for both work related and non-work related conditions.

On 06/20/06 Petitioner saw Dr. Jay Pickett regarding her upper extremity conditions. It was noted at that visit that her legs began hurting when driving two months ago, right leg more than the left. The records reflect that Petitioner continued to follow up with Dr. Pickett during this time primarily for her upper extremities.

On 03/12/07 Petitioner presented to Dr. Michael Kirk, in Dr. Pickett's office, for a chief complaint of persistent left knee pain. Petitioner reported her knee seemed to be getting worse. She reported difficulty walking upstairs. Petitioner reported her knee was aggravated by running or other weight bearing activities. She reported weakness with weight bearing or walking, a sensation of giving way, and the inability to fully bend or extend the knee. Knee effusion was noted. ROM was normal; muscle strength was normal. Petitioner was assessed with a knee pain/strain and medial meniscal tear. X-rays and a MRI were scheduled of the left knee. An x-ray of the left knee was taken for medial left knee pain, no injury.

On 03/15/07 Petitioner underwent a MRI of the left knee which revealed grade 3-4 chondromalacia of the patella with small joint effusion; no evidence of meniscal tear or cruciate/collateral ligament injury.

On 04/03/07 Petitioner returned to Dr. Michael Kirk for follow-up on left knee pain. Petitioner presented for follow-up knee pain with recent MRI showing chondromalacia. Petitioner reported a long

standing history of bilateral foot pain. Petitioner was assessed with chondromalacia and bilateral foot pain. Dr. Kirk ordered x-rays of both feet and ankles and referred Petitioner to Dr. Martin in Podiatry.

On 08/28/07 Petitioner returned to Dr. Pickett. Petitioner presented for back pain and pain in both knees, left worse than right. Petitioner had no swelling but was having a lot of pain, worse with a lot of standing. Lower back was painful as well without radiation. Petitioner was assessed with bilateral knee arthritis and degenerative arthritis of the lower back at L5-S1. CT scans of the lumbosacral spine and right knee were ordered. She was referred for an MRI of the LS spine to evaluate the severe degeneration changes at L5-S1. If the knee pain persisted, Dr. Pickett recommended Synvisc injections.

On 05/16/08 Petitioner returned to Dr. Pickett for complaints of being under a lot of stress and needing some time off of work. Petitioner reported she was very stressed over several family situations and just needed time to get it together. She also reported insomnia. Petitioner was assessed with situational anxiety and was to continue with Xanax and was given Lexapro.

On 05/27/08 Petitioner returned to Dr. Pickett for follow-up on anxiety. Petitioner was still under a lot of stress. Petitioner wanted an increase in her Lexapro. Petitioner also needed a release to go back to work. Petitioner was assessed with situational anxiety and depression.

On 07/03/08 Petitioner returned to Dr. Pickett's office and was seen by Jennifer Riebeling, PA-C. Petitioner presented with an injury to her left leg and left foot. Petitioner was stepping off chair and knee gave out causing her to fall on the leg. Petitioner had tenderness to the medial tibial plateau, trochlear groove and patella. MRI of the left knee was ordered. Petitioner was assessed with knee pain/sprain and patellar/quadriceps tendonitis. Petitioner was sent to PT for two weeks, three times per week.

On 07/08/08 Petitioner underwent a MRI of the left knee at Southern Illinois Imaging Associates for left knee pain and gives out. A comparison was made with the MRI of the left knee taken on March 15, 2007. The radiologist's impressions were: slightly progressed grade 4 chondromalacia in the patellofemoral articulation and no meniscal tear.

On 07/21/08 Petitioner presented to Dr. Sigmund at Premier Care with a chief complaint of left knee pain. Petitioner reported that her left knee pain radiated down the front of her leg. It felt like her knee was unstable at times. It has bothered her for years. Over the past two months, it became worse. The pain was on the inside and superior aspect of the knee. Petitioner just continued to have discomfort with it and had not really improved over time. Petitioner's MRI of the left knee showed grade IV chondromalacia of the patellofemoral joint, no meniscus tear was seen. Evaluation of the left knee revealed signs and symptoms of chondromalacia of the patella. Petitioner was tender in and around the patella itself. She had patellofemoral crepitation. She had no obvious effusion, no atrophy, and she walked without a limp. Petitioner reported a little difficulty trying to step up with the left leg getting up onto the step stool. The right knee was unaffected. There may be mild patellofemoral crepitation, full range of motion, and stability was 5/5 with no significant pain.

On 09/29/08 Petitioner returned to Dr. Pickett. Petitioner had paperwork that she requested to be filled out for "workers' compensation." Petitioner reported that her left knee continued with pain and required bracing. Petitioner had a second steroid injection in the knee by Dr. Sigmund at Premier Ortho, which did not

help. Examination of the knee revealed patellar compression tenderness and flexion/extension was limited due to severe pain with movement. Petitioner was assessed with bilateral carpal tunnel syndrome and left knee chondromalacia patella by MRI.

Petitioner continued to follow up with Dr. Pickett on a monthly basis while awaiting authorization to see an orthopedist for her knee. Petitioner's left knee remained painful.

On 04/15/09 Petitioner returned to Dr. Sigmund for follow-up of the left knee. Petitioner continued to have a lot of difficulty with her left knee. Petitioner reported she worked at a correctional facility in Illinois and has to walk quite a few stairs. Petitioner gave Dr. Sigmund a list of her activities. She was employed as a LPN/CMT by the State of Illinois. She has been there since 1995 and works the nightshift (11:00 pm-7:00am). Her responsibilities include preparing and administering insulin, morning medications and responding to any medical emergency. Petitioner reported that during the course of performing her normal job duties, she walks up and down 32 flights of stairs, each flight consisting of approximately 10-12 steps, for approximately nine months at a time depending on the job assignment. Petitioner also reported being mandated to work a second shift which required additional walking. Petitioner reported she had not worked since September due to the knee pain. She continued to wear the brace and stated that she needed something done. The cortisone injection failed. She says it helped very little. Petitioner was assessed with left knee chondromalacia patella and pain. Petitioner had failed to improve over a significant amount of time. She had not worked. Petitioner stated she has had time off and the knee continued to bother her. Petitioner was ready to have something done. Petitioner had a tight lateral retinaculum. Most of the problem seemed to be in the patellofemoral region. Petitioner was asked to continue with anti-inflammatory medication. Dr. Sigmund noted that they could proceed with an arthroscopic evaluation of the knee and most possibly perform a lateral release and chondroplasty.

On 05/06/09 Petitioner underwent a left knee arthroscopy with partial medial mensicectomy, chondroplasty of patellofemoral joint, and lateral release performed by Dr. Robert Sigmund at Old Tesson Surgery Center.

On 05/11/09 Petitioner returned to Dr. Pickett. Petitioner reported that she just had a left knee arthroplasty with left lateral release on 05/06/2009. Petitioner was noted to be in obvious pain, using a walker.

On 05/13/09 Petitioner returned to Dr. Sigmund for her left knee. She was status post arthroscopy with a lateral release. At surgery, they found a small medial meniscal tear and chondromalacia of the patella. Petitioner did pretty well afterwards and the knee felt good. Petitioner had been able to walk and do most things. Petitioner was to return as needed. Petitioner stated she has a lot of steps to climb at work but she stated she was not working now. Petitioner needed to give herself another 3 weeks before doing anything strenuous.

On 06/15/09 Petitioner returned to Dr. Pickett. At this point Petitioner was noted to have bilateral knee pain from arthritis. Petitioner again followed up with Dr. Pickett monthly with continued complaints of bilateral knee pain.

On 08/24/09 Petitioner returned to Dr. Sigmund. Dr. Sigmund noted that in the past he had done an arthroscopy with a partial medial meniscectomy and a lateral release. Petitioner stated she had done pretty well. She had not been back to work because she had carpal tunnel surgery recently. Petitioner still had some pain in

the knee. She had known patellofemoral problems. At the time of surgery she was found to have grade II to III patellofemoral joint changes with subluxation. Petitioner had difficulty going up and down stairs, and that was part of her livelihood at work. Petitioner worked at Menard, the state prison in Illinois and she stated she goes up and down multiple flights numbering at least 30-32 a day. She reported doing that for the past 12-13 years or so. She did not think she could go back and do her job because of the climbing, and because of her knees. She was having pain in the right knee, as well. Dr. Sigmund's impression was left knee patellofemoral chondromalacia status post arthroscopy, lateral release; arthritis to the patellofemoral joint and symptomatology on the opposite side as well. Dr. Sigmund believed Petitioner would be a good candidate for the Orthovisc supplementation. With regards to her work, Petitioner stated she just couldn't go back and do it yet. She was unable to climb. She had been in touch with a lawyer because she thinks this is related to her job. Petitioner reported climbing flights of stairs, carrying heavy work items and also prisoners now and then. She reported that she did not have any of these issues prior to having this job. Dr. Sigmund explained to Petitioner that arthritis has multiple etiologies, one of which is repetitive activities. She was at risk for developing this secondary to the job that she has. She was to come back and see him for the right knee.

Petitioner continued to follow up with Dr. Pickett on a monthly basis. She consistently reported complaints of bilateral knee pain.

On 03/25/10 Petitioner returned to Dr. Sigmund. The history taken at that time was as follows:

> Ms. Bievenue is a pleasant 55 year old female who is well-known to me for her left knee. She complains of pain and weakness in the right knee that is worse with stairs. She has a lot of pain when she gets up from a seated position or stands for a lengthy period of time. There is a lot of crunching and grinding in the knee. The knee is progressively worsening. She does a lot of stairs at work and she says this is what started a lot of her problems. She is unable to climb stairs now and she has been unable to work.

Petitioner's past surgical history was remarkable for a left knee arthroscopy. X-rays of the right knee showed advanced patellofemoral changes. The medial and lateral joint spaces showed slight irregularity and arthritis, but were not significantly narrowed. Dr. Sigmund's impression was right knee osteoarthritis and patellofemoral chondromalacia. Dr. Sigmund offered viscosupplementation. Petitioner was advised she may need some rehab on her legs. If her knee symptoms persisted, she may need a knee replacement because she had considerable patellofemoral changes.

On 04/01/10 Petitioner returned to Dr. Sigmund and underwent the first Orthovisc injection to her left knee. She returned on 04/08/10 and reported persistent pain and chondromalacia left of the patella. She underwent a second Orthovisc injection. On 04/15/10 Petitioner returned to Dr. Sigmund for her third and final Orthovisc injection to her left knee. She reported she was not getting any relief at all. She had difficulty getting around at home and going up and down stairs. Dr. Sigmund noted that with regard to her knee, Petitioner has osteoarthritis and will have a great deal of difficulty going up and down stairs. Petitioner was to return in one month.

Petitioner returned to Dr. Pickett in April and May. She was noted to have had bilateral knee injections of Orthovisc, 3 injections to each knee, without any relief. The next step was knee replacement. Disability and placard paperwork was to be completed.

On 05/11/10 Dr. Sigmund authored a "Supplemental Medical Report" in which he noted Petitioner has osteoarthritis in both of her patellofemoral joints as well as some slight arthritic changes about the medial and lateral joint spaces as demonstrated on her X-rays.

On 05/13/10, Petitioner returned to Dr. Sigmund. She continued to have problems with both knees. The left knee seemed to be a little worse than the right. It continued to click and pop around the patellofemoral joint. Petitioner was walking with a cane and stated that she could not do stairs. There was mild patellofemoral crepitation. She had a difficult time trying to get up from a seated position. Her kneecap seemed to be her biggest problem. Dr. Sigmund reviewed her radiographs from March. She had mild arthritic changes to the left knee and slight changes to the right knee. Most of these were in the patellofemoral joint of both knees. Dr. Sigmund noted that they had performed an arthroscopy; she had been through physical therapy and received cortisone and viscosupplementation injections. She had progressed poorly and had not done well. She stated that at work her job required her to climb multiple flights of stairs every night. Dr. Sigmund felt she was unable to do this and needed to be more on a flat surface. He indicated she can walk and should be allowed to use a cane. Dr. Sigmund discussed an option of seeing Dr. Robert Hagan, a plastic surgeon who is skillful at relieving knee pain and other joint pain with different forms of nerve blocks or even nerve surgery. He further felt that at some point, Petitioner would need a total knee replacement but it was difficult to say.

Petitioner continued to follow up with Dr. Pickett on a monthly basis. She consistently reported complaints of bilateral knee pain.

On 01/29/13 Petitioner was examined by Dr. David T. Volarich at the request of her attorney. Dr. Volarich did not treat Petitioner. Dr. Volarich found Petitioner's current condition of ill-being in her bilateral knees was related to her job duties at Menard CC. He felt that the repetitive work activities performed by Petitioner contributed to cause Petitioner's bilateral knee condition. He believed Petitioner required additional care for her left knee, most likely a knee joint replacement. In the right knee, depending on how she responded to conservative measures, surgical repairs such as arthroscopy may be needed as well. Dr. Volarich gave Petitioner restrictions referable to her lower extremities.

On 07/09/13, Petitioner was examined by Dr. Richard Lehman pursuant to §12 of the Act. Petitioner reported that her knee pain had been ongoing due to repetitive walking. Dr. Lehman reviewed Petitioner's medical records, performed a physical examination of Petitioner's bilateral knees, and had x-rays performed of the bilateral knees. The x-rays revealed significant degenerative changes in the patellofemoral articulation bilaterally. Dr. Lehman reviewed the deposition of Dr. Volarich and Dr. Volarich's report. Dr. Lehman opined to a reasonable degree of medical certainty that Petitioner had significant arthritis of the patellofemoral joint due to subluxation of her patella and lateral tracking. Dr. Lehman believed this was a long-term, chronic and pre-existing. Dr. Lehman did not believe that Petitioner's bilateral knee conditions were related to the repetitive walking while employed at Menard CC. Dr. Lehman believed that her bilateral knee conditions were related to preexisting patellofemoral arthritis which she had for a long period of time. Dr. Lehman believed that the

medical treatment given to the bilateral knees was not related to her work activities at Menard Correctional Center, but thought the medical treatment was reasonable and necessary due to preexisting arthritis. Dr. Lehman believed Petitioner needed restrictions. Dr. Lehman believed Petitioner was a candidate for arthroplasty to attempt to resolve her pain, but did not believe the need for the treatment was in any way causally related to her job duties with Menard CC.

On 04/30/14, Petitioner returned to Dr. Sigmund for her bilateral knees. She stated that she was continuing to have pain and was ready to have something done.

Dr. Volarich testified by deposition. Dr. Volarich pointed out that what Petitioner did on a daily basis was a significant stress to her lower extremities. (PX 4, p. 7) Dr. Volarich diagnosed overuse trauma causing progression of the patellofemoral chondromalacia bilaterally. (PX 4, p. 14) Dr. Volarich explained that were her position sedentary, her weight would not be a factor. (PX 4, p. 72) He felt that Petitioner's weight was a factor in her condition, but only when weight bearing such as getting up from a seated position, squatting, or climbing the stairs. Dr. Volarich testified consistently with his earlier report in which he wrote:

> It is my opinion the repetitive overuse work activities performed by Ms. Bievenue leading up to 09/29/08 as described in the history and job activity sections of this report including extensive stair climbing, repetitive squatting, performing hot runs to evaluate prisoners in distress and transporting patients with the fixed chair down steps, are the competent producing factors causing the left knee internal derangement that included medical meniscus tear and irreversible aggravation of chondromalacia patella that required arthroscopic repairs including partial medical meniscectomy, lateral release and chondroplasty of the patellofemoral joint. It is noted that she has developed accelerated posttraumatic arthropathy in the left knee as well. She has symptoms of right knee patellofemoral syndrome that are similar to, but not as severe as the left knee from the same job activities." (PX 5, p. 7)

Dr. Volarich noted that the Petitioner's activities were competent, producing factors causing left knee pain and an irreversible aggravation of chondromalacia. The right knee condition was likewise job related. The right knee condition was similar though not severe but also job related. (PX 4, p. 7)

Dr. Richard Lehman was also deposed. Dr. Lehman opined that Petitioner's current conditions of ill-being to her bilateral knees were not causally related to her job duties at Menard. He offered two reasons for his conclusion: 1) it takes many years for the problem to occur, and 2) the problem was essentially the same on the right and the left. He felt that her job duties did not suggest any abnormal trauma. (RX 8, p.13). He also felt that Petitioner's weight was a cause of her difficulties. He testified that when walking she puts more stress on her kneecaps. (RX 8, p. 27) He also indicated if obese, when walking over many years the joint prematurely wears out. (RX 8, p. 28) He acknowledged that squatting adds to the stress on the knees. (RX 8, p. 30) Dr. Lehman did not know that the Petitioner was required to perform repetitive squatting on her job. (RX 8, p. 41) He was not given the job description video (RX 6), or a written job description. (RX 8, p. 32)

Dr. Robert Sigmund testified by deposition as swell. Dr. Sigmund felt Petitioner's arthritic condition had several contributing causes, including the repetitive activities performed during the course of Petitioner's employment. (PX 2, p. 21). Dr. Sigmund stated that, "[t]here certainly is an association with her climbing the

stairs and the activity that she did at work for that amount of years and the overuse that she had on her knee through her employment period." (PX 2, p. 13) Her work was a cause of the osteoarthritis in her knees. (PX 2, p. 68) He felt the Petitioner was at risk for developing arthritic conditions secondary to the job she had. (PX 2, p. 21) Dr. Sigmund explained that once the arthritic process begins it is not uncommon for a person to restrict their activities and yet experience worsening of the knees due to the progression of the arthritis.

Petitioner had crepitus in the right knee at the time of Dr. Sigmund's first evaluation on 07/21/08; it was not yet to the point of causing pain but the condition was present. (PX 2, p. 57) Dr. Sigmund first charted right knee pain on 08/24/09. Dr. Sigmund explained that Petitioner's work stressed both knees and her work is a contributing factor to the arthritic conditions in both knees (PX 2, p. 36) He testified that the condition of Petitioner's right knee is also more likely than not related to her work activity. (PX 2, p. 59)

Petitioner testified that as of the date of hearing she could not kneel nor squat. Her husband carries the laundry up and down the basement stairs. Her daughter and husband help her out around the home. She can be on her feet about thirty minutes at the most before she must sit down. When shopping she uses a seated cart and takes her daughter with her. She cannot walk up the stairs at her church. She has difficulty standing up from a sitting position. She can walk only approximately two blocks at a time before she must sit down. She is limited in her ability to stand and she must change positions frequently. She has constant pain in her knees. Her day consists mostly of sitting on the couch watching television or sitting outside on the porch. She occasionally watches her grandchildren ages two and six, but she is not able to lift the two year old. She started taking Morphine seven or eight months before the hearing. She started taking Percocet at that time because Vicodin did her no good.

Petitioner testified that she doesn't want knee surgery because she has heard of people who did poorly following surgery. She has also had bad experiences with anesthesia. Her left knee pain hasn't progressed much since leaving Menard, but her right knee has worsened because she relies on it more than the left.

CONCLUSIONS

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?

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). 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 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n*, 825 N.E.2d 773, (2nd Dist. 2005). 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 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose 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. *Id.* "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.*

In this case, the evidence shows that Petitioner used her legs and knees extensively during the performance of her job duties for Respondent. Her job required climbing a significant number of stairs on a daily basis as well as squatting and carrying. Further, the Arbitrator finds the opinions and testimony of Dr. Sigmund and Dr. Volarich much more persuasive than those of Dr. Lehman in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that she sustained accidental injuries to both knees which arose out of and in the course of her employment with Respondent and that her current condition(s) of ill-being are causally related to the employment.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

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 in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 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 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 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. 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. 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 also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of the cause of their symptoms. *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 *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Three "D" Discount*, the Court held the manifestation date of claimant's injury was the date "petitioner first learned that his condition of ill-being was work related." (*Id.*, 556 N.E.2d at 265) The Court went on to caution "[a]lthough our finding that the injury in this case 'manifested itself' on July 10, rather than August 10, does not affect the Commission's ruling in petitioner's favor, we emphasize that the peculiar facts of each case must be closely analyzed in repetitive-trauma cases to be fair to the faithful employee and his employer as well as to the employer's compensation insurance carrier." (*Id.*)

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. The law also 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).

In this case Petitioner credibly testified that she first became aware that her conditions of ill-being were work related when she met with Dr. Pickett on 09/29/08. The Arbitrator notes that although some earlier records do mention climbing of stairs there is no direct statement regarding the relationship between Petitioner's condition and her employment contained therein.

Petitioner further credibly testified that she had notified the employer repeatedly of her ongoing knee problems but had not reported that they were job related before her 09/59/08 visit with Dr. Pickett. The next business day after Dr. Pickett advised the Petitioner that her knee problems were work related she called in and reported her knee condition as work related. Petitioner also turned in her doctor's paperwork dated 09/29/08 regarding her knee problems. On 05/11/09 Dr. Pickett told the Petitioner that her right knee problems likewise were related to her work. When Dr. Pickett confirmed the right knee was work related she called at or near that time and spoke with Henry Fields, the charge nurse on midnight shifts notifying him of the right knee condition.

Respondent's office coordinator, Cindy Cowell, testified that found a file for the Petitioner. She did not remember if it included paperwork from the Petitioner's physician, Dr. Pickett. Inexplicably, she did not bring the file to the hearing. When asked whether the Petitioner turned in medical records from Dr. Pickett discussing a particular condition before 2011, she said that it could be in her file and she would have to look at the file to know whether the documents were there.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that 09/29/08, is an appropriate manifestation date under the Act. Petitioner has met her burden of establishing her date of accident and further has provided proper notice as required by 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?

Petitioner attempted conservative treatment including cortisone injections, anti-inflammatories, and activity modification without relief. Arthroscopic surgery followed. The surgeon noted a small medial meniscus tear and performed a lateral release of tissues in hopes the patella would seat better within the groove.

Petitioner's medical bills totaling $31,317.00 were admitted into evidence. (PX 7)

The medical experts in this case agree that Petitioner's condition necessitated the treatment provided to date. Dr. Lehman, however did not believe the treatment was necessitated by the employment.

Based upon the foregoing and the record taken as a whole, including the Arbitrator's findings with regard to Issues C – F above, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $31,317.00, 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.

Issue (O): Prospective medical?

Dr. Sigmund opined that at some point Petitioner may need a knee replacement because she has considerable patellofemoral changes. He suggests a knee replacement on both knees. Dr. Volarich likewise reported that future medical treatment would be necessary. Dr. Lehman also felt that the Petitioner may need an arthroplasty in the future. However no specific recommendations for future treatment have been made. Therefore no award for future medical treatment is made at this time.

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

Petitioner lives with restrictions which have largely been confirmed by the testifying physicians.

Dr. Volarich noted that the Petitioner should avoid, "all stooping, squatting, crawling, kneeling, pivoting, climbing, and all impact maneuvers.... navigating uneven terrain, slopes, steps, and ladders especially if she must handle weight. She can handle weight to tolerance. She should limit prolonged weight bearing including standing or walking to 15 minutes or to tolerance." (PX 4, p. 8) Dr. Volarich reported that the

Petitioner uses a shower chair because she is unable to get in and out of the bathtub. She has difficulty putting her shoes and socks on. The problems are worse with cold and rainy weather. (PX 4, p. 9)

Dr. Lehman acknowledged that his report does list that the Petitioner needs restrictions specifically with squatting and squatting with weight. He suggested that she take the elevator instead of the stairs and otherwise self-compensate. He noted that Petitioner would be restricted in lifting and that the Petitioner had significant grinding in the patellofemoral joint of the right and left knee. She has end stage degenerative arthritis in the patellofemoral articulation in both left and right knees.

Dr. Sigmund performed arthroscopic surgery on Petitioner's left knee on 05/06/09. Dr. Sigmund observed grade two to three chondromalacia at the time of surgery. Petitioner has significant chondromalacia underneath her kneecap and patellofemoral joint. Petitioner's right knee has crunching and grinding which is audible. The right leg likewise showed advanced patellofemoral changes indicative of an arthritic condition. Dr. Sigmund felt the Petitioner is not doing well regarding her kneecaps. He attempted orthovisc injections in each knee. The doctor felt the Petitioner should be allowed to use a cane. Dr. Sigmund noted that the Petitioner has great difficulty arising from a seated position because of her knee pain. He gave her restrictions regarding bending, squatting, stooping, stairs, and avoiding walking as much as possible. Dr. Sigmund explained that the Petitioner had struggled during the job she had at Menard, and could never go back to doing what she did before, but she is employable in other jobs. She should avoid climbing activities such as stairs and squatting activities. She will struggle with days requiring long periods of walking or standing. She can walk, but she should be allowed to use a cane.

No doctor has released Petitioner to return to her former position at Menard in light of the knee injury. She testified she stopped working in September of 2008 due to knee pain.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner sustained 35% loss of the left leg and 25% loss of the right leg.

Respondent shall pay Petitioner permanent partial disability benefits of $643.94/week for 129 weeks, because the injuries sustained caused the 35% loss of the left leg (75.25 weeks), and 25% loss of the right leg (53.75 weeks) as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Phillip O' Gorman,
Petitioner,
vs.

NO: 10 WC 05569

17IWCC0465

Avalon Petroleum Company,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, 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 December 22, 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 the 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 a Review in Circuit Court.

DATED: JUL 21 2017
O062917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

O'GORMAN, PHILLIP
Employee/Petitioner

Case# **10WC005569**

AVALON PETROLEUM COMPANY
Employer/Respondent

17IWCC0465

On 12/22/2016, 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 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
HAYLEY K GRAHAM
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

1454 THOMAS & PORTELA
ERIC A BURGESON
500 W MADISON ST SUITE
CHICAGO, IL 60661

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Phillip O'Gorman
Employee/Petitioner

v.

Avalon Petroleum Company
Employer/Respondent

Case # **10** WC **05569**

17IWCC0465

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **10/14/2015**. 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 _____

FINDINGS

On **1/20/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$44,902.00**; the average weekly wage was **$817.96**.

On the date of accident, Petitioner was **21** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$1,151.47** under §8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being is causally related to the claimed accident of January 2, 2010, therefore benefits are denied.

Respondent shall be given a credit of $1,151.47 for group health 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

December 21, 2016
Date

DEC 22 2016

INTRODUCTION

This matter proceeded to hearing before Arbitrator Ketki Steffen. The disputed issues were: ***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 accident?; ***J:*** Were the 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? TTD; ***L:*** What is the nature and extent of the injury?

After Arbitrator Steffen's appointment as Circuit Judge the parties agreed to have Arbitrator Steven Fruth review the record and render a decision rather than retry the case.

FINDINGS OF FACT

Petitioner Phillip O'Gorman testified that he was employed as a helper for Respondent, Avalon Petroleum Company. Petitioner worked for Respondent for three years as a helper from 2007 to February of 2010. Petitioner testified that he refueled various diesel vehicles and tanks. Petitioner would ride along in a fuel truck and stop at various locations to refuel vehicles and fuel tanks. Petitioner testified that he worked six to seven nights per week and would work 12 to 18 hours each day. He would refuel between 500 and 1,000 vehicles per work day. Petitioner testified that he worked 60 to 100 hours per week. His job involved unrolling a 150-foot fuel hose that was approximately two inches in diameter and weighed approximately 400 pounds when filled with diesel fuel. Petitioner would carry the hose close to his hips and bend over at his waist to begin refueling.

Petitioner testified that the level of strength and force he would use to pull the hose was about a 7 on a scale of 1-10 (10 being his greatest strength). However, depending on the weather conditions, it could require 10/10 strength. He testified that it would require all of his strength at a level 10 to pull the hose if there was snow on the ground. He would kneel, crouch and bend over 50% of a shift because the position of the gas tanks on vehicles varies. For example, he would have to kneel to refuel a refrigeration trailer, bus, or a box truck.

Prior to his January 20, 2010 claimed injury, Petitioner treated at Morris Hospital February 16, 2009, complaining of low back pain (RX #2). Petitioner was diagnosed with a low back strain and prescribed Valium.

On January 20, 2010, the date of his alleged accident, Petitioner awoke at home with terrible back pain. He had worked the night before. Petitioner testified that the winter months were especially busy at work because diesel vehicles needed to run their engines all day to avoid freezing up. Accordingly he had to make more refueling stops.

Petitioner testified that he started to have back pain while working for Respondent. He stated that the pain got progressively worse to the point where it became so unbearable he sought medical treatment on January 20, 2010. He woke up on January 20, 2010 with extreme pain in his back that was shooting down his right hip and leg.

That day, Petitioner went to the emergency room at Morris Hospital complaining of low back pain radiating down the right leg (PX #1 & RX #2). It was noted that there was no known injury, onset being 3 weeks before. Another note recorded onset as 2 days before. Petitioner was diagnosed with low back pain and discharged with prescriptions, rest, and follow-up with family physician in 7 days.

On January 25, 2010, Petitioner returned to Morris Hospital with complaints of back pain that began 30 days before (PX #1 & RX #2). There was note documentation of a work-related injury. He was again diagnosed with low back pain.

On February 1, 2010, Petitioner treated with Dr. Aftab Khan (PX #2 & RX #3). Dr. Khan noted Petitioner's complaints of mid and low back pain. Dr. Khan ordered physical therapy and took Petitioner off work retroactively to January 20, 2010 until the completion of physical therapy. Dr. Khan's undated Attending Physician's report noted that Petitioner's injury arose out of his employment but also noted that petitioner did not ever have the same or similar condition. Dr. Khan further noted 10 pound lifting restrictions and that MMI was anticipated within 1 - 3 months and return to work within 30 days. Petitioner continued to follow Petitioner through March 18, 2010, when it was noted Petitioner was feeling better. Dr. Khan released Petitioner to return to work full duty with no restrictions. Petitioner testified that he needed money and asked Dr. Khan to release him to work.

On cross-examination Petitioner testified that he applied for short term disability (STD) benefits for his back pain. Petitioner identified page 13 of RX #3 (Employee Request For Information) as his application for STD. He confirmed that he checked "no" on the form when asked whether the injury occurred at work and checked "no"

when asked if he had suffered an injury. The STD application notes Petitioner worked about 50 hours per week.

Petitioner underwent an initial physical therapy evaluation at ATI February 4, 2010 (PX #3). Petitioner reported significant low back pain while at work for the past one year. He was discharged from ATI March 22, 2010 after his last therapy session on March 18.

Petitioner testified that he was laid off 2 weeks after reporting his injury and then was terminated. He did not work from February 2010 through March of 2011. In April 2011, he found work in Miami, Florida installing conduit. He did not seek medical treatment for his low back for one year.

Petitioner went to the emergency department of Adventist Bolingbrook Hospital March 25, 2011, complaining of severe mid and low back pain radiating down into his legs (PX #4 & RX#1). He reported that his pain began at school that day when he bent over. The records indicate that Petitioner complained of back pain after bending over in school that morning. On cross-examination he testified that he "blew out" his back while bending over to set down his backpack while attending welding school that day. The clinical notes document his back pain had been off-and-on for a year since an injury at work. The physical examination revealed lumbar midline tenderness. The diagnosis was back pain and severe spasm. Lumbar x-rays were unremarkable. He was advised to follow up with a primary care doctor, perform home exercises and return if the symptoms worsened. Petitioner testified that he was not able to immediately follow up with a primary care physician because he did not have health insurance and no money to pay out of pocket.

Petitioner testified that he then found new employment as a pipefitter in June of 2011. Petitioner testified that he is still employed as a pipefitter. He works at various job sites in Indiana and Illinois.

Petitioner then did not treat for about seven months. On October 14, 2011, Petitioner consulted with Dr. Hassnain Syed complaining of low back pain and strep throat (PX #5). Petitioner testified that he did not seek medical treatment because he did not have insurance and he did not have any money. Petitioner then did not follow up for about 5 months. Petitioner returned to Dr. Syed on March 8, 2012. On March 10, 2012, Dr. Syed recommended a lumbar MRI. On March 19, 2012, Petitioner underwent a lumbar MRI, which was unremarkable (PX #5).

Petitioner was examined by Dr. Jeffrey Coe, who is board certified in occupational medicine, on May 22, 2012 at the request of Petitioner's counsel (PX #6).

Petitioner reported progressive lower back pain while working. He reported that he worked 60 or more hours per week handling charged hoses weighing 350 pounds or more. He had to pull and drag hoses, crouch, and kneel while refueling trucks and heavy equipment. Petitioner reported that he had low back pain which became increasingly severe up to January 20, 2010. He awoke January 20 with severe back pain shooting into his right hip and leg. He reported that increased severity of pain and the right leg pain were new.

Dr. Coe summarized Petitioner's medical care up to the point of his examination (PX #6).

The examination revealed tender trigger points in the right perithoracic and lumbar musculature. Tenderness was also present over the right hip trochanteric bursa. He had decreased lumbar extension of 20°, where a normal exam is 35°. Dr. Coe opined that Petitioner suffered a series of repetitive strain injuries to his lower back while handling the heavy hoses working for Respondent. Dr. Coe further stated that the repetitive strain injuries caused chronic lumbar myofascial pain and right hip trochanteric bursitis with some symptoms of right lumbar radiculopathy.

Dr. Coe testified at evidence deposition January 28, 2013 (PX #7). He opined that the treatment Petitioner had received for his injuries had been reasonable and necessary. Dr. Coe also testified that his diagnosis of chronic myofascial lower-back pain and right hip trochanteric bursitis was causally related to Mr. O'Gorman's work activities for Respondent. Dr. Coe further testified that Petitioner's condition at the time of the examination was still causally related to his work for Respondent. Dr. Coe further testified that the pain Mr. O'Gorman had experienced related to wearing a backpack at school was also related to the pain he developed while working for Respondent.

Dr. Coe finally noted that Petitioner should be seen by a spine specialist or physiatrist and could benefit from physical therapy, lumbar trigger point injections, or a trial of lumbar facet blocks for pain control. Dr. Coe also testified that he would recommend Mr. O'Gorman work with restrictions of limited repetitive bending or twisting.

Petitioner testified that he did not follow up with a spine surgeon despite continued back pain. He stated that he is the sole bread winner and supports his family of 6 and would be unable to miss work. He testified that he would not be able to support his family if he had to have surgery.

Petitioner testified that presently his back pain is 8/10. He testified that his daily activities are very limited and he has difficulty picking up his young kids and bike riding. Petitioner testified that his job as a pipefitter requires him to do heavy lifting and crouching and kneeling in confined spaces as well as turning wrenches. Petitioner testified that he manages his day-to-day back pain by just "dealing with it" as he does not want to be dependent on medication. Petitioner testified under cross examination that he has not sought medical treatment for his low back since March of 2012.

CONCLUSIONS OF LAW

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

Petitioner failed to prove that he sustained an injury on January 20, 2010 that arose out of and in the course of his employment by Respondent. Petitioner has claimed that he sustained a repetitive injury to his low back that manifested itself on January 20, 2010. Petitioner's claim must rise or fall on his credibility. The Arbitrator acknowledges the difficulty in evaluating the credibility of a witness that he did not observe during their testimony. Nonetheless, there are numerous elements in the evidence that call the credibility of Petitioner into question.

Petitioner's medical records contain numerous notes regarding Petitioners report of the onset of his complaints that are inconsistent and contradictory. He testified at trial that he awoke on January 20, 2010 with extreme low back pain. That pain was shooting down his right hip and leg. When he reported for emergency care at Morris Hospital on that day he reported that he reported that there had been no injury and that his complaints began 3 weeks before. Another note recorded that he reported the onset of his complaints being 2 days before. When he returned to Morris Hospital emergency department on January 25 it was noted that Petitioner reported his back pain began 30 days before that day. When he was examined by Dr. Jeffrey Coe, on an examination obtained by his own counsel, Petitioner reported that his pain had begun a year before the complaints on January 20, 2010. He reported that those complaints had worsening progressively up to January 20.

In addition, Petitioner testified at trial that his normal work week was 60 to 80 hours per week, often 6 to 7 days a week, working 12 to 18 hours a day. When he applied for short-term disability he reported on the application, Employee Request for Information from Respondent's Exhibit #3, he reported that his normal work-week was 50 hours.

Also, Petitioner testified at trial that during the course of his day while refueling trucks and buses he had to manage and carry a 150 foot fuel hose waiting 400 pounds, a clear exaggeration. The Arbitrator notes that Olympic weightlifters do not attempt to lift such weights.

Finally, and most compelling, is Petitioner's denial of work-related injury on his application for short term disability benefits, Employee Request for Information, Respondent's Exhibit #3.

Therefore, based on a finding that Petitioner's testimony and evidence was not credible, the Arbitrator finds that Petitioner failed to prove that he was injured in a an accident on January 20, 2010 that arose out of and in the course of his employment by Respondent.

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

Based on the Arbitrator's finding that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment, this issue is moot.

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

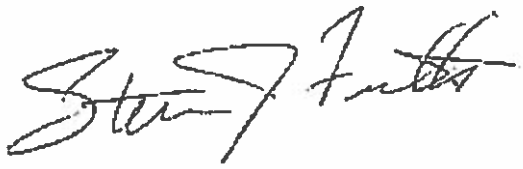
Based on the Arbitrator's finding that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment, this issue is moot.

K: What temporary benefits are in dispute? TTD

Based on the Arbitrator's finding that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment, this issue is moot.

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

Based on the Arbitrator's finding that Petitioner failed to prove that he was injured in an accident arising out of and in the course of his employment, this issue is moot.



Steven J. Fruth, Arbitrator

December 21, 2016

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

Charles Conner,

Petitioner,

vs.

NO: 10 WC 18983

17IWCC0437

Adjustable Forms, Inc,,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

17IWCC0437

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

DATED: JUL 14 2017
TJT:yl
o 7/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONNER, CHARLES
Employee/Petitioner

Case# **10WC018983**

10WC032004

ADJUSTABLE FORMS INC
Employer/Respondent

17IWCC0437

On 8/10/2015, 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:

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Charles Conner
Employee/Petitioner

v.

Adjustable Forms, Inc.
Employer/Respondent

Case # **10** WC **18983**

consolidated with **10** WC **32004**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2015, February 23, 2015, March 25, 2015, and April 20, 2015, and June 17, 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 **March 11, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

ORDER

Benefits are denied, because Petitioner's current condition of ill-being is not causally related to the accident.

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

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

Milton Black

Signature of Arbitrator

August 10, 2015

Date

FACTS

AUG 10 2015

Petitioner was employed by Respondent Adjustable Forms on March 11, 2009 and was performing work as a cement finisher. He was a member of the Local 502 Cement Masons Union.

Petitioner described his duties, including the use of specific tools. Cement masons use a trowel machine, which is three feet or four feet in size and weighs 100 to150 pounds or more. This machine is operated by one person and is used to smooth out concrete in a back up motion. The Vibra Strike is a two person operated machine, which vibrates the rocks down behind the concrete. This machine weighs 90 to100 pounds. The bull float and the 2 by 4 are used by bending over and smoothing out cement. Everything a cement finisher does on the job is backwards as the cement is made smooth. Petitioner had to watch out for obstacles, and he would turn his head as far possible in order to see as much behind him as he could.

A cement finisher job description video was viewed on the record and was submitted into evidence. Tr. March 25, 2015 at 6-7. CS RX #3.

Petitioner's job duties were also described in April 11, 2011 correspondence from Petitioner's attorney to Respondents' attorneys. According to that letter Petitioner started working for Concrete Structures in

approximately August 2009 and approximately 12 hours per day performing the cement finisher duties repetitively each and every working date for the approximate 6 month period that he was employed by Concrete Structures. AF RX #13.

On March 11, 2009, Petitioner was working on a cement pour inside a high rise building core, which is where the elevator shafts are located, and which is the first component of the building. Tr. January 22, 2015 at 37-39. Petitioner was working on the twentieth floor and about 15 feet from the elevator shaft, which was behind him. Petitioner testified that he was standing outside of the wood form, or frame, surrounding the concrete pour. The form gave way and struck him. Concrete started pouring out of the broken form and headed toward the elevator shaft. Petitioner testified that the concrete was taking him with it and that he grabbed on to rebar with both hands. Rebar is metal framing inside the core. Petitioner testified that half of his body was in the elevator shaft. Petitioner testified that he was hanging on the rebar for a couple of seconds and then co-workers pulled him up Petitioner testified that he did not notice much about himself physically except for his leg where the concrete form struck him.

Petitioner was offered, but declined, medical treatment on March 11, 2009. He presented to Dr. Ornowski on March 21, 2009 who released him to full duty work. The history indicates that he was hit by a piece of plywood involving the left knee. AF RX #5. Petitioner was scheduled for a follow up appointment on April 1, 2009, but he was a no call, no show. AF RX #5. Petitioner next saw Dr. Ornowski on February 17, 2010.

The Adjustable Forms written documentation for the March 11, 2009 accident referred to an injured knee. AF RX#1, AF RX#2, AF RX#3, AF RX#4.

Robert Easton was called by Petitioner to testify. Mr. Easton worked for Adjustable Forms and was at the job site on March 11, 2009. He testified that he assisted Petitioner get back to the top of the form after it broke and that Petitioner was three or four feet below standing on a platform. The platform was attached to the outside of the form, which was the barrier for the finished concrete.

Roy Bittner was called by Adjustable Forms to testify. Mr. Bittner prepared certain accident reports on March 11, 2009. He testified that he was on the job site on March 11, 2009 and was not aware that Petitioner was being pushed down an elevator shaft by concrete and had to grab on to rebar to avoid falling down the shaft. He testified that if this had happened it would have been brought to his attention and would have been noted in the reports.

Edward Foggie was called by Adjustable Forms to testify. Mr. Foggie was the general foreman and was called to the job site on March 11, 2009 after the incident. The accident that he was told of was that Petitioner had hurt his knee. He met with Petitioner immediately after the incident and offered him medical treatment. Petitioner did not accept the offer of medical treatment and indicated that he would finish the work day. Petitioner did not tell him about being pushed down an elevator shaft by pouring concrete. He testified that if something like that happened he probably would have heard about it.

After March 9, 2009 Petitioner worked as a concrete finisher for several different companies including Concrete Structures, the Respondent in consolidated case 10 WC 32004. In late May or early June 2009 Petitioner started working for Concrete Structures. Petitioner was able to perform all of the job duties of a concrete finisher and use all the tools he previously described. Petitioner testified he started feeling clumsy but did not go to any doctors. He continued working with Concrete Structures through February 16, 2010. Starting

in September 2009 Petitioner was working on the Rush Hospital project. The job involved long hours and more concrete than other jobs. He was performing the same job duties, but for longer days.

Petitioner initialed a Daily Sign-In Sheet at the end of his workday on February 16, 2010. CS RX1. Lori Cannata, the safety director for Concrete Structures, testified that the form was used by Concrete Structures as a time sheet for its workers to sign in when they arrive at work and to sign out when they leave work. The form shows that the Petitioner placed his initials in a column on the sheet for "Not Injured on the Job Today". Ms. Cannata testified that it means that Petitioner acknowledged not suffering an injury on February 16, 2010.

She testified that to her knowledge Petitioner was able to perform all the job tasks expected of a concrete finisher during his employment with Concrete Structures in between September 2009 and February 2010. She was never told that Petitioner had any balance issues was dropping tools while working for Concrete Structures.

William Palmer was called by Concrete Structures to testify. He worked with Petitioner during 2009 and 2010 and did not recall Petitioner ever losing his balance or falling over. He did not recall Petitioner dropping work related equipment at any time. He indicated Petitioner was able to perform all of the job duties of a concrete finisher when he worked for Concrete Structures.

Jason Price, a coworker, testified that he personally observed Petitioner leaving the jobsite on February 16, 2010, that Petitioner looked fine, and that Petitioner did not say anything about being injured. Mr. Price testified that he remembers walking with Petitioner for a quarter mile to their respective cars. Mr. Price testified that Petitioner appeared to be walking normally and that Petitioner did not say anything about falling on the jobsite. Mr. Price testified that he observed Petitioner get into his car and drive away.

Jason Price testified was not aware of any problems Petitioner was having at the Rush job site. Petitioner was able to perform all of the job duties of a cement finisher on the Rush project. Mr. Price was not aware of any clumsiness or balance issues of Petitioner. He was not aware of any issues Petitioner had dropping tools.

Petitioner testified that on February 16, 2010, he worked from 7:00 a.m. to 9:00 p.m. and that when he was leaving, getting off the elevator, he went to take a step and fell on his face. Petitioner testified that his right side went out on him and he lost control of his bladder.

On February 17, 2010, Petitioner presented to Dr. Ornowski. Petitioner complained of right leg weakness for three weeks on and off. The assessment was recurrent weakness L5-S1, and a lumbar MRI was recommended. AF RX #5.

On February 22, 2010, Petitioner underwent a MRI of the lumbar spine. PX #4 at 111-112. It revealed:

1. Severe changes of degenerative disc disease at L5-S1, with disc space narrowing, endplate degenerative signal changes, and mild enhancement likely reactive and degenerative in etiology.

2. At L4-L5, there were moderate central broad based disc herniations causing mass-effect on the ventral margin of the thecal sac. There was also bilateral inferior foraminal narrowing at both of these levels.

On March 4, 2010, Petitioner underwent a MRI of the cervical spine. The indication was severe weakness in the right leg, possible spinal cord compression. PX #4 at 113-114. It revealed:

1. Markedly abnormal MRI of the cervical spine. There were moderate to large disc herniations with superimposed osteophytes at both C5-C6 and C6-C7. There was abnormal increased T2 signal within the cervical spinal cord most prominently at C6-C7.

2. Severe multilevel degenerative changes throughout the cervical spine and a prominent disc bulge and central osteophyte formation at C3-4.

On March 4, 2010, Petitioner also underwent a MRI of the thoracic spine. PX #4 at 108. It revealed:

1. Degenerative changes and right paracentral asymmetric disc bulge and proliferative change at C3-4.
2. No cord compression in the thoracic spine.

On March 4, 2010, Petitioner presented to Dr. Martin Luken who reviewed the MRI scans. He indicated that Petitioner had severe and apparently progressive cervical spondylitic myelopathy and was a candidate for operative decompression of his spinal cord as soon as it can be arranged. PX #5 at 122.

On March 6, 2010, Petitioner underwent multiple decompressive cervical laminectomies and foraminotomies, C2-7, performed by Dr. Luken. The diagnosis was cervical spondylitic myeloradiculopathy with spastic quadriparesis due to multilevel cervical spondylitic spinal stenosis. PX #4 at 101.

In the operative report Dr. Luken noted that Petitioner could not recall any neck injuries in the recent or remote past, though within the past several days his clumsy right foot tripped on a carpet at home and caused him to fall. Petitioner had abrasions on his forearm from this incident. PX #4 at 102.

Petitioner followed up with Dr. Luken who noted improvement in the strength of his right arm and leg. Petitioner continued to have spastic quadriparesis. Physical therapy was to begin. PX #4 at 61.

On April 20, 2010, Petitioner followed up with Dr. Ornowski who noted that the "relation of cervical spondylosis and lumbar radiculopathy to work is impossible for me to judge." PX #9 at 2.

On April 30, 2010, Petitioner followed up with Dr. Luken reporting that he was comfortable most of the time but had some right side clumsiness and weakness. Petitioner was undergoing physical therapy. Petitioner was to remain off work. PX #4 at 62.

On June 7, 2010, Petitioner presented to Dr. Luken reporting substantial improvement in strength and dexterity of his right hand and leg. A history of injury was noted where Petitioner stated he had a frightening fall down an elevator shaft in the course of his work on March 9, 2009. This was the first reporting of this history to Dr. Luken. Physical therapy was to continue and a cervical MRI was recommended to confirm a satisfactory decompression. PX #4 at 63.

On July 1, 2010, Petitioner underwent a subsequent cervical MRI. The only change noted was a wide laminectomy C3-7. PX #4 at 105.

On July 9, 2010, Petitioner presented to Dr. Luken stating that his workers' compensation claim had been rejected because of the absence of any documented link between a specific work injury and the onset of his symptoms. Petitioner complained of a spastic quadriparesis with a distinct right sided reflex preponderance. Petitioner was to remain off work. PX #4 at 64.

On August 6, 2010, Petitioner presented to Dr. Luken stating that he felt progressively steadier on his feet but doubted he would be able to return to his usual industrial work. Petitioner was to remain off of work. PX #4 at 65.

A letter dated October 16, 2010 from Dr. Luken to Petitioner's attorney provides a narrative of treatment. Dr. Luken noted that if the history counsel provided is accurate then the incident of March 15, 2009 precipitated or critically aggravated Petitioner's cervical spinal cord compromise such as to result in the progressively severe symptoms and the disability for which Dr. Luken treated Petitioner. According to Dr. Luken the repetitive trauma culminating on February 16, 2010 at Concrete Structures was also a contributing factor. PX #4 at 67-70.

On October 22, 2010, Petitioner followed up with Dr. Luken, who noted that Petitioner's symptoms remained the same, and he wanted to wean Petitioner from his narcotics and substitute ibuprofen. Physical therapy was to continue. PX #4 at 71.

Petitioner underwent approximately numerous physical therapy sessions at Landmark Physical Therapy from March 26, 2010 through October 25, 2010. PX #7 at 8-76.

As of November 21, 2011, Dr. Luken found that Petitioner had significant permanent impairment consistent with a spastic quadriparesis. PX #1 at 42-44.

Petitioner's treatment included additional physical therapy at Progressive Therapeutics. PX #8 at 3-4, 90. Petitioner signed a patient registration questionnaire on December 21, 2012. PX #8 at 5-9. In answering a question inquiring when Petitioner's symptoms began he wrote March 6, 2010. PX #8 at 6. March 6, 2010 is the date of Petitioner's cervical spine surgery.

Petitioner testified that he has a company named 3C Construction, with this company on his voicemail and with business cards to try to get side construction work. He testified that he can still use his mind regarding general construction business.

At the request of Respondents, Petitioner presented to Dr. Alexander J. Ghanayem who later testified via deposition. AF RX #6. Dr. Ghanayem opined that the spinal cord was compressed because there was not enough room in Petitioner's neck to carry the spinal cord and that there was no medical support for causation. AF RX #6 at 11-17.

Dr. Luken testified via deposition. Dr. Luken testified that the fall into the elevator shaft aggravated an underlying degenerative disease. PX #1 at 49-50. Dr. Luken testified that the details of the elevator shaft incident came from Petitioner's attorney. PX #1 at 68, 74, 81. Dr. Luken testified that his causation opinion depended on the accuracy of the history and the history was at least in part provided by Petitioner's attorney. PX #1 at 83. Dr. Luken testified the lack of medical treatment between March 21, 2009 and February 17, 2010 was at odds with his understanding of the medical history. PX #1 at 86.

Petitioner presented to Dr. Jeffrey Coe at Petitioner's attorney's request. Dr. Coe testified via deposition. Dr. Coe's testified that he was unable to state to a reasonable degree of medical certainty that Petitioner's condition was causally related to the accident described as having occurred in March of 2009. PX #2 at 42, 53. Dr. Coe further testified that the work Petitioner performed for Concrete Structures was a factor aggravating the preexistent cervical degenerative disc disease and degenerative arthritis, causing the onset of both acute and chronic cervical symptoms. PX #2 at 43.

Petitioner was interviewed by Susan Entenberg, a vocational rehabilitation counselor, at Petitioner's attorney's request, she testified via deposition. Ms. Entenberg opined that Petitioner was restricted to sedentary work and that he was a poor candidate for vocational rehabilitation. PX #3 at 24. She testified that if Petitioner did not have hand tremors he could perform sedentary jobs earning up to $10.00 per hour. PX #3 at 28. She testified that she did not conduct a job search or perform employment counseling. PX #3 at 58.

At the request of Respondents, Sharon Babat provided opinions regarding Petitioner's employability and her deposition was taken. She drafted a vocational assessment report and a labor market survey. AF RX #10, Deposition Exhibits # 2 and #3. Ms. Babat opined that Petitioner would be able to locate employment earning between $9.00 and $28.80 per hour. AF RX #10 at 23.

Petitioner testified to current complaints as of January 22, 2015 being issues walking, trembling and numbness in his hands, and tingling on the right side of his neck. Tr. January 22, 2015 79-80. Petitioner testified that his medical treatment did not help his symptoms.

March 11, 2009

CAUSATION

The histories in the various records and testimonies are not consistent regarding specific details. Petitioner testified he was hanging on to the rebar and then he was pulled up by co-workers. However, the testimony of Robert Easton was that he assisted Petitioner up from the wood platform which was four feet below the rebar Petitioner claims he was hanging on to. In other words Petitioner would not have been hanging in the air. He would not have been standing on a platform with his weight supported by his legs.

The records and the testimony of the treating surgeon Dr. Luken, indicate that he was not made aware of the elevator shaft incident until he noted it in his June 7, 2010 record. Dr. Luken testified the history of this event was provided to him in much more detail in correspondence from Petitioner's attorney, as opposed to the Petitioner himself.

Petitioner did not present for emergency treatment the date of the March 11, 2009 incident. When he did present to Dr. Ornowski ten days later, on March 21, 2009, there is no history of the alleged elevator fall incident noted.

Petitioner returned to full duty cement finishing work for various different construction companies including Respondent Concrete Structures. He worked at Concrete Structures from March 2009 through February 16, 2010. He worked up to 12 hour days. The job duties would be considered heavy and strenuous, but Petitioner was apparently able to do this work following the March 11, 2009 incident after he left his employment with Adjustable Forms.

There are no medical records between March 2009 and February 2010. Witnesses testified that they could not recall any physical issues Petitioner had during this time period.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the March 11, 2009 incident.

The remaining issues regarding case 10 WC 18983 are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ 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 Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Harold McCoy,

Petitioner,

vs. NO: 10 WC 23695

17IWCC0474

Prairie Farms Distribution (PFD Supply),

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and Respondent herein and notice provided to all parties, the Commission after considering the issues of causal connection, temporary total disability benefits, medical expenses, nature and extent of permanent disability, penalties under §19(k) and §19(l) and §16 attorneys' fees and additional evidence 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.

Credit

The Commission notes the Arbitrator neglected to provide a credit to Respondent of $4,500.00 for an advance of permanent partial disability benefits in the Decision's findings. The Arbitrator did grant the same in the body of the Decision. The Commission corrects the clerical error awarding the $4,500.00 for the advance of permanent partial disability benefits paid by Respondent along with the $15,269.08 paid for temporary total disability benefits for a total credit of $19,769.08.

17IWCC0474

Medical Expenses

The Commission has reviewed PX11- claimed medical expenses- in detail and discovered multiple duplicative billings as well as unsupported interest charges. The following is noted by the Commission:

*Dr. Gornet: $120,671.82 claimed from MFG Spine LLC and The Orthopedic Center of St. Louis. However, the account financial history for MFG Spine LLC evidences charges of $77,936.51 less payments of $12,871.67 and adjustments of $1,535.99 rendering a balance due of $63,528.85. Contained within these charges are unsupported interest charges of $7,876.03. The Commission declines to award these interest charges. As such the Commission awards the remaining balance from MFG Spine LLC in the amount of $55,661.82. The account financial history for The Orthopedic Center of St. Louis evidences charges of $57,142.97 of which $6,573.97 is due for interest. The remaining charges totaling $50,569.00 relate to spine surgery performed on June 16, 2014 also billed by MFG Spine LLC in the same amount under the same medical code. The Commission denies as duplicative the bill from The Orthopedic Center of St. Louis in the amount of $57,142.97.

*MRI Partners of Chesterfield: $2,645.00 claimed. However, the account financial history evidences charges of $7,245.00 less payments of $4,600.00 rendering a balance due of $2,645.00. Included in the charges are unsupported interest charges of $345.00 which the Commission declines to award. Therefore, the Commission awards the bill in the amount of $2,300.00.

*CT Partners of Chesterfield: $7,024.32 claimed. However, the account financial history evidences charges of $14,330.52 less payments of $6,082.59 and adjustments of $1,223.61 rendering a balance due of $7,024.32. Included in the charges are unsupported interest charges of $520.32 which the Commission declines to award. Therefore, the Commission awards the bill in the amount of $6,504.00.

*The Work Center: $6,115.00 listed for physical therapy 8-15-13 through 10-3-13. Therefore, the Commission awards the bill in the amount of $6,115.00.

*Pain and Rehabilitation Specialists of St. Louis: $5,597.00 claimed. However, the account financial history evidences charges of $5,597.00 less payments of $4,999.92 and adjustments of $597.08 rendering no balance due. Therefore, the Commission denies the bill.

*The Spine & Orthopedic Surgery Center: $138,393.86 claimed. However, the account financial history evidences charges of $147,423.86 less payments of $5,447.69 and adjustments of $3,582.31 rendering a balance due of $138,393.86. Included in the charges are unsupported interest charges of $14,061.52 which the Commission declines to award. Therefore, the Commission awards the bill in the amount of $124,332.34.

*West County Care Center: $3,120.15 claimed. However, the account financial history evidences charges of $3,120.15 with no payments made and no adjustments rendering a balance due of $3,120.15. Included in the charges are unsupported interest charges of $358.93 which the Commission declines to award. Therefore, the Commission awards the bill in the amount of $2,761.22.

*Dr. Oliver: $198.61 claimed. No itemized statement is contained within PX11 and the records submitted reference treatment to the right knee. Therefore, the Commission denies this bill.

The Commission modifies the medical expense award pursuant to §8(a) of the Act to $197,674.38, subject to the limits of the Medical Fee Schedule pursuant to §8.2 of the Act.

Penalties

The Commission finds Petitioner is entitled to penalties pursuant to §19(l) of the Act in the amount of $10,000.00. Penalties pursuant to §19(l) are in the nature of a late fee. *Mechanical Devices v. Industrial Commission*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). In addition, the assessment of a penalty pursuant to §19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552 (1998). "The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. [citation omitted]." *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶19. The employer bears the burden to justify the delay. *Id.*

In its September 2, 2011 decision, the Commission awarded prospective medical care as recommended by Dr. Gornet. The decision did not specify the exact treatment awarded. On April 18, 2013 the Appellate Court affirmed the Commission's decision. Petitioner re-commenced treatment with Dr. Gornet on June 3, 2013 following a two year hiatus. During Petitioner's August 8, 2013 visit, Dr. Gornet recommended Petitioner exhaust conservative treatment including injections and physical therapy prior to undertaking the surgery which was previously recommended in 2011. On October 7, 2013 Dr. Gornet re-evaluated Petitioner who continued to complain of low back pain but was functional. Dr. Gornet recommended a watch and see approach in order to determine if Petitioner could function with potential restrictions in an effort to avoid surgery. Dr. Gornet recommended follow-up in three to four months. On Dr. Gornet's recommendations, Petitioner was re-evaluated four months later on February 6, 2014. Dr. Gornet recommended proceeding with the previously discussed surgery as Petitioner's pain affected all aspects of his life. PX1.

Given the above sequence of events, Respondent's failure to pay for the treatment recommended by Dr. Gornet beginning in 2014, including but not limited to surgical intervention was objectively unreasonable. Dr. Petkovich's opinion of November 21, 2013 that the surgery was neither reasonable nor necessary was the same opinion and with the same basis as he

articulated in December of 2010, an opinion rejected by the Commission with its decision of September 2, 2011. RX12, p. 37. Dr. Gornet attempted conservative management of Petitioner's back condition, and when such treatment modalities failed, Dr. Gornet recommended and performed surgery. Respondent's denial of such treatment was unreasonable.

The Commission in its discretion declines to award penalties pursuant to §19(k) and attorney's fees pursuant to §16 of the Act. The standard for awarding penalties and fees under §§19(k) and 16 are higher than §19(l) of the Act. The standard requires "more than an 'unreasonable delay' in payment of an award. [citation omitted]. It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. Instead, section 19(k) penalties and section 16 fess are 'intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose.' *McMahan*, 183 Ill. 2d at 515." *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶23.

The Commission finds Respondent's conduct was not deliberate nor the result of bad faith or improper purpose. Respondent paid for the treatment provided by Dr. Gornet through 2013. Petitioner appeared to be functioning without significant issue following his appointment with Dr. Gornet on October 7, 2013. Dr. Petkovich re-evaluated Petitioner on November 21, 2013 at which time Petitioner advised of some pain into his lower back and into his left extremity. RX12, p.8. Dr. Petkovich recommended no further treatment at that time. Although Respondent's subsequent denial of Petitioner's treatment following this evaluation was not reasonable as outline above, Respondent's conduct did not rise to the level of bad faith or improper purpose as such medical opinion did question the reasonableness and necessity of the surgery.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $433.33 per week for a period of 37-6/7 weeks, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $197,674.38 for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 4.1 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the right hand to the extent of 2%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 18.975 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the right arm to the extent of 7.5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 12.65 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the left arm to the extent of 5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the cervical spine injuries sustained caused the permanent disability of the person as a whole to the extent of 7.5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the lumbar spine injuries sustained caused the permanent disability of the person as a whole to the extent of 15%.

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 $15,269.08 in temporary total disability benefits and $4,500.00 for an advance towards permanent partial disability benefits for a total credit of $19,769.08.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical expenses that have been paid, if any, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

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

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: JUL 25 2017
LEC/maw
o06/06/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCOY, HAROLD
Employee/Petitioner

Case# **10WC023695**

17IWCC0474

PRAIRIE FARMS DISTRIBUTION (PFD SUPPLY)
Employer/Respondent

On 9/6/2016, 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 0.48% 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:

0438 BROWN & CROUPPEN
KERRY I O'SULLIVAN
211 N BROADWAY 16TH FL
ST LOUIS, MO 63102

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD POB 446
EDWARDSVILLE, IL 62025

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

Harold McCoy
Employee/Petitioner

v.

Prairie Farms Distribution (PFD Supply)
Employer/Respondent

Case # **10** WC **23695**

Consolidated cases: **N/A**

17IWCC0474

An *Application for Adjustment 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 **Collinsville**, on **August 26, 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

17IWCC0474

On **April 7, 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 **$33,800.00**; the average weekly wage was **$650.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$$15,269.08** for TTD, **$0** for TPD, **$0** for maintenance, and **$4500.00** for other benefits, for a total credit of **$19,769.08**.

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 $283,765.58, as set forth in P.X. 11 as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $433.33/week for 37 6/7 weeks, commencing 1/6/11 through 6/10/11 (22 2/7 weeks), and 5/27/14 through 9/12/14 (15 4/7 weeks), as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $$15,269.08 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $390.00/week for 35.725 weeks, because the injuries sustained caused the 2% loss of the right hand (4.1 weeks relative to the right wrist), 7.5% loss of the right arm (18.975 weeks relative to the right arm), and 5% loss of the left arm (12.65 weeks relative to the left arm), as provided in Section 8(e) of the Act.

Respondent shall also pay Petitioner permanent partial disability benefits of $390/week for 112.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole (37.5 weeks relative to the cervical spine), and 15% loss of the person as a whole (75 weeks relative to the lumbar spine), as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/1016
Date

ICArbDec p. 2

SEP - 6 2016

BACKGROUND

This matter was tried previously pursuant to Section 19(b) of the Workers Compensation Act and a decision was issued by Arbitrator Andrew Nalefski on January 25, 2011. (P.X. 12). Arbitrator Nalefski found that an accident occurred which arose out of and in the course of Petitioner's employment on April 7, 2010, and that Petitioner's condition of ill-being was causally related to the work injury. Arbitrator Nalefski ordered that Respondent shall pay medical bills in the amount of $9,473.00 and temporary total disability benefits for a period of 37 and 2/7ths weeks from April 7, 2010 through July 5, 2010 and from July 19, 2010 through January 5, 2011. Arbitrator Nalefski further ordered that Respondent shall authorize and pay for the prospective medical treatment recommended by Dr. Gornet, subject to the Fee Schedule. The decision issued by Arbitrator Nalefski on January 25, 2011 references Dr. Gornet's deposition testimony which stated that he would like to exhaust conservative measures, such as physical therapy and if that fails, then he would order injections and if injections fail, then surgery is an option. (P.X. 12). Arbitrator Nalefski's decision was appealed through the Illinois Workers Compensation Commission, Circuit Court and Appellate Court and affirmed at all levels of appeal. (P.X. 12).

The Arbitrator notes that among the exhibits submitted at Arbitration are two depositions of Dr. Petkovich. One deposition occurred prior to the hearing held before Arbitrator Nalefski. Since it is presumed Arbitrator Nalefski has previously ruled on any objections in the first deposition this Arbitrator will only consider objections raised in the second Dr. Petkovich deposition of April 14, 2014.

FINDINGS OF FACT

On April 7, 2010 Harold McCoy fell four to five feet off of the top of the ramp on his trailer. (P.X. 12). He landed on his right arm, head, and left elbow. He sustained a right minimally displaced fracture of the radial head of his right elbow, a right wrist sprain, left elbow traumatic bursitis, cervical disc herniations at C5-6 and C6-7 and an L4-5 annular disc bulge with left paracentral disc extrusion with caudal migration behind L5 and an annular disc bulge at L5-S1 with a paracentral disc protrusion and an annular tear. (P.X. 12). On September 10, 2010 Mr. McCoy's was sent a letter stating that his only route with PFD Supply, Church's Chicken, had been cancelled, thereby ending his employment. (T. 65).

On September 20, 2010, Dr. Gornet had recommended attempting conservative medical treatment for Petitioner's low back, and further indicated that if conservative measures were unsuccessful surgery was an option. (P.X. 1). The 19(b) hearing before Arbitrator Andrew Nalefski took place on January 5, 2011. (P.X. 12). After the 19(b) decision was issued on January 25, 2011, Petitioner continued to follow up with Dr. Gornet through April 25, 2011.

On March 21, 2011, Dr. Kaylea Boutwell administered an L4-5 epidural steroid injection on the referral of Dr. Gornet. (P.X. 5). On April 11, 2011, Dr. Boutwell administered an L5-S1 epidural steroid injection. Id.

On April 25, 2011, Dr. Gornet reexamined Petitioner's low back. At that time, Dr. Gornet recommended an anterior L5-S1 fusion and disc replacement at L4-5 and opined that Petitioner was temporarily and totally disabled. (P.X. 1). Petitioner testified that Dr. Gornet would not see him back after the April 25, 2011 appointment because workers compensation was not approving treatment. (T. 16). From April 25, 2011

through May 9, 2013, when his Appellate Court case was finalized, Respondent did not authorize treatment or pay TTD benefits. (R.X. 1, 2).

Approximately six weeks later, on June 8, 2011, Petitioner completed a physical exam for a commercial driver's license (CDL) so that he could attempt to obtain employment with AC Trucking. (R.X.4). Petitioner testified that on June 8, 2011 he checked off on the CDL physical exam form that he had a prior injury of a right elbow fracture, but he did not tell them he had chronic low back pain, neck pain, left elbow or wrist pain. He testified he did not disclose the true extent of his condition because he knew he would not be hired. He was not receiving benefits and he has a family to support. He further indicated that the job at AC Trucking he was applying for was low impact with nothing to move or carry. He would just be driving a truck. (T. 20, 21, 23). Petitioner did obtain the truck driving job at AC Trucking and he worked there from June 10, 2011 through June 27, 2011. (T. 22). He quit when he got a truck stuck in the mud and got into an argument with the boss. (T. 23).

Respondent offered Petitioner's tax records into evidence. His tax returns show that in 2010, he had net drywall earnings of $2,356.00. (R.X. 17 2010). Petitioner believed that the drywall side work he performed in 2010 was during the winter prior to his work injury on April 7, 2010, because he remembered that he left his PFD Supply coat at the job site and he was worried about having to buy a new coat. Petitioner's 2011 tax return shows gross income of $18,186.00, including net drywall earnings of $1,738.00. (R.X. 17). His 2012 tax returns gross income of $27, 965.00 indicate earnings from his work at Wehmeier Drywall, his current employer, and side jobs. (T. 50, R.X. 17).

On June 22, 2012 Petitioner began working at Wehmeier Drywall as a drywall taper. He continues to work at Wehmeier Drywall at the time of trial.

On April 4, 2013 was involved in a motor vehicle incident while leaving a bar when his brake pedal had a drink bottle stuck under it and he tried kicking it out, accidentally hit the gas causing his truck to go over the curb and crush a trash can against a wall. He testified was not injured and sought no treatment as a result of the incident. He was, however cited for driving while intoxicated and leaving the scene of an accident.

On April 18, 2013 the Appellate Court filed its decision. The time to appeal ran and the decision became final on May 9, 2013. On May 10, 2013, Petitioner's attorney provided Respondent a signed Satisfaction of Award/Judgement for the 19(b) decision. (R.X. 21). Petitioner's attorney noted that this was a "partial" satisfaction of award/judgment since Petitioner was awaiting authorization of medical treatment and confirmation of payment of the medical bills submitted at the 19(b) hearing. Id.

On June 3, 2013, Dr. Gornet reexamined Petitioner. (P.X. 1). Dr. Gornet noted that Petitioner had no new slips, falls or other issues. Id. Dr. Gornet prescribed a new MRI and allowed Petitioner to continue to work full duty. Id. Dr. Gornet recommended conservative measures to treat Petitioner's low back condition at that time, and Respondent approved this conservative medical treatment. (P.Ex.1; R.Ex.1:1; R.Ex.18:12).

Petitioner underwent physical therapy for his low back at the Work Center from August 15, 2013 to October 3, 2013. (P.X. 4). Respondent approved this physical therapy. (R.Ex.1:1; R.Ex.18:12). Dr. Boutwell administered a left L4-5 transforaminal epidural injection on August 19, 2013, a left L5-S1 transforaminal epidural injection on September 4, 2013, and a left L4-5 epidural steroid injection on September 23, 2013. (P.Ex.5).

On October 7, 2013, Dr. Gornet noted that conservative measures had failed. Dr. Gornet's note of that date addresses his concerns about proceeding to surgery which would require placing permanent restrictions on Petitioner. He indicated that as Petitioner "continues to work, albeit with significant symptoms," his recommendation for the time being was to continue to observe Petitioner. Petitioner was to return in three to four months. (P.X. 1).

Respondent obtained another Section 12 examination from Dr. Petkovich on November 23, 2013. Dr. Petkovich had previously examined Petitioner prior to the hearing before Arbitrator Nalefski. Dr. Petkovich reviewed Petitioner's DOT medical records and employment records from June of 2010 along with Petitioner's imaging studies (MRI and CT scans) from March of 2011 and August of 2013. Dr. Petkovich stated Petitioner's imaging studies showed the normal progression of the degenerative process in Petitioner's lumbar spine. Dr. Petkovich diagnosed Petitioner with degenerative lumbar disc disease at the L3-4, L4-5 and L5-S1 levels. Dr. Petkovich testified that these findings would have not been related to Petitioner's fall from April 7, 2010 since they occurred over a number of years and were longstanding. Dr. Petkovich testified that Petitioner required no additional medical treatment for his low back. Dr. Petkovich believed that Petitioner reached maximum medical improvement ("MMI") from the April 7, 2010 accident a long time ago. Dr. Petkovich further testified that Petitioner's proposed surgeries of disc replacement at L4-5 and a fusion at L5-S1 would not be reasonable and necessary for Petitioner's current condition based on his examination.

The Arbitrator notes that the opinions of Dr. Petkovich in November 2013 essentially the same as those he espoused in his July 26, 2010 report, which were found to be less credible than that of Dr. Gornet by Arbitrator Nalefski at the time of the Section 19(b) hearing in January 2011. Dr. Petkovich again opined that Petitioner's diagnosis is degenerative lumbar disc disease at L4-5 and L5-S1 and that the April 7, 2010 may have caused only a temporary exacerbation of his preexisting degenerative condition. Dr. Petkovich again opined that no further treatment was necessary. (R.X. 12).

After Dr. Petkovich's section 12 examination, Respondent denied additional medical treatment for Petitioner's low back. (R.Ex.18:14-16).

On February 6, 2014, Petitioner returned to Dr. Gornet as planned. Dr. Gornet and Petitioner again discussed surgical options. At this visit Dr. Gornet noted "I have tried to manage him conservatively for a long period of time, but at this point his pain affects all aspects of his life and his quality of life.

Dr. Gornet proceeded with surgery on May 27, 2014. The surgery included anterior decompression L4-5 and L5-S1, anterior lumbar fusion L5-S1 with 14x23 mm LT cages, large kit BMP and crushed cancellous allograft, and disc replacement at L4-5 with ProDisc L with two AmnioClear sheets. Dr. Gornet saw Petitioner in follow up on June 16, 2014 and July 10, 2014 and kept him off of work. (P.X. 1). On September 8, 2014, Dr. Gornet continued Petitioner off of work and ordered physical therapy. Petitioner did not obtain that physical therapy as it had not been authorized by Respondent. (P.X. 1). It was at this point that Petitioner returned to work full duty and part time at Wehmeier Drywall on September 12, 2014. Petitioner testified that he returned to work in the hopes that it would strengthen his back and the physical therapy was because financially he "was losing everything." On May 21, 2015, Dr. Gornet released the Petitioner at maximum medical improvement. Dr. Gornet noted that the CT scan confirmed solid fusion at L5-S1. (P.X. 1).

Petitioner testified that with regard to his neck, he has stiffness and it hurts to move his head to the right or left. (T. 34). He looks up a lot while drywall taping on ceilings and it is painful. (T. 34). He takes Aleve every day. With regard to his right wrist, he testified that he has stiffness and it pops and goes numb about once a week. (T. 34). With regard to his right arm, he wears a sock/sleeve/tube on it like baseball players wear, because it pops and locks up. He has to change hands when using a cell phone. (T. 35). With regard to his left arm, he testified that it pops and has some numbness but it is workable and not as bad as the complaints with regard to his right arm. (T. 35). Petitioner testified that following surgery his numbness went away for the most part, but his left leg is still numb. (T. 35). He has not slept through the night yet and has to get up multiple times per night to change positions. He cannot turn around to back up in his truck and has to use the mirrors. He cannot go on rides at Six Flags anymore, golf or help buddies with construction projects like roofing. (T. 35). He cannot bend over to tie his shoes, he has to sit down. He cannot lift over 50 pounds. He testified that after carrying groceries for a group of nuns at a jobsite, he was forced to remain in bed for a week due to back pain. He has pain in his rear end and left leg numbness which he does not think will ever go away. (T. 36).

CONCLUSIONS

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

Arbitrator Nalefski found on January 5, 2011 that Petitioner's medical condition was causally related to the April 7, 2010 work injury and that prospective medical treatment as recommended by Dr. Gornet was awarded to Petitioner. This issue has already been determined by the Commission and affirmed up through the Appellate Court and is therefore determined again in Petitioner's favor in accordance with the law of the case doctrine.

Under the law of the case doctrine, a court's unreversed decision on an issue that has been litigated and decided settles the question for all subsequent stages of the action. *Miller vs. Lockport Realty Group*, 377 Ill.App.3d 369, 374, 878 N.E.2d 171 (2007). The law of the case doctrine applies to matters resolved in proceedings before the Commission. *Ming Autobody vs. Industrial Commission*, 387 Ill.App.3d 244, 899 N.E.2d 365 (Ill.App.Ct. 1st Dist 2008). In *Irizarry v. Industrial Commission*, 337 Ill. App.3d 598, 786 N.E.2d 218 (2003), the Court noted that where an award of benefits, based on a finding of a causal connection between the claimant's work accident and the claimed injuries becomes final, same cannot be challenged in a permanency hearing. Once the first causation finding became a final judgment, it became the law of the case and is not subject to further review. *Ming*, 387 Ill.App.3d 244 (citing *Irizarry* at 606-607).

This Arbitrator also finds the opinions of Dr. Gornet more persuasive than those of Dr. Petkovich. Dr. Gornet's opinion that Petitioner's low back pain was caused by the April 7, 2010 fall that was significant enough to also fracture Petitioner's right elbow and herniate cervical discs is more persuasive than Dr. Petkovich's opinion that this is a long standing condition, despite no prior treatment.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related the accident of April 7, 2010.

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?

Arbitrator Nalefski's January 25, 2011 decision held Respondent liable for the prospective medical care recommended by Dr. Gornet. The course of treatment followed subsequent to the 2011 hearing was consistent with the recommendations of Dr. Gornet at the time of and before Arbitrator Nalefski's decision.

Respondent has submitted an opinion from Dr. Petkovich dated August 12, 2015 stating that Petitioner's medical bills from St. Louis Spine and Orthopedic Center and the Orthopedic Center of St. Louis are excessive and not customary for this geographical area. (R.X. 13). No basis or explanation was given for this assertion. Certified medical bills are presumed reasonable pursuant to Section 16 of the Act. Furthermore, the payment of the medical bills is subject to the Medical Fee Schedule, which dictates what reasonable payment shall be made for the specific geographic area.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the care and treatment provided to Petitioner was reasonable and necessary.

Respondent shall pay reasonable and necessary medical services of $283,765.58, as set forth in P.X. 11 as provided in Sections 8(a) and 8.2 of the Act.

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

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

Respondent has paid temporary total disability benefits pursuant to the January 25, 2011 Order from April 7, 2010 through July 5, 2010 and from July 19, 2010 through January 5, 2011 at the rate of $433.33. Respondent has also paid TTD benefits from January 6, 2011 through June 25, 2011.

Despite Dr. Gornet ordering Petitioner off of work on April 25, 2011, returned to his former occupation as a truck driver with AC Trucking on June 10, 2011. He was able to perform these duties until he left that employer due to a dispute with a supervisor which followed his getting a truck stuck in mud.

Petitioner claims he is entitled to further TTD benefits from June 27, 2011 through June 22, 2012 and May 27, 2014 through September 12, 2014. Not only did Petitioner return to his former occupation as a truck driver for a time with AC Trucking, he applied for a number of other truck driving jobs during the June 27, 2011 through June 22, 2012. He was also doing drywall work on the side.

Respondent offered Petitioner's tax records into evidence. His tax returns show that in 2010, he had net drywall earnings of $2,356.00. (R.X. 17 2010). Petitioner believed that the drywall side work he performed in 2010 was during the winter prior to his work injury on April 7, 2010. Petitioner's 2011 tax return shows gross income of $18,186.00, including net drywall earnings of $1,738.00. (R.X. 17). His 2012 tax returns gross income of $27, 965.00 indicate earnings from his work at Wehmeier Drywall, his current employer, and side jobs. (T. 50, R.X. 17). On June 22, 2012 Petitioner began working at Wehmeier Drywall as a drywall taper. He continues to work at Wehmeier Drywall at the time of trial.

The Arbitrator did not find Petitioner's testimony regarding entitlement to TTD during the period from June 27, 2011 through June 22, 2012 to be credible. Further, Petitioner was able to return to his former occupation with AC Trucking in June of 2011. His reason for leaving that employment had nothing to do with

his injury. There was no change in his condition between his leaving AC Trucking and June 22, 2012 when he went to work for Wehmeier Drywall.

While Dr. Gornet opined that Petitioner could not return to work, Petitioner himself proved him wrong. The Arbitrator finds Petitioner was capable of returning to his former occupation during the June 27, 2011 through June 22, 2012 time frame when he returned to construction work for a drywall company. Benefits for that period are denied.

Petitioner also claims he is entitled to TTD from May 27, 2014 through September 12, 2014. This corresponds to the date of Petitioner's surgery and the day he actually returned to work. Based upon the foregoing and the record taken as a whole, including the Arbitrator's findings with regard to Issues F and J, the Arbitrator finds Petitioner is entitled to TTD benefits from May 27, 2014 through September 12, 2014 (15 and 4/7ths weeks). The Arbitrator further finds Petitioner is entitled to TTD benefits from January 6, 2011 through June 10, 2011 (22 and 2/7ths weeks)

Respondent shall pay Petitioner temporary total disability benefits of $433.33/week for 37 6/7 weeks, commencing January 6, 2011 through June 10, 2011 (22 and 2/7ths weeks), and May 27, 2014 through September 12, 2014 (15 and 4/7ths weeks), as provided in Section 8(b) of the Act.

The Arbitrator notes that the parties stipulated that Respondent is entitled to $26,786.07, however this amount includes the benefits paid pursuant to Arbitrator Nalefski's decision as well as those paid from January 6, 2011 through June 25, 2011.

The parties agree Respondent paid TTD benefits from April 8, 2010 through July 5, 2010 twice, once at the time the benefits were due in 2010 and again on May 9, 2013 at the time Respondent paid the January 25, 2011 Arbitration award. This creates a TTD credit owed to Respondent in the amount of $5,612.01. The total amount of benefits paid during the period of January 6, 2011 through June 25, 2011 is $9,657.07. The total credit against TTD awarded in this decision therefore is:

$ 5,612.01
9.657.07
$15,269.08

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

Petitioner's current occupation as a drywall finisher includes taping and finishing drywall to get it ready for paint. Petitioner was 41 years old at the time of the injury. Petitioner has many years remaining in the work force. Petitioner no longer works with Respondent as a truck driver. Petitioner testified that he was a "terrible truck driver". Petitioner was a drywall finisher for 15 years prior to working for Respondent. However, when the economy crashed, he was out of a job in drywall so he took the job as a truck driver with Respondent. Petitioner has now returned to drywall work. Petitioner testified that prior to the April 7, 2010 injury, he used to run tools like a bazooka, boxes and angle tools, but he can no longer use tools due to his back, so now he is forced to hand tape and consequently is less productive. He avoids lifting due to his low back. He has trouble looking up to drywall ceilings due to his cervical condition.

Petitioner testified that with regard to his neck, he has stiffness and it hurts to move his head to the right or left. He looks up a lot while drywall taping and it hurts. Petitioner testified that he has stiffness in his right

wrist, and it pops and goes numb about once a week. Petitioner wears a brace/sleeve on his right arm like baseball players wear, because it pops and locks up. He has to change hands when using a cell phone. With regard to his left arm, he testified that it pops and has some numbness but is workable and not as bad as his complaints with regard to his right arm. Petitioner testified that after his spine surgery, his back pain and numbness went away for the most part, but his left leg is still numb. Petitioner testified that he does not sleep through the night and he has to get up multiple times per night to change positions. He cannot turn at the waist to drive his truck in reverse and has to use the mirrors. Petitioner does not go on rides at Six Flags anymore, golf or help buddies with construction projects like roofing. He cannot bend over to tie his shoes, he has to sit down. He does not lift over 50 pounds. Petitioner complaints of pain in his buttock and left leg numbness which he does not think will ever go away. Petitioner takes Aleve every day.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that as a result of the injuries sustained in the accident Petitioner sustained:

With regard to the right wrist	2% loss of use of the right hand (4.1 weeks)
With regard to the right arm	7.5% loss of use of the right arm (18.975 weeks)
With regard to the left arm	5% loss of use of the left arm (12.65 weeks)
With regard to the cervical spine	7.5% loss of use of the whole person (37.5 weeks)
With regard to the lumbar spine	15% loss of use of the whole person (75 weeks)

This is a total of 148.225 weeks.

Respondent shall pay Petitioner permanent partial disability benefits of $390.00/week for 35.725 weeks, because the injuries sustained caused the 2% loss of the right hand (4.1 weeks relative to the right wrist), 7.5% loss of the right arm (18.975 weeks relative to the right arm), and 5% loss of the left arm (12.65 weeks relative to the left arm), as provided in Section 8(e) of the Act.

Issue (M) Should penalties or fees be imposed upon Respondent?

Respondent had a good faith basis and valid defense to payment of a significant portion of the TTD benefits as demanded by Petitioner. With regard to the payment of medical expenses, while the prior decision of Arbitrator Nalefski did address the provision of prospective medical in general terms, Respondent was not specifically ordered to provide the surgical procedure Petitioner ultimately received. Between the time of Arbitrator Nalefski's decision and the date of the surgery Dr. Gornet's records reveal that he was somewhat equivocal with regard to performing the surgery. On October 7, 2013, Dr. Gornet addressed his concerns about proceeding to surgery which would require placing permanent restrictions on Petitioner. He indicated that as Petitioner "continues to work, albeit with significant symptoms," his recommendation for the time being was to continue to observe Petitioner. Respondent then obtained another Section 12 examination from Dr. Petkovich on November 23, 2013. It was not until February 6, 2014, when Petitioner returned to Dr. Gornet that surgery was actually recommended with Dr. Gornet noting "I have tried to manage him conservatively for a long period of time, but at this point his pain affects all aspects of his life and his quality of life." The surgery then took place on May 27, 2014.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish that he is entitled to penalties or attorney's fees under the Act. Petitioner's request for those benefits is denied.

Issue (N): Is Respondent due any credit?

As indicated above, Respondent is entitled to a credit of $15,269.08 against TTD benefits awarded in this decision. Further, the parties stipulated Respondent is entitled to a credit of $4,500.00 for PPD previously paid. Respondent is therefore entitled to a total credit of $19,769.08.

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

Charles Conner,

Petitioner,

vs.

NO: 10 WC 32004

17IWCC0438

Concrete Structures,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

17IWCC0438

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

DATED: JUL 14 2017
TJT:yl
o 7/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONNER, CHARLES
Employee/Petitioner

Case# **10WC032004**

10WC018983

CONCRETE STRUCTURES
Employer/Respondent

17IWCC0438

On 8/10/2015, 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:

4642 O'CONNOR & NAKOS
STEPHEN J CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

1454 THOMAS & ASSOCIATES
JOSEPH FITZPATRICK
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

17IWCC0438

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

Charles Conner
Employee/Petitioner

v.

Concrete Structures
Employer/Respondent

Case # **10** WC **32004**

consolidated with **10 WC 18983**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **January 22, 2015, February 23, 2015, March 25, 2015, and April 20, 2015, and June 17, 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 **February 16, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$8,707.00**; the average weekly wage was **$1,674.00**.

On the date of alleged accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

ORDER

Benefits are denied, because Petitioner did not sustain an accident that arose out of and in the course of employment.

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

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

Milton Black

Signature of Arbitrator

August 10, 2015
Date

AUG 10 2015

FACTS

The facts, as set forth in consolidated case 10 WC 18983, are incorporated herein.

February 16, 2010

ACCIDENT

Respondent's counsel argues vigorously that the first mention of this alleged fall was during the Petitioner's trial testimony.

Respondent's witnesses testified that they never saw the Petitioner lose his balance or stumble on the jobsite.

There is no corroborating documentary evidence to support this claim of an accident.

Jason Price, a coworker, testified that he personally observed Petitioner leaving the jobsite on February 16, 2010, that Petitioner looked fine, and that Petitioner did not say anything about being injured. Mr. Price testified that he remembers walking with Petitioner for a quarter mile to their respective cars. Mr. Price testified that Petitioner appeared to be walking normally and that Petitioner did not say anything about falling on the jobsite. Mr. Price testified that he observed Petitioner get into his car and drive away.

Petitioner initialed a Daily Sign-In Sheet at the conclusion of his workday on February 16, 2010. Lori Cannata, the safety director for Concrete Structures, testified that the form was used by Concrete Structures as a time-sheet for its workers to sign in when they arrive at work, and to sign out when they leave work. The form shows that the Petitioner placed his initials in a column on the sheet for "Not Injured on the Job Today". Ms. Cannata testified that it means that Petitioner acknowledged not suffering an injury on February 16, 2010.

Based upon the foregoing, the Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of employment on February 16, 2010.

The remaining issues regarding case 10 WC 32004 are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Simone Wilson,
Petitioner,
vs.

NO: 10 WC 33445

LeRoy Manor,
Respondent,

17IWCC0469

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, 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 July 27, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,800.00. 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: JUL 21 2017
o071317
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, SIMONE
Employee/Petitioner

Case# **10WC033445**

LeROY MANOR
Employer/Respondent

17IWCC0469

On 7/27/2016, 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 0.42% 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:

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

1337 KNELL LAW LLC
LLIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Simone Wilson
Employee/Petitioner

v.

LeRoy Manor
Employer/Respondent

Case # 10 WC 33445

Consolidated cases: n/a

17IWCC0469

An *Application for Adjustment 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 Bloomington, on June 29, 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 July 28, 2009, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did sustain an accident that arose out 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 (as it relates to the back and left leg).

In the year preceding the injury, Petitioner earned $13,645.26; the average weekly wage was $296.64.

On the date of accident, Petitioner was 46 years of age, single with 1 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 $4,576.23 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $4,576.23.

Respondent is entitled to a credit of $13,517.41 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $245.33 per week for 15 weeks because the injuries sustained caused the three percent (3%) loss of use of the body as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

July 26, 2016
Date

JUL 27 2016

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on July 28, 2009. According to the Application, Petitioner was "injured at work" and sustained injuries to the "back and other parts of the body" (Respondent's Exhibit 1). There was no dispute that Petitioner sustained a work-related accident on July 28, 2009; however, Respondent disputed liability on the basis of causal relationship. Based upon the preceding, Respondent disputed liability for various medical bills and the extent of Petitioner's entitlement to temporary total disability benefits. Petitioner claimed to be entitled to temporary total disability benefits from September 29, 2009, through April 22, 2010. Respondent disputed Petitioner's entitlement to temporary total disability benefits subsequent to February 26, 2010. There was also a dispute in regard to the computation of Petitioner's average weekly wage. Petitioner claimed an average weekly wage of $400.00. Respondent claimed that the appropriate average weekly wage was $296.64 (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a CNA for approximately two and one-half years. On July 28, 2009, Petitioner was helping a resident get up off of a toilet. The resident began to fall and Petitioner held on to the resident to prevent her from falling and proceeded to assist the resident to the floor. Petitioner testified that she felt nauseous, her stomach began cramping and she experienced low back and buttock pain as well as left leg pain. Petitioner completed and signed an injury report the following day, July 29, 2009 (Petitioner's Exhibit 2).

Petitioner subsequently testified that she also sustained an injury to her neck and left shoulder on July 28, 2009. The injury report completed by Petitioner did not indicate that Petitioner sustained any injury to either the neck or left shoulder (Petitioner's Exhibit 2).

Petitioner testified that she previously sustained a work-related low back injury in 2001. Petitioner stated she had fully recovered from it and was working full duty at the time of the accident of July 28, 2009.

On cross-examination, Petitioner stated that she was off work for approximately two years as a result of the 2001 injury. She also stated that she continued to experience some back discomfort afterward. Petitioner also stated that the pain she experienced after the July, 2009, accident was more intense than what it was after the 2001 accident.

In regard to Petitioner's earnings, she testified that she was paid $11.25 per hour and usually worked six days a week. She was not certain how many hours she worked per week. Respondent tendered into evidence a wage statement. For the year preceding the date of accident, Petitioner was paid for 46 weeks and her total earnings were $13,645.26 (Respondent's Exhibit 3).

Petitioner initially sought medical treatment at Healthpoint on July 29, 2009. The Healthpoint record of that date contained a history of the accident and that Petitioner had low back and left buttock pain afterward. There was no reference to Petitioner having neck or left shoulder pain (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Grant Zehr, a physician associated with Healthpoint, on August 3, 2009. Petitioner still had complaints of low back and left buttock pain. The records of that date noted the prior injury that occurred in 2001. Dr. Zehr opined that Petitioner sustained a lumbar strain/sprain and authorized Petitioner to work light duty only (Petitioner's Exhibit 5).

Petitioner was treated by Dr. Zehr from August through November, 2009. During that time Petitioner continued to complain of low back and left buttock pain; however, there were no references to Petitioner having neck or left shoulder pain contained in the records for that period of time. Dr. Zehr provided conservative treatment and ordered physical therapy. When Dr. Zehr saw Petitioner on October 15, 2009, he opined that her condition had improved to where she could return to work at full duty on a trial basis.

At trial, Petitioner testified that she returned to work following the October 15, 2009, appointment with Dr. Zehr. Petitioner stated she was only able to work for about two days but was unable to continue to work because of her back symptoms.

Dr. Zehr referred Petitioner to Dr. Craig Carmichael, an orthopedic surgeon, who initially evaluated Petitioner on December 14, 2009. Dr. Carmichael's record of that date noted that Petitioner had sustained a back injury in 2001, but that the back pain did not completely resolve. The history of the accident of July 28, 2009, was noted and that Petitioner had complaints of low back and left buttock pain afterward. Dr. Carmichael recommended that Petitioner have an MRI scan (Petitioner's Exhibit 11).

The MRI was performed on December 22, 2009. According to the radiologist, the scan revealed minimal degenerative disc disease at L5-S1 without disc herniation or spinal stenosis. The study was described as being "Essentially unremarkable." (Petitioner's Exhibit 11).

Dr. Carmichael saw Petitioner on January 4, 2010, and reviewed the MRI. He opined that the MRI revealed decreased T2 signal intensity and slight central protrusion at L5-S1. He recommended steroid injections, home exercises and imposed work restrictions (Petitioner's Exhibit 11).

When Petitioner was seen by Dr. Carmichael on February 8, 2010, she continued to complain of back and left leg pain. Petitioner also complained of neck pain with numbness/tingling and associated weakness in the left arm. Petitioner stated that this neck/arm pain started a couple of months ago and she thought it was secondary to guarding her neck as an extension of her low back pain. However, Petitioner denied "...any particular injury to her neck at work." Dr. Carmichael recommended Petitioner have an MRI of the cervical spine.

At the direction of Respondent, Petitioner was examined by Dr. Morris Soriano, a neurosurgeon, on February 10, 2010. In connection with his examination of Petitioner, Dr. Soriano reviewed medical records and the diagnostic studies provided to him by Respondent. Dr. Soriano's report was dated February 24, 2010, and was received into evidence at trial. Dr. Soriano opined that Petitioner sustained a lumbar strain as a result of the accident of July 28, 2009, that she was at MMI and that she could return to work without restriction. When Dr. Soriano examined

Petitioner, he noted four positive Waddell's signs indicative of symptom exaggeration (Respondent's Exhibit 7).

Subsequent to the examination by Dr. Soriano, Petitioner continued to be treated by Dr. Carmichael for both her back/leg and neck/arm symptoms. Dr. Carmichael treated both conditions conservatively in March and April, 2010. He also recommended Petitioner be seen by Dr. John Atwater for a surgical consultation in regard to her neck issues (Petitioner's Exhibit 11).

Petitioner was later seen by Dr. Carmichael on August 23, 2010, and he recommended Petitioner have a cervical MRI. However, Dr. Carmichael opined that Petitioner's neck condition was "... likely not work-related." (Petitioner's Exhibit 11).

On August 24, 2010, Dr. Carmichael sent a letter to Petitioner's counsel regarding Petitioner's condition and causality. Dr. Carmichael noted that Petitioner had injured her back in 2001 and, again, on July 28, 2009. He opined that Petitioner's current condition was related to the accident of July 28, 2009, and suggested referral to a spine surgeon. In that same letter, Dr. Carmichael also opined that Petitioner's cervical spine issues did not appear to be work-related (Petitioner's Exhibit 4).

An MRI of Petitioner's cervical spine was performed on October 26, 2010. The MRI revealed a disc extrusion at C3-C4 and disc bulges at C4-C5 and C5-C6 (Respondent's Exhibit 12).

Petitioner was seen by Dr. Carmichael on December 23, 2010. At that time, Petitioner continued to complain of back, neck and left shoulder pain. Petitioner stated that her neck and left shoulder pain began in November, 2009, when she attempted to return to work. Dr. Carmichael recommended that Petitioner have an MRI of the left shoulder and renewed his recommendation that Petitioner be referred to Dr. Atwater (Petitioner's Exhibit 11).

An MRI of Petitioner's left shoulder was performed on January 5, 2011. The MRI revealed degenerative changes and tendinopathy but was negative for a tear (Respondent's Exhibit 12).

Dr. Carmichael saw Petitioner on January 13, 2011, and he reviewed the MRI scan. He recommended Petitioner be evaluated by a shoulder specialist and again renewed his recommendation that Petitioner be seen by Dr. Atwater (Petitioner's Exhibit 11).

Petitioner continued to be treated from May, 2011, through April, 2012, by Dr. Atwater and Dr. Mark Hanson, for her neck and shoulder conditions, respectively (Petitioner's Exhibit 11).

Dr. Carmichael was deposed on October 3, 2011, and his deposition testimony was received into evidence at trial. Dr. Carmichael's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, as it related to the low back and left leg symptoms, Dr. Carmichael opined that the July, 2009, accident caused or aggravated the condition of discogenic back pain that he diagnosed. In regard to Petitioner's neck and left shoulder condition, he could not relate those conditions to the July, 2009, accident (Petitioner's Exhibit 1; pp 29-34).

Dr. Soriano was deposed on May 4, 2015, and his deposition testimony was received into evidence at trial. Prior to his deposition being taken, Dr. Soriano reviewed further medical records and Dr. Carmichael's deposition testimony and prepared supplemental reports dated March 23, 2011, and November 21, 2011, wherein he stated that his prior opinions remained unchanged (Respondent's Exhibit 6; Deposition Exhibits 4 and 5).

Dr. Soriano testified that Petitioner's complaints were out of proportion to her objective findings and that there were positive Waddell signs. He reaffirmed his opinion that Petitioner was at MMI as of his examination of February 10, 2010. In regard to Petitioner's neck and shoulder symptoms, he testified that they were not related to the accident of July, 2009 (Respondent's Exhibit 6; pp 23-29).

At trial, Petitioner testified that she continues to have low back, left leg, neck and left shoulder pain. Petitioner has not been able to return to work and has significant problems with activities of daily living.

Carrie Polen testified on behalf of Respondent at trial. Polen is Respondent's administrator and she testified that Respondent was able to accommodate light duty restrictions and offered this work to Petitioner in February and March, 2010.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to the accident of July 28, 2009 (as it relates to the back and left leg conditions).

In support of this conclusion the Arbitrator notes the following:

In regard to Petitioner's neck and left shoulder condition, the injury report completed by Petitioner on July 29, 2009, contained no reference at all to any neck or left shoulder complaints.

The medical records did not contain any reference to Petitioner having any neck or left shoulder pain until February 8, 2010, approximately six months post accident.

Both Dr. Carmichael and Dr. Soriano opined that Petitioner's neck and left shoulder conditions were not related to the accident of July 28, 2009.

In regard to Petitioner's low back and left leg condition, Petitioner previously sustained a low back injury in 2001. Petitioner initially testified that she had fully recovered from that injury; however, she later stated that she still lost over two years from work as a result of that accident and continued to have some ongoing back complaints prior to July 28, 2009.

Dr. Carmichael treated Petitioner over a significant period of time and his diagnosis was simply discogenic back pain. Dr. Soriano conducted an extensive review of Petitioner's medical records and his findings on examination were not consistent with Petitioner's severe complaints of pain.

Dr. Soriano also noted that Petitioner had Waddell signs indicative of symptom exaggeration. He opined that Petitioner had sustained a lumbar strain as result of the accident of July 28, 2009, and that Petitioner was at MMI.

The Arbitrator finds the opinion of Dr. Soriano to be more persuasive than that of Dr. Carmichael.

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

The Arbitrator concludes that Petitioner had an average weekly wage of $296.64.

In support of this conclusion the Arbitrator notes the following:

Petitioner claimed an average weekly wage of $400.00, but presented no evidence, other than her testimony, that she made $11.25 per hour and worked six days a week.

Respondent tendered a wage statement for Petitioner which noted that Petitioner was paid for 46 weeks during the year preceding the date of accident, a total of $13,645.26. This computed to an average weekly wage of $296.64.

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

The Arbitrator concludes that Respondent has paid all charges for reasonable and necessary medical care related to Petitioner's low back and left leg conditions and does not owe any additional medical.

In support of this conclusion the Arbitrator notes the following:

As previously noted, Dr. Soriano opined that Petitioner was at MMI. Dr. Soriano examined Petitioner on February 10, 2010; however, his report was not prepared until February 24, 2010, so, for the purposes of calculation, the Arbitrator will use the date of February 24, 2010, as being the date Petitioner was at MMI.

The Arbitrator has reviewed the medical bills tendered by Petitioner at trial (Petitioner's Exhibit 12) and it appears as though all of the medical bills for services rendered prior to February 24, 2010, have been paid. Further, most of the medical bills incurred thereafter were for the non work-related neck and left shoulder conditions.

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

The Arbitrator concludes that Respondent paid Petitioner temporary total disability benefits through February 26, 2010, and no further temporary total disability benefits are owed.

In support of this conclusion the Arbitrator notes the following:

As previously noted herein, the Arbitrator determined that Petitioner was at MMI as of February 24, 2010, meaning that Respondent actually paid Petitioner two additional days.

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

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of three percent (3%) loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Petitioner sustained a lumbar strain as a result of the accident of July 28, 2009.

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 13 INC 340
v.	)	
Bianca Linares, President & Secretary of Sammy & Company Corp., d/b/a Supermercado La Victoria Foods	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents.

Commissioner Michael Brennan

Dated: 7-14-2017

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLY MARGRAVE,
Petitioner,

vs. NO: 11 WC 47239

SOUTHWEST AIRLINES,
Respondent.

ORDER

This matter comes before the Commission pursuant to the Appellate Court's Order filed November 18, 2016. Subsequently, the parties provided the Commission with a "Stipulation for Return of Case to Arbitration Call" on May 23, 2017.

Per the Stipulation, the parties have advised the Commission that the issues outlined in the Appellate Court's Order relative to penalties and attorney's fees have been satisfied by the Respondent.

Based upon its review of the Appellate Court's Order and the Stipulation of the parties, the Commission finds that issues contained within the Appellate Court's Order are now resolved.

Therefore, the Commission remands this matter back to the Arbitrator for further proceedings consistent with the Appellate Court's Order of November 18, 2016.

DATED: JUL 20 2017
MJB/pm
5-23-17
52

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lynniece Smith,
Petitioner,
vs.

NO: 11 WC 5724
13 WC 25335

Department of Children & Family Services,
Respondent,

17IWCC0476

DECISION AND OPINION ON REVIEW

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

The Commission notes that the Arbitrator's Decision was issued with both case numbers (11 WC 5724 and 13 WC 25335). However, Petitioner's attorney had voluntarily dismissed the 13 WC 25335 case on the record at the hearing because it was a duplicative filing. T.53.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 17, 2016 is hereby affirmed and adopted with the clarification noted above.

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

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

DATED: JUL 31 2017
o072617
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, LYNNIECE
Employee/Petitioner

Case# **11WC005724**

13WC025335

DEPARTMENT OF CHILDREN & FAMILY SERVICES
Employer/Respondent

17IWCC0476

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:

1315 DWORKIN AND MACIARIELLO
GERALD F CONNOR
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

5782 ASSISTANT ATTORNEY GENERAL
KELLY E KAMSTRA
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

FEB 17 2016

RONALD A. RIOPELLE, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0476

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LYNNIECE SMITH
Employee/Petitioner

Case #11 WC 5724
#13 WC 25335

V.

DEPARTMENT OF CHILDREN & FAMILY SERVICES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 2, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 17, 2010, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $69,528.13; the average weekly wage was $1,337.08.
- At the time of injury, the petitioner was 47 years of age, single with one child under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $891.39/week for 39-6/7 weeks, from November 3, 2010, through August 8, 2011, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $669.64/week for a further period of 43.05 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 3% of her left hand and 18% of her right hand.
- The respondent shall pay the petitioner compensation that has accrued from August 17, 2010, through February 2, 2016, and shall pay the remainder of the award, if any, in weekly payments.
- The medical care rendered the petitioner for her bilateral carpal tunnel syndrome was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right 3rd and 4th fingers was not reasonable or necessary and is denied. The

respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

February 16, 2016

Date

FEB 17 2016

FINDINGS OF FACTS:

On August 17, 2010, the petitioner, a right-hand dominant clerical worker, saw Dr. Cornelius Rogers at Advocate Health Centers for left knee pain, headaches, and trigger fingers and cramping for two months. The date of the medical care is the date of injury for her bilateral carpal tunnel claims #11 WC 5724 and #13 WC 25335. Dr. Rogers' assessment was tendonitis and trigger finger. Dr. Brooker at Midland Orthopedics saw the petitioner on September 13th and noted that she had renewed anterior knee pain. Dr. Sonnenberg at Midland Orthopedics saw her on September 22nd and noted complaints of hand numbness and tingling for several years, right greater than left, that she attributed to work duties of writing, typing and other repetitive activities. His diagnosis was bilateral carpal tunnel syndrome and right 3rd trigger finger.

On November 3rd, the petitioner reported complete relief of her left hand symptoms after bilateral carpal tunnel cortisone injections but continued numbness, tingling and weakness in her right hand and recurrent popping in her right 3rd and 4th digits with the A-1 pulley cortisone injection of her right 3rd digit. An EMG of her upper extremities on November 12th was consistent with moderate bilateral median neuropathies and no evidence of any active cervical radiculopathy or ulnar neuropathy. Dr. Sonnenberg recommended trigger finger releases and a right carpal tunnel release on November 17th. She was given a second right carpal injection on December 15th that provided a week of relief and a third injection on January 19, 2011, that improved her symptoms approximately 50 to 75%. Dr. Sonnenberg noted on January 26th that the petitioner had spontaneous muscle spasms on the right side of her neck.

On April 1st, Dr. Sonnenberg performed a right carpal tunnel release, a median nerve neurolysis and releases of her right 3rd and 4th trigger fingers. Dr. Sonnenberg noted that the petitioner's 3rd trigger finger was problematic and gave her a steroid injection into the surgical area and manipulation on June 27th. The doctor noted that the petitioner's carpal tunnel symptoms were relieved on July 11th. On August 8th, Dr. Sonnenberg stated that the petitioner's pain in her palm was not from the median nerve but due to the stiffness over her long finger. Repeat manipulations of the petitioner's 3rd finger were done on September 12th, December 19th and January 11, 2012. Dr. Sonnenberg noted on May 9th that the petitioner had a very satisfactory release of a flexion contracture of her right 3rd finger and an excision of the contracted tendon sheath with release of the volar plate. The petitioner reported increased numbness and tingling in her hands on October 8th and was given injections over her carpal tunnels. On June 5, 2013, Dr. Sonnenberg felt the petitioner had plateaued and ordered an FCE. He testified on December 10, 2015, that the petitioner was given permanent restrictions pursuant to the FCE of 10-pound lifting and carrying, rest intervals with writing and typing, computer work limit of 40 minutes and driving limits of nine minutes; and, that the petitioner reached maximum medical improvement on May 3, 2015.

The petitioner returned to Dr. Sonnenberg on February 10, 2014, with complaints of recurrent bilateral hand numbness. The doctor opined on March 31, 2014, that a repeat EMG revealed that her right carpal tunnel syndrome had improved and that her left hand was basically the same. Dr. Sonnenberg noted on October 14, 2014, that the petitioner did not have any triggering of her 3rd finger but tenderness and a loss of complete PIP and DIP active flexion, and that there was no evidence of recurrent carpal tunnel syndrome.

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

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained repetitive carpal tunnel injuries on August 17, 2010, arising out of and in the course of her employment with the respondent. Although, the petitioner had bilateral wrist pain and numbness off and on for several years prior to 2010, her job duties for over five years prior to August 17, 2010, required typing/keyboarding, data entry, signing forms and writing, answering and making phone calls, filing and retrieving, attending meetings and other administrative duties during a 7.5-hour workday for approximately thirty case files.

The petitioner failed to prove that her right third and fourth trigger finger conditions arose out of and in the course of her employment with the respondent on August 17, 2010. The petitioner had bilateral trigger fingers in her second, third and fourth fingers for several years prior to August 17, 2010, and the evidence is insufficient to establish that her work duties or that repetitive activity caused the recurrence of her right 3rd and 4th trigger fingers. The petitioner's request for benefits for her right 3rd and 4th fingers is denied.

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

The medical care rendered the petitioner for her bilateral carpal tunnel syndrome was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right 3rd and 4th fingers was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that the current condition of ill-being with her bilateral carpal tunnel syndrome is causally related to the work injury. The petitioner failed to prove that her current condition of ill-being with her right 3rd and 4th fingers is causally related to the work injury. The petitioner's request for benefits for her right 3rd and 4th fingers is denied.

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

On November 3, 2010, Dr. Sonnenberg advised the petitioner not work until after her EMG test and on April 1, 2011, Dr. Sonnenberg performed a right carpal tunnel release. On July 11, 2011, the petitioner's carpal tunnel symptoms were relieved and on August 8, 2011, Dr. Sonnenberg opined that the petitioner's pain in her palm was due to the stiffness over her long finger. The respondent shall pay the petitioner temporary total disability benefits of $891.39/week for 39-6/7 weeks, from November 3, 2010, through August 8, 2011, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of tingling, numbness and cramping in her right hand and fingers. She feels her writing is affected.

The respondent shall pay the petitioner the sum of $669.64/week for a further period of 43.05 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 3% of her left hand and 18% of her right hand.

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Brooks a.k.a, Michelle Williams
Petitioner,

vs.

Regional Elite Airline Services, LLC, and Federal Insurance Company and Gallagher Bassett Services
Respondent.

No. 11WC 12905
17IWCC 0405

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated June 27, 2017, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner David L. Gore.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued simultaneously with this Order.

David L. Gore

DATED: JUL 11 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Brooks,

Petitioner,

vs.

NO: 11 WC 12905
17IWCC0405

Regional Elite Airline Services, LLC,
Federal Insurance Company and
Gallagher Bassett Services
Respondent,

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, prospective medical, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 22, 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.

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

DATED: JUL 11 2017
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

BROOKS, MICHELLE
Employee/Petitioner

Case# **11WC012905**

REGIONAL ELITE AIRLINE SERVICES
Employer/Respondent

17IWCC0405

On 7/22/2016, 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 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0696 RITTENBERG BUFFEN GULBRANDSEN
IVAN M RITTENBERG
309 W WASHINGTON ST SUITE 900
CHICAGO, IL 60606

2904 HENNESSY & ROACH PC
EMILIE A MILLER
2501 OLD CHATHAM RD
SPRINGFIELD, IL 62704

17IWCC0405

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michelle Brooks
Employee/Petitioner

v.

Regional Elite Airline Services
Employer/Respondent

Case # **11 WC 12905**

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 **April 13, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Vocational rehabilitation**

FINDINGS

On the date of accident, **5/12/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$9,888.00**; the average weekly wage was **$190.00**.

On the date of accident, Petitioner was **42** 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 **$10,437.60** for TTD, **$0** for TPD, **$4,266.56** for maintenance, and **$0** for other benefits, for a total credit of **$14,704.16**.

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

ORDER

Prospective medical treatment is denied as Petitioner's current conditions of ill-being are not causally related to her work accident.

TTD and maintenance beyond that already paid by Respondent, or stipulated to be paid at the time of hearing is denied.

Vocational rehabilitation is denied.

Penalties and fees pursuant to Section 16, Section 19(k) and Section 19(l) are denied.

Respondent shall pay reasonable and necessary medical services incurred through March 27, 2013, pursuant to the fee scheduled as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical 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.

Edeal Lee
Signature of Arbitrator

7/22/16
Date

ICArbDec19(b)

JUL 22 2016

FINDINGS OF FACT

Petitioner worked for Respondent as a customer service agent and ground service worker. (T. 17). Petitioner was hired in March of 2010 and worked part-time earning $8.25 per hour. (T. 18). Petitioner testified that her job duties included loading and unloading baggage and freight from planes, hooking up ground power units, running the jet bridge, checking passengers in, cleaning the planes, stocking the planes, taking out the trash, running the deicer and marshaling in planes. Petitioner testified that the baggage she handled weight up to 70 pounds and that she would classify her job as heavy duty. (T. 26).

On May 12, 2010 Petitioner was helping a co-worker bring a jet bridge into a plane when she was struck by the plane's door. Petitioner testified that she was warned by her co-worker that the door was opening and in response turned her back to the door, put her hands behind her head with her hands interlocked and bent forward protecting her head with her shoulders up and her neck bent. (T. 33). Petitioner testified that when the door struck her it hit her upper back, neck, head, shoulders and elbows. (T. 31). Petitioner testified that when the door struck her it knocked her to her knees and she rolled over. (T. 33). Petitioner testified that the door that struck her was approximately three feet wide and weighed 600 pounds. (T. 31 and 34).

Petitioner was transported from the scene of her accident to Carle Foundation Hospital by ambulance. A CT scan of her neck and head were performed but were reported as normal. Petitioner was diagnosed with a head contusion and cervical strain and prescribed medication and light duty restrictions of no overhead work and no twisting with her neck. Petitioner was referred to Carle Clinic for follow up with Dr. Thomas Sutter. (Px's 6).

Petitioner first presented to Dr. Sutter on May 14, 2010. Based on Dr. Sutter's recommendation, Petitioner underwent multiple diagnostic tests of her cervical spine. Other than evidence of mild degenerative changes, Dr. Sutter noted Petitioner's diagnostic tests were normal. Dr. Sutter diagnosed Petitioner with chronic neck pain and recommended physical therapy and use of a TENS unit. He also continued Petitioner on light duty restrictions of no overhead work and no twisting her neck. After Petitioner's complaints worsened, Dr. Sutter recommended a second opinion. (Px's 6).

Petitioner was seen by Dr. David Fletcher on May 17, 2011. Dr. Fletcher diagnosed Petitioner with cervical myofascial pain syndrome superimposed on degenerative disc disease, but confirmed right shoulder impingement needed to be ruled out. Dr. Fletcher restricted Petitioner to light duty work involving no overhead activities and prescribed ongoing physical therapy and use of a TENS unit. He also recommended an MRI arthrogram of Petitioner's right shoulder. The MRI arthrogram of Petitioner's right shoulder completed on July 18, 2011 revealed a partial tear of the supraspinatus tendon and AC joint arthritis. (Px's 7 and 7a).

Subsequently, Petitioner came under the care of Dr. Lawrence Li for her right shoulder. Dr. Li initially administered a steroid injection into Petitioner' shoulder; however, when conservative treatment did not resolve her symptomology Dr. Li recommended arthroscopic rotator cuff repair and subacromial decompression. (Px's 3). That surgery was authorized following an Independent Medical Examination at Respondent's request with Dr. Richard Kube. Dr. Kube felt that if someone was struck from behind "very soundly with a large object" it was reasonable that could have resulted in the condition of Petitioner' right shoulder. (Px's 12).

On November 4, 2011, Petitioner underwent a right shoulder arthroscopic rotator cuff repair and subacromial decompression and distal clavicle excision with Dr. Li. Postoperatively Petitioner was sent for physical therapy and continued to treat with Dr. Li and Dr. Fletcher. (Px's 2). Shortly after her surgery Petitioner began to experience numbness in her lower right arm near the elbow and extending towards the hand. Dr. Li diagnosed Petitioner with right cubital tunnel syndrome and recommended a release and transposition of the ulnar nerve. However, EMG/NCV testing completed did not confirm cubital tunnel syndrome. . (Px's 3). Petitioner has a documented history of right cubital tunnel syndrome and release in 2006

Based on Dr. Li's new surgical recommendation, Respondent submitted Petitioner for an Independent Medical Examination with Dr. Thomas Kiesler on April 9, 2012. Based on Dr. Kiesler's opinion that Petitioner did not have cubital tunnel syndrome, but rather ulnar neuritis and that her symptoms of pain were not related to her work injury on May 12, 2010, surgery as recommended by Dr. Li was denied. (Rx's 5).

Petitioner also continued to complain of pain and popping in her right shoulder. Another injection was attempted by Dr. Li; however, after a bone scan revealed moderate radionuclide uptake in the right acromion in the area of the right AC joint Dr. Li recommended revision right shoulder arthroscopy with excision of the distal clavicle and debridement of scar tissue. That surgery was done on June 1, 2012 and revealed right shoulder AC joint dysfunction and scar tissue formation. (Px's 3).

Following her second surgery Petitioner did well; however, she continued to report symptoms in her right elbow and neck, as well as headaches. On August 7, 2012, Dr. Fletcher recommended a home exercise program and functional capacity evaluation. Petitioner submitted for a FCE at Safeworks Illinois on August 27, 2012. (Px's 7 and 7a). Petitioner was also submitted for updated EMG/NCV testing by Dr. Li on June 26, 2012. Petitioner's updated testing confirmed ulnar neuropathy at the right elbow. (Px's 3).

Based on the results of her FCE Dr. Fletcher placed Petitioner at maximum medical improvement effective September 4, 2012, with the exception of her right cubital tunnel, and released her with permanent restrictions per the FCE of no lifting more than 5 pounds floor to waist, 5 pounds waist to crown, and 5 pounds front carry on an occasional basis. However, Dr. Fletcher also referred Petitioner for a neurology consult due to her report of ongoing cervicogenic headaches. Dr. Fletcher's diagnosis for Petitioner as of September 4, 2012 included cervical myofascial pain syndrome imposed on degenerative disc disease, recurrent right ulnar neuropathy and cervicogenic headaches. (Px's 7 and 7a).

Petitioner was seen by neurologist Dr. Barry Riskin on September 20, 2012 for her headaches. After reviewing the results of an updated MRI of Petitioner's cervical spine completed on September 14, 2012, Dr. Riskin noted no cervical radiculopathy and recommended she work on her guarding behaviors, including elevation of the shoulders and forward thrusting of the chin to prevent a cycle of spasms and pain, and advised her to stop smoking. Dr. Riskin noted that smoking has been reported to intensify pain sensitivity. (Rx's 5).

After seeing Dr. Riskin Petitioner returned to Dr. Fletcher on September 24, 2012. Due to Petitioner's ongoing reports of cervicogenic headaches Dr. Fletcher

referred her back to Dr. Thatcher for pain management treatment and cervical epidural steroid injections. (Px's 7 and 7a).

Medical records from Dr. Thatcher confirm that Petitioner underwent a series of three epidural steroid injections on October 10, 2012, November 14, 2012 and December 11, 2012. (Px's 5). Petitioner testified that the injections helped a lot. (T. 78).

After her first injection Petitioner returned to Dr. Fletcher on November 8, 2012 and reported improvement in her cervicogenic headaches and neck pain. On examination Dr. Fletcher noted improved range of motion in Petitioner's cervical spine and right shoulder. Range of motion in Petitioner's right shoulder was noted to be normal. Dr. Fletcher noted Petitioner's cervical spine was definitely improved. Due to Petitioner's response to the first injection, Dr. Fletcher recommended a second injection. (Px's 7 and 7a).

After her second injection on November 14, 2012 Petitioner returned to Dr. Fletcher on November 29, 2012. Despite her exam findings and noted improvement, Petitioner reported right shoulder pain and swelling and swelling in her neck with pressure in her head. However, Dr. Fletcher continued to note improvement in Petitioner's cervicogenic headaches and range of motion. (Px's 7 and 7a).

Petitioner again returned to Dr. Fletcher on December 31, 2012 with reports of popping in her neck with headaches. After noting that Petitioner had been seen for 35 visits for two years, Dr. Fletcher again confirmed Petitioner was a maximum medical improvement and noted that aside from her right ulnar nerve issue she would not benefit for any further medical treatment. (Px's 7 and 7a).

Despite confirming again that Petitioner was at maximum medical improvement and required no further treatment as of December 31, 2012, Dr. Fletcher saw Petitioner again on January 28th, February 28th and March 27th, 2013. As of March 27, 2013 Petitioner reported that her condition was worse. However, again Dr. Fletcher confirmed Petitioner was at maximum medical improvement. (Px's 7 and 7a).

After March 27, 2013 there is no record of treatment of Petitioner again until March 10, 2014. On March 10, 2014 Petitioner presented to the emergency room at Carle Foundation Hospital with complaints of a headache, neck pain and right shoulder

pain after falling on ice and hitting the right side of her face on the bumper of a car and then falling to the ground. (Px's 6).

Thereafter, on April 17, 2014 Petitioner presented to Dr. Patrick Sweeney with complaints of ongoing popping and grinding to the back right side of her neck, headaches, neck pain radiating into both shoulder blades, and burning, numbness, and tingling in her right elbow down to her right fourth and fifth fingers related to her work injury on May 12, 2010. Petitioner testified that her examination with Dr. Sweeney was arranged by her attorney. Petitioner did not report her March 10, 2014 fall to Dr. Sweeney. (Px's 8).

After examining Petitioner and reviewing her medical records Dr. Sweeney diagnosed Petitioner with cervical facet syndrome and suboccipital neuritis. For treatment Dr. Sweeney recommended referral for a facet block trial and suboccipital injections. (Px's 8).

Dr. Sweeney was deposed on October 2, 2015 and testified that in his opinion Petitioner's neck problems were causally related to her work accident. On cross examination Dr. Sweeney explained that in his opinion Petitioner's facet joints were chronically injured at the time of her accident due to the fact that her accident involved a complex whiplash type injury. Dr. Sweeney explained that a whiplash type injury involves a sudden acceleration and deceleration that results in injuries to the ligaments, the tendons, the facet joint capsules and the muscles. However, on cross examination, Dr. Sweeney admitted that Petitioner's ongoing problems as of April of 2014 could be related to her falling and hitting her head on the bumper of a car rather than her work accident, especially if there were no medical records between the end of 2012 or beginning of 2013 and March 10, 2014 showing ongoing complains by Petitioner related to her work accident. (Px's 10).

After seeing Dr. Sweeney, Petitioner was submitted for an Independent Medical Examination with Dr. Timothy VanFleet to address her need for ongoing treatment related to her work accident. Dr. VanFleet examined Petitioner on October 22, 2014 and was deposed on December 9, 2015. Dr. VanFleet testified that after examining Petitioner and reviewing all of her medical records he diagnosed her with chronic cervicalgia and cervical spondylosis. Dr. VanFleet testified that in his opinion Petitioner's current condition was not casually related to her work accident. Dr.

VanFleet explained that given the period of time between Petitioner's accident and her intervening injury of March 10, 2014, her current condition is related to her intervening injury and not her work accident. Dr. VanFleet also testified that in his opinion Petitioner did not require ongoing work restrictions. (Rx's 4).

Dr. Kube was also deposed by Petitioner's attorney related to his examinations of Petitioner. Dr. Kube's deposition took place on October 19, 2015. Dr. Kube examined Petitioner at Respondent's request on July 1, 2011 and February 24, 2012 in regard to both her neck and right shoulder. Dr. Kube testified that after examining Petitioner on July 1, 2011 he diagnosed her with a crush injury to her shoulder and neck. Dr. Kube testified he felt Petitioner's conditions were causally related to her work accident and recommended ongoing treatment for her right shoulder as of July 1, 2011 in the form of an MRI and physical therapy and TENS unit for her neck. Petitioner ultimately had that treatment and more upon authorization by Respondent. Dr. Kube testified that after conducting an updated examination of Petitioner on February 24, 2012, it was his opinion that she required ongoing treatment of her right shoulder with Dr. Li, but had reached maximum medical improvement for her neck absent work conditioning and possibility an FCE. Dr. Kube had no opinion as to Petitioner's status after February 24, 2012. (Px's 12).

Petitioner ultimately underwent an FCE as recommended by Dr. Fletcher; however, Dr. Fletcher never ordered work conditioning for Petitioner. Instead, Dr. Fletcher imposed permanent restrictions as noted based on the FCE and discharged Petitioner at maximum medical improvement effective September 4, 2012. (Px's 7 and 7a).

In addition to seeking ongoing treatment related to her neck as recommended by Dr. Sweeney, Petitioner is also seeking ongoing treatment of her right arm related to her right cubital tunnel syndrome. Dr. Li, who initially diagnosed Petitioner's right cubital tunnel syndrome in 2011 testified via deposition on December 7, 2015. Dr. Li testified that in his opinion Petitioner has recurrent right cubital tunnel syndrome that resulted from her being placed in a sling for six weeks following her first shoulder surgery on November 4, 2011. Dr. Li testified that cubital tunnel sometimes occurs in these cases as a result of swelling from the shoulder pooling in the elbow. However, Dr. Li testified that this only occurs in 5 out of 150 cases, or less than 0.04% of the time. (Px's 11).

As noted, Petitioner was previously diagnosed with right cubital tunnel syndrome in 2006 and underwent surgery. Records from that surgery were not admitted into evidence. However, EMG/NCV testing completed in December of 2011, right after Petitioner was taken out of the sling, showed no evidence of right ulnar neuropathy. In fact, Dr. Li testified that the EMG/NCV results from December of 2011 were within normal limits and could have been residuals from her prior surgery. (Px's 11).

Dr. Li testified that Petitioner did not begin complaining of pain in her elbow or numbness and ringing until after her first surgery. However, Petitioner testified to pain in her elbow since the time of her accident. Petitioner also reported to Dr. Kiesler, Respondent's IME doctor, ongoing swelling in her right elbow since her surgery in 2006. (Rx's 5).

Dr. Kiesler was deposed on November 3, 2015and testified that Petitioner did not have recurrent right cubital tunnel syndrome, but rather ulnar neuritis unrelated to her work accident. (Rx's 5).

While Petitioner ultimately had an updated EMG/NCV study of her right upper extremity in June of 2012 that showed right ulnar neuropathy, Dr. Li noted in his review of the results of that testing on July 10, 2012 that Petitioner's condition was related to a work injury she suffered in 2006 and the fact that the previous surgeon had not performed transportation of the ulnar nerve (Px's 3).

Dr. Sweeney also provided an opinion related to Petitioner's right cubital tunnel at Petitioner's attorney's request. Dr. Sweeney opined that in his opinion Petitioner's ulnar neuropathy was not causally related to her work injury. (Px's 10, Exh. 1).

Petitioner returned to Dr. Li for treatment on October 28, 2015. Prior to October 28th Petitioner had not been seen by Dr. Li since July 10, 2012. As of October 28th Dr. Li ordered an updated MRI of Petitioner's right shoulder and EMG/NCV study. Petitioner's MRI was completed on October 30, 2015 and was negative for any recurrent tear but showed residual tendinopathy consistent with Petitioner's surgery. Petitioner's EMG/NCV was completed on November 17, 2014 and confirmed right ulnar neuropathy. After both tests Petitioner followed up with Dr. Li on November 24, 2015 Dr. Li again recommended Petitioner proceed with a right cubital tunnel release and ulnar nerve transposition. Dr. Li recommended no ongoing treatment related to Petitioner's right shoulder. (Px's 11, Exh. 1-8).

Despite initially returning to work light duty for Respondent after her accident, Petitioner's employment with Respondent ended effective August 31, 2010 when Respondent went out of business. (T. 47). Petitioner remained off work until released at maximum medical improvement effective September 4, 2012. Respondent has paid and/or stipulated to paying Petitioner TTD from August 31, 2010 through September 4, 2012 and maintenance from September 5, 2012 through March 10, 2013. Petitioner's maintenance benefits were terminated effective March 10, 2013 for failure to conduct a job search.

Petitioner testified that she looked for work after being laid off by Respondent. Petitioner testified that she looked at 30 to 40 places but no one would accommodate her restrictions. (T. 48). No documentation of job searches was admitted into evidence by Petitioner.

Petitioner testified that she has continued to experience pain in her head, neck, shoulders and elbows since her accident. Petitioner testified that she became subsequently employed in April of 2014 as a cashier at a gas station. (T. 57). Petitioner testified that she found the job through her fiancé's uncle who was the manager. (T. 58). Petitioner testified she was original hired in the kitchen but that the kitchen never opened so they moved her to a cashier. (T. 70). Petitioner testified that she earned $9.00 an hour when initially hired but received a raise to $9.25. Petitioner testified that she worked full time 40 hours a week and worked within her restrictions. (T. 57 and 75).

Respondent admitted a copy of Petitioner's employment file from her employer, Gilman OPCO, into evidence. Those records confirm Petitioner's employment beginning April 21, 2014. At the time Petitioner's position was changed to a cashier she signed a job description confirmed her acknowledgement of her job duties. Within the job description is a section entitled "Requirement of the Job" that outlines the "essential functions" of the job of a cashier. Included in those functions is the following: (Rx's 3).

1. Can lift up to 50 pounds, and carry cases of milk cartons and soft drinks, beer, and juice containers;
2. Stands and walks 8-10 hours a day without breaks on a tile or concrete surface while completing job duties.

3. Lifts and carries stock weighing up to twenty-five (25) pounds while stocking shelves and cooler.
4. Pulls and pushes up to twenty0five (25) pounds to move stock.
5. Bends and stoops to stock low shelves in store, cooler and to clean.
6. Frequently reaches in order to stock and clean store. *Id.*

All of these essential functions exceed Petitioner's restrictions as imposed by Dr. Fletcher. Petitioner acknowledged signing the job description, but testified that she did not perform these functions. (T. 72 and 78).

Petitioner testified that she remained employed with Gilman OPCO until October 4, 2015 when they went out of business. After October 4, 2015 Petitioner testified she was unemployed until April 12, 2016 when she found employment as a cashier at Casey's gas station. (T. 73-74).

CONCLUSIONS OF LAW

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

The current conditions of Petitioner's neck and right arm are not causally related to her work accident on May 10, 2010. After last seeking active treatment for her neck in 2012 Petitioner sustained an intervening injury that severed the chain of causation between her condition and work accident. Petitioner had a significant accident on March 10, 2014 requiring emergency room treatment after she fell on ice and hit her face on the bumper of a car. Upon presenting to the emergency room Petitioner complained of a headache, neck pain and right shoulder pain, since her fall. Petitioner did not report a history of ongoing headaches, neck pain or right shoulder pain related to her work accident. While Petitioner testified that she had ongoing headaches, neck pain, right shoulder pain and right elbow pain since her work accident, Petitioner did not seek treatment for these complaints after the end of 2012 beginning of 2013.

Petitioner testified that the reason she did not seek treatment was that Respondent's insurance carrier was denying her treatment. However, it is noted from records admitted into evidence by Petitioner that she did in fact seek medical treatment between the end of beginning of 2013 and March 10, 2014 at Carle Clinic for conditions unrelated to her work accident. During those visits Petitioner did not report any

complaints of headaches, neck pain, right shoulder pain or elbow pain. It is also noted that Petitioner failed to report her intervening injury to Dr. Sweeney even though it occurred only one month prior to her visit with him.

These facts when taken together with Dr. VanFleet's and Dr. Sweeney's testimony, supports that the current condition of Petitioner's neck is not causally related to her work accident. Both Dr. VanFleet and Dr. Sweeney testified that Petitioner's ongoing neck problems could solely be related to her intervening injury in March of 2014. This Arbitrator believes that if Petitioner's neck continued to be a problem after the beginning of 2013 she would have sought treatment as she did for problems unrelated to her work injury.

With regard to Petitioner's cubital tunnel, Dr. Li's opinion that Petitioner's recurrent cubital tunnel syndrome is causally related to her work accident is not credible. Dr. Li testified that Petitioner's problems with her cubital tunnel only began after her first surgery. However, Petitioner reported ongoing problems with her right elbow following her first surgery in 2006. Also, the EMG/NCV testing conducted in December of 2011, most contemporaneously with the time Petitioner was in a sling, was normal. It was not until June of 2012 that Petitioner's EMG/NCV testing showed a right ulnar neuropathy. Furthermore, Dr. Li testified that Petitioner's findings on EMG/NCV could have been consistent with a residual from her surgery in 2006. Also, Dr. Sweeney opined that Petitioner cubital tunnel was unrelated to her work accident.

J. Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner is seeking payment of medical bills incurred from the date of her accident to the present. Respondent is ordered to pay Petitioner's related medical bills incurred through March 27, 2013, Petitioner's last visit with Dr. Fletcher. Respondent is also given a credit for any bills already paid. Respondent is not responsible for Petitioner's unpaid medical bills incurred after March 27, 2013.

K. Is Petitioner entitled to prospective medical care?

As a finding has been made that Petitioner's current conditions of ill-being are not causally related to her work injury, Petitioner's request for prospective medial treatment is denied.

L. Is Petitioner entitled to TTD and/or maintenance benefits?

Petitioner is seeking payment of TTD or maintenance from March 11, 2013 through April 21, 2014 and October 4, 2015 through April 12, 2016. The Arbitrator finds Petitioner is not entitled to TTD or maintenance for these periods. First, maintenance and TTD are separate and distinct benefits. *Freeman United Coal Mining Co.* v. *Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144,251 Ill.Dec. 966 (5th Dist. 2000). Once the petitioner has reached maximum medical improvement, he or she is no longer temporarily and totally disabled, and entitlement to TTD benefits ceases.

Taking the first period alleged by Petitioner from March 11, 2013 through April 21, 2014, Petitioner's condition had stabilized as of September 4, 2012 when she was placed a maximum medical improvement by Dr. Fletcher. Therefore, all benefits paid after September 4, 2012 are classified as maintenance. Section 8(a) provides that the employer shall pay for the "physical, mental and vocational rehabilitation of the employee, *including all maintenance costs and expenses incidental thereto.*" Therefore, payment of maintenance benefits is incidental to vocational rehabilitation and Petitioner is only entitled to maintenance where there is proof of participation in a vocational rehabilitation program. There is no proof in this case from testimony or records that Petitioner participated in a vocational rehabilitation program.

While Petitioner testified to a self-direct job search beginning after she was placed at maximum medical improvement, no evidence of such job search, via job logs or applications was provided. Petitioner testified that she kept records and provided those records to her prior attorney, Kevin Markes; however, again, those records were not admitted into evidence to support Petitioner's testimony. In fact, Petitioner provided no specific testimony related to any jobs she applied for after she was placed at maximum medical improvement. While Petitioner testified that she ultimately became subsequently employed in April, 2014 with Gilman OPCO, she testified that that job was offered to her by a family friend and was not part of any active job search. (T. 58).

With regard to the second period claimed by Petitioner from October 4, 2015 through April 12, 2016, Petitioner is not entitled to TTD for this period as she was at maximum medical improvement for her work injury. She is also not entitled to maintenance benefits there is no proof of participation in a vocational rehabilitation program.

M. Should penalties and fees be imposed upon Respondent?

Petitioner argues that she is entitled to penalties and attorney's fees pursuant to Section 19(k), 19(l) and 16 due to Respondent's failure to provide her vocational rehabilitation and TTD or maintenance benefits after March 10, 2013. As a finding has been made (see findings with regard to issue O) that Petitioner was not entitled to vocational rehabilitation and Petitioner failed to provide evidence of participation in a job search, Petitioner's petition for penalties and fee is denied.

O. Is Petitioner entitled to vocational rehabilitation?

Petitioner argues that she was entitled to vocational rehabilitation at Respondent's expense after her employment with Respondent ended on August 31, 2013 (Px's 16). The Arbitrator finds Petitioner was not entitled to vocational rehabilitation then or now.

It is undisputed that Petitioner's employment with Respondent ended as of August 31, 2010 due to Respondent going out of business. After Respondent went our of business and Petitioner was laid off Respondent continued to pay Petitioner TTD until she was discharged at maximum medical improvement by Dr. Fletcher effective September 4, 2012 with permanent restrictions. Thereafter, Petitioner's benefits were continued as maintenance benefits until March 10, 2013 when her benefits were terminated for failure to provided evidence of a job search. (Rx's 2). While Petitioner testified that she looked for a job after August 31, 2010, she offered no proof of a job search at hearing.

Petitioner's argument appears to be that Respondent had a statutory right to provide her vocational assistance under Section 8(a) after she was prescribed

permanent restrictions by Dr. Fletcher; however, the Supreme Court in *Hunter Corp.* v. *Industrial Commission* has confirmed that it is the petitioner that has the burden of proving the necessity for any rehabilitative efforts, as well as the actual benefit that would flow from them. 86 Tll.2d 489, 427 N.E.2d 1247,56 lll.Dec. 701 (1981). The Arbitrator finds that Petitioner has not met her burden of proof in this regard.

The Supreme Court set forth guidelines in *National Tea Co.* v. *Industrial Commission,* 97 Tll.2d 424, 454 N.E.2d 672, 73 lll.Dec. 575 (1983), to help determine when an award of vocational rehabilitation is necessary. Those factors include:

Factors favoring rehabilitation:

a. The employee has sustained an injury that caused a reduction in earning power, and there is evidence rehabilitation will increase his or her earning capacity.

b. The employee is likely to lose job security due to the injury.

c. The employee is likely to obtain employment upon completion of rehabilitation training.

Mitigating factors against rehabilitation:

a. The employee has unsuccessfully undergone similar treatment in the past.

b. The employee has received training under a prior rehabilitation program that would enable him or her to resume employment.

c. The employee is not trainable due to age, education, prior training, and occupation.

d. The employee has sufficient skills to obtain employment without further training or education. *Id. at 432*

Other appropriate factors to consider are (a) the relative costs and benefits to be derived from the program, (b) the employee's work-life expectancy, (c) the employee's ability and motivation to undertake the program, and (d) the employee's prospects for recovering work capacity through medical rehabilitation or other means. *Id. at 433.*

There are no factors here favoring the need for vocational rehabilitation. Petitioner was an unskilled part-time employee earning minimum wage. Petitioner had sufficient skills to obtain employment without further training or education within her restrictions. This is evidenced by the fact that Petitioner found two subsequent jobs without assistance earning more than she was earning when employed by Respondent.

Furthermore, the cost of vocational assistance in this case would have been outweighed by any benefits. Therefore, no benefit would have flowed from vocational rehabilitation.

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 Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EMILY LANGSTON,

Petitioner,

vs.

NO: 11 WC 15273

BIG TEN NETWORK,

17IWCC0426

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, , medical expenses, temporary total disability, nature and extent, and "objections on record," and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection relating to the right shoulder, modifies the Decision as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission initially notes that Petitioner listed "objections on record" on the Petition for Review but did not detail what those objections are in her brief. Since we are unable to determine which objections are at issue, we find that this issue is waived. The Commission affirms the Arbitrator's finding that Petitioner's lumbar condition is causally related to her undisputed slip and fall at work on February 1, 2011. However, we find that Petitioner also proved that she sustained a right shoulder strain in that incident but that this condition of ill-being resolved by September 8, 2011.

The triage note from the emergency room at Advocate Hospital on February 3, 2011 includes a complaint of shoulder pain. When Petitioner saw Dr. James Melia on February 8th, most of the examination was related to her lumbar condition. However, Petitioner complained of 7/10 pain to the right half of her body and she had minimal tenderness to the bilateral trapezius area. On October 3, 2011, Dr. Melia appended this record to include examination findings of decreased range of motion of the right shoulder with some tenderness. He added "shoulder

strain" as a diagnosis. This is consistent with Dr. Melia's March 10th record which reflects positive trigger points in the right shoulder at the trapezius and lower back. His impression was back pain and right shoulder strain. He recommended physical therapy for the back and shoulder, which was started on March 15, 2011.

On March 24, 2011, Dr. Melia noted continued trigger points in the right shoulder and buttocks. His impression on that date was back pain with muscle spasm and right shoulder strain. On April 28th, Dr. Melia performed trigger point injections in the bilateral sacroiliac joints, coccygeal area, and the right shoulder scapular area. However, this record also indicates that within 15 minutes of that procedure, Petitioner complained of dizziness, difficulty swallowing, and possible tongue swelling. Epinephrine was administered and Petitioner was transferred to hospital via ambulance. Hospital records indicate that Petitioner was admitted for anaphylaxis secondary to lidocaine and Depo-Medrol and she was discharged on April 29th.

Petitioner returned to Dr. Melia on May 2, 2011, and there is no mention of Petitioner's right shoulder in this record. On May 13th, Petitioner underwent a right shoulder physical therapy evaluation. On May 27th, Dr. Melia noted that aqua therapy was helping Petitioner's back and that she was also getting exercised for her sore shoulder and decreased range of motion. His impression remained "shoulder strain" that was improving with therapy but he was considering an MRI to rule out a rotator cuff tear if Petitioner did not improve in four weeks.

A June 2, 2011 phone note indicates that Petitioner's attorney contacted Dr. Melia's office suggesting that, in addition to the MRI of the low back, Petitioner should have MRIs of the cervical spine and hips. Notes from Dr. Melia's office on June 3rd reflect that Petitioner was scheduled for MRIs of the cervical spine, right shoulder, and right hip but Dr. Melia canceled the cervical MRI. On June 6, 2011, Dr. Melia wrote a letter to Gallagher Basset focusing on Petitioner's lumbar condition but also indicating that Petitioner's work related injuries included right shoulder pain.

A phone note from Elena Norman, R.N. at Dr. Melia's office reflects that she called Petitioner on June 22, 2011, and that Petitioner informed her that she was going to be seeing Dr. Silver that day and that this specialist appointment was organized by Petitioner's attorney. Dr. Ronald Silver's note on June 22nd reflects Petitioner's history of a work accident on February 1, 2011, and Dr. Silver's impression of rotator cuff impingement. He recommended an MRI and consideration of arthroscopic surgery along with work restrictions and medications.

A phone note from June 24, 2011, indicates that Petitioner wanted a referral from Dr. Melia to see Dr. Silver for right shoulder and hip pain related to the work accident. Dr. Melia's records do indicate that an "orthopedic referral" was given but no particular doctor was specified.

Dr. Melia's June 28th record focuses on the lumbar condition but also includes an impression of right shoulder strain and "Prob rotator cuff, this was related to the accident in February also, was benefiting from Physical therapy but this was stopped by workmans [sic] comp in the middle of treatement [sic] Further evaluation MRI recommended by Dr. Silver."

A right shoulder MRI on June 29, 2011, revealed an intact rotator cuff with mild tendonitis and/or bursitis involving the distal supraspinatus tendon. On July 22nd, Dr. Melia again diagnosed a shoulder strain but noted that Petitioner told him that the MRI showed inflammation and that the orthopedic surgeon may recommend surgery. Also on July 22nd, Dr. Silver found that Petitioner's MRI was consistent with inflammation and a diagnosis of rotator cuff impingement. He recommended arthroscopic surgery and causally related this to her work accident.

On September 8, 2011, Petitioner was examined by Respondent's §12 physician, Dr. Nikhil Verma who testified via deposition on January 14, 2015. (Rx4). Dr. Verma testified that he is board-certified in orthopedic surgery with an added qualification in sports medicine and that his practice is focused primarily on the knee and shoulder. He examined Petitioner and reviewed her treatment records and radiographic studies. Dr. Verma testified that the June 29, 2011 MRI of the right shoulder showed an intact rotator cuff. On examination, Petitioner's shoulder was normal with no atrophy, deformity, swelling, or other abnormality. Her cervical motion was normal with full range of motion and no reproduction of pain either in the cervical spine or shoulder with cervical motion. Dr. Verma testified that Petitioner had no pain over the AC joint, SC joint, or biceps. Petitioner had full range of motion of the shoulder with no pain and 5/5 strength, which was symmetric to the opposite side. Petitioner had no impingement or labral signs and had an intact neurovascular exam. Dr. Verma testified that his interpretation of the MRI was a normal study and his objective physical examination was normal. He did not find any abnormal diagnosis regarding the shoulder. Dr. Verma did not think that the surgery recommended by Dr. Silver was indicated. Dr. Verma testified that he saw no evidence that Petitioner sustained any shoulder injury on February 1, 2011, and that, regarding the shoulder, she was at maximum medical improvement and was capable of working.

We note that Petitioner's medical records reflect continued right shoulder complaints after Dr. Verma's examination, and these are addressed below. She underwent lumbar surgery on April 23, 2012, and we affirm the Arbitrator's findings regarding the lumbar condition so we will not address those records here. Petitioner then underwent arthroscopic right shoulder surgery with Dr. Silver on July 14, 2012.

Dr. Silver testified via deposition on December 5, 2014. (Px15). He is a board-certified orthopedic surgeon who limits his practice to the shoulder and knee. Dr. Silver testified that Petitioner's physical examination and MRI were consistent with rotator cuff impingement. He testified that his intraoperative findings were also consistent with rotator cuff impingement and that her treatment and surgery were related to her original work injury. Dr. Silver testified that he reviewed Dr. Verma's reports and that Dr. Verma's findings on September 8, 2011, that Petitioner had full shoulder range of motion with no impingement signs are not consistent with his own examination, which was performed about seven weeks prior on July 22, 2011. After that date, Dr. Silver did not see Petitioner again until March 6, 2012.

Dr. Verma testified that he examined Petitioner again on March 28, 2013, and reviewed additional records from Dr. Silver including his operative report, which did not change any of his prior opinions. He did not see an indication for the surgical procedures that were performed. Dr. Verma testified that objectively, if anything, Petitioner had gotten worse after the surgical procedure, which is consistent with his opinion that it was not necessary. Dr. Verma again opined that Petitioner was at maximum medical improvement and required no further treatment for her right shoulder. Dr. Verma discussed the operative report in detail and testified that the only way one could support the procedures that were performed is if there had been a dramatic change in Petitioner's physical examination findings after he initially saw her on September 8, 2011, and, if that was the case, then her condition would not be related to her work injury.

After carefully weighing the conflicting evidence, we find that Dr. Verma's testimony and opinion is more persuasive than that of Dr. Silver. We find that Petitioner did sustain a right shoulder strain on February 1, 2011, as diagnosed by Dr. Melia, but that this had resolved by the time of the examination by Dr. Verma on September 8, 2011. Although there are medical records documenting continued right shoulder complaints after this date, we also are mindful of

the testimony of Kim Beauvais, the head of human resources at Respondent in 2011. She testified that she witnessed Petitioner, both prior to and after her accident, "dancing in her chair" with her hands in the air while she listened to music on headphones in the office. Ms. Beauvais testified that she has a specific recollection of Petitioner doing this after February 1, 2011, and that both of Petitioner's hands were up, with her elbows slightly bent, and her arms swaying. On rebuttal, Petitioner testified that she did listen to music on her headphones at work but she was never dancing because she was in pain. The Commission finds the testimony of Ms. Beauvais to be credible and consistent with a finding that Petitioner's right shoulder strain had resolved at some point prior to her examination with Dr. Verma.

Based on the above, we find that Petitioner's right shoulder strain had resolved by September 8, 2011, and that she had reached maximum medical improvement by that date. We find that Petitioner failed to prove that the treatment for her right shoulder condition after that date, including the surgery, was reasonable and necessary. We hereby award the medical expenses related to the right shoulder treatment through September 8, 2011.

We affirm the Arbitrator's award of medical expenses related to the lumbar condition. Respondent argues that the medical bill for the July 24, 2013 Clinical Evoked Potential Lower Extremities test is not supported by records of Dr. Kranzler. However, Petitioner testified that Dr. Kranzler recommended this test when she returned to him on March 31, 2013. Dr. Chhabria's report of this test is in evidence and it indicates that it was on referral from Dr. Kranzler. We find that, in this case, Petitioner has proven that this test was reasonable, necessary, and causally related to her work-related lumbar injury.

Regarding Petitioner's initial complaints of head and right foot/ankle pain, we award the bills for the emergency room visit, CT scans, and x-rays. However, these tests were negative and no further treatment for Petitioner's head and right foot was undertaken. We find that Petitioner has failed to prove any permanent partial disability for these conditions.

Regarding the right shoulder, we find that Petitioner's current, post-operative condition is not causally related to her work injury. We find the opinion and testimony of Dr. Verma to be persuasive that, as of September 8, 2011, Petitioner had full, painless range of motion and no impingement signs. We find that Petitioner's complaints after that date are not credible, that her right shoulder strain had resolved, and that Petitioner has failed to prove any permanent partial disability for the right shoulder.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $453.33 per week for a period of 30-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $408.00 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 20% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses related to the emergency room visit on February 3, 2011, the medical expenses related to the right shoulder treatment through September 8, 2011, and the medical expenses related to her lumbar treatment under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

17IWCC0426

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $13,729.10 in temporary total disability benefits pursuant to §8(b) of the Act and $5000.00 in other benefits pursuant to §8(j) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 30 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 5/17/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LANGSTON, EMILY
Employee/Petitioner

Case# **11WC015273**

BIG TEN NETWORK
Employer/Respondent

17IWCC0426

On 12/10/2015, 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:

1315 DWORKIN AND MACIARIELLO
ADRIAN CHERIKOS
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

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

17IWCC0426

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

EMILY LANGSTON
Employee/Petitioner

Case #11 WC 15273

v.

BIG TEN 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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 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?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On February 1, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $35,360.00; the average weekly wage was $680.00.
- At the time of injury, the petitioner was 35 years of age, single with three children under 18.
- The petitioner agreed that the respondent paid $13,729.10 in temporary total disability benefits and $5,000.00 in Section 8(j) benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits from March 24 through April 20, 2011, and from April 23 through October 23, 2012.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $453.33/week for 30-2/7 weeks, from March 24, 2011, through April 20, 2011, and from April 23, 2012, through October 23, 2012, which is the period of temporary total disability for which compensation is payable. The $13,729.52 due the petitioner is offset by the $13,729.10 previously paid by the respondent.
- The respondent shall pay the petitioner the sum of $408.00/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained

caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person as a whole. The petitioner's request for benefits for her right shoulder is denied.

- The respondent shall pay the petitioner compensation that has accrued from February 1, 2011, through November 18, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her lumbar spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right arm and shoulder and for her other medical problems and symptoms was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

Signature of Arbitrator

December 10, 2015
Date

DEC 10 2015

FINDINGS OF FACTS:

On February 1, 2011, the petitioner sustained injuries after slipping on ice descending stairs. She sought care at Advocate Trinity Hospital on February 3rd and reported injuries to her right scalp, midline neck, right low back, shoulder, and right foot and ankle. The musculoskeletal exam revealed normal range of motion and strength, no swelling or deformities and mild tenderness to palpation of her spine and right foot. A CT scan of her cervical spine was negative except for mild cervical levoscoliosis. An x-ray of her right foot was negative. Dr. Melia at Lawndale Christian Health Center saw the petitioner on February 8th for a myriad of complaints including back pain, right rotator cuff injury and neck pain. Dr. Melia's diagnosis was back pain and muscle spasm. Dr. Melia's assessment on March 10th was a right shoulder strain and noted clinical findings of trapezius trigger points and back pain. On October 8th, Dr. Melia's diagnosis was a right shoulder strain. On March 10th, Dr. Melia noted complaints of low back and leg pain and positive trigger points at the low back and on the right shoulder at the trapezius. He reiterated his diagnosis of a right shoulder strain.

The petitioner started physical therapy for her back on March 15th. On March 24th, the petitioner's complained of pelvic pain and Dr. Melia noted trigger points in her right shoulder and buttocks. The diagnosis was right shoulder strain, back pain and back muscle spasms. Pursuant to the petitioner's request to be taken off of work due to drowsiness with Valium, Dr. Melia recommended no work. On April 28th, the doctor noted right trapezius spasms and trigger points, and sacroiliac trigger points, bilaterally and in the coccygeal area. She was given trigger point injections into her right and left sacroiliac area, coccygeal area and right shoulder and scapular area. The diagnosis was

the same. The diagnosis on May 27th was back pain, sacroiliac joint dysfunction, back muscle spasms and right shoulder strain. The petitioner followed up regularly with Dr. Melia for her back, right shoulder and other medical conditions. A lumbar MRI on June 14th, revealed a disk herniation at L5-S1.

The petitioner was contacted on June 22nd about seeing Dr. Leonard Kranzler and she informed Dr. Melia's nurse that she was starting care with Dr. Ronald Silver. Dr. Silver's diagnosis on June 22nd was rotator cuff impingement. Dr. Kranzler's impression on June 23rd was lumbar radiculopathy at L5-S1 on the right. An MRI of her right shoulder at Instant Care Medical Group on June 29th revealed an intact rotator cuff, mild rotator cuff tendonitis and/or bursitis involving the distal supraspinatus tendon.

On July 18th, Dr. Phillips evaluated the petitioner at the respondent's request and opined that the lumbar MRI revealed a very subtle disc desiccation and a central right-sided disk protrusion at L5-S1 just contacting the S1 nerve root and not causing any frank thecal sac contact or compression. Dr. Silver recommended right shoulder surgery on July 22nd. Dr. Kranzler opined on September 1st that a DSSEP test showed an S1 conduction delay on the right. He recommended lumbar surgery.

On September 8th, Dr. Nikhil Verma of Midwest Orthopedics evaluated the petitioner at the respondent's request. He opined at his deposition on January 14, 2015, that her shoulder examination was normal and that the MRI revealed an intact rotator cuff with no partial or full thickness tear, no fluid in the glenohumeral joint or subacromial space, no significant tendinosis or inflammatory changes of the rotator cuff, an intact subscapularis and no labral tears. Based on the facts that the petitioner's symptoms were all related to her back and shoulder blade area and not being consistent with an

impingement syndrome, that a right shoulder injection resulted in no benefit and not being consistent with an impingement syndrome, a normal objective physical examination and an MRI scan void of abnormalities, Dr. Verma opined that the petitioner did not sustain an injury to her right shoulder on February 1, 2011.

The petitioner began treatment for depression and anxiety at Lawndale Christian Health Center on January 31, 2012. On April 23rd, the petitioner had a lumbar hemilaminectomy and discectomy on the right at L5-S1. At Instant Care Medical Group on July 14, 2012, the petitioner had a right arthroscopic subacromial decompression, a partial anterior acromioplasty, a coracoacromial ligament transection, a lysis of adhesions, a distal clavicle resection, a synovectomy and a debridement. Dr. Silver noted on October 3rd that the petitioner had regained full lateral abduction and that rotational and strengthening exercises were next. On December 12th, Dr. Silver noted that the petitioner had completed physical therapy, was at maximum medical improvement and was able to return to normal work activities effective December 17, 2012.

Dr. Phillips opined on March 5th that he felt the petitioner's lumbar symptoms were due to her injury. An off-work status report dated March 16, 2013, indicated a rotator cuff impingement, however, the treatment record is not in evidence. On March 28th, Dr. Verma evaluated the petitioner at the respondent's request and opined that there was no indication of an impingement in her right shoulder, that she was at maximum medical improvement, that surgery was not necessary and that no restrictions were needed.

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

The medical care rendered the petitioner for her lumbar spine was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right arm and shoulder and for her other medical problems and symptoms was not reasonable or necessary and is denied. Dr. Verma's opinions are more believable and reliable than Dr. Silver's and more in line with the evidence and Dr. Melia's assessment on March 10, 2011, of a right shoulder strain and his clinical findings of trapezius trigger points.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her lumbar spine is causally related to the work injury on February 1, 2011. The petitioner failed to prove that her current condition of ill-being with her right arm is causally related to the work injury on February 1, 2011. Dr. Melia's assessment of a right shoulder strain on March 10, 2011, was based on clinical findings of trapezius trigger points. Dr. Verma's opinion on January 14, 2015, that the petitioner did not have a right shoulder impingement was based on a normal objective physical examination on September 8, 2011, an MRI revealing an intact rotator cuff with no partial or full thickness tear, no fluid in the glenohumeral joint or subacromial space, no significant tendinosis or inflammatory changes of the rotator cuff, an intact subscapularis and no labral tears. His opinion was also based on the inconsistency of an impingement syndrome with back and shoulder blade symptoms and a right shoulder injection without any benefit. Moreover, Kimberly Beauvais remembered the petitioner swaying her arms up in air without limitation after February 1, 2011. When her recollection was challenged, she specifically remembered because there was no change in the petitioner's behavior after her injury. Dr. Verma's opinions are more reliable,

coherent and consistent with the initial clinical findings of Dr. Melia, the diagnostic testing and the evidence. The petitioner's request for benefits for her right shoulder is denied.

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

The petitioner was unable to work and off of work due to her lumbar injury from March 24, 2011, through April 20, 2011, and from April 23, 2012, through October 23, 2012. The respondent shall pay the petitioner temporary total disability benefits of $453.33/week for weeks, from March 24, 2011, through April 20, 2011, and from April 23, 2012, through October 23, 2012, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of back pain with weather, an inability to dance, and pain with exercise and with vacuuming. She has stiffness in her back and symptoms in her tailbone. The respondent shall pay the petitioner the sum of $408.00/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHER SMITH,

Petitioner,

vs.

NO: 11 WC 19917

MANHATTAN PARK DISTRICT,

17IWCC0462

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Cher Smith failed to establish a work-related accident arising out of and in the course of her employment on December 13, 2010. Petitioner's claim for compensation is, therefore, denied.

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

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1. Cher Smith filed an Application for Adjustment of Claim on March 24, 2011, alleging injury to her right leg as the result of a slip and fall on December 13, 2010.

2. Smith was employed as a program coordinator. On December 13, 2010, she completed her shift at 4:00 p.m., left the building and walked towards her car located in the parking lot. She was "probably" carrying her work bag with 2 to 3 files in the bag. T.21, T.36. Smith walked to her car and put her hand on the door handle when she fell down and backwards onto her collapsed knee. T.23. Her co-workers came to her assistance and an ambulance was called. T.24.

3. Smith testified that it was very snowy on December 13, 2010 and that it had snowed throughout the entire day. T.19. Smith described the snow as wet. T.37. She stated that the superintendent cleared the parking lot prior to the start of the work day. T.19. To the best of her knowledge the lot was salted. T.20. Smith did not know if the superintendent attempted to clear the parking lot after the employees began working in the morning. T.21.

4. Smith testified that she thought there was ice on the lot as the ambulance men were sliding around and had to brace themselves between two cars to get her up. T.37. She is 5'4" tall and weighs 260 pounds. T.42.

5. Smith testified that she was told where to park when she began working for the Park District. T.16. She stated that there are 7 parking spaces along the far left of the driveway and 2 on the right side at the back door. There were 8 employees working in the building. She was told that this was their parking lot and they could park anywhere in the lot. She never gave it any thought whether she could have parked elsewhere. T.38.

6. Smith stated that at the time of the accident, the lot was not used much by the general public. T.17. She stated that the district had just purchased an additional building a block up that had a very large parking lot. That new building was where the public would go and sign up for the park district programs. The old building where she worked became the office primarily for employees. *Id.* Smith stated there was very little interaction with the public at her building as all public business was now done in the new building, which was a block away. T.18.

7. Smith's supervisor, Julie Popp, testified that she did not witness the fall, but went out to help Smith after the fall. Popp testified that she did not see anything lying on the ground next to Smith. T.47. Popp did not see any snow accumulation on the ground when she went outside. *Id.* She stated that the lot is open to the general public and the lot at the new building is next door and has 40 parking spots. That lot is also used by the public. T.49. Popp further testified that employees are not told where to park and are also free to park in the street, which does not require a special permit. T.50. The employee handbook also does not indicate that employees have to park in a specific location. T.51.

8. Popp stated, on cross-examination, that members of the general public would come into their office about twice a day. T.54. She stated that the lot was cleared of snow that day. T.55. She does not know how many times it was cleared during the day. T.56. Popp further stated that the superintendent did salt the lot. T.57. It was probably applied in the morning before the employees arrived. *Id.*

9. Smith presented to Silver Cross Hospital on December 13, 2010 following her fall. The x-ray of the right knee revealed moderate to severe degenerative changes of the right knee. The impression was right ankle sprain, and right knee and leg sprain. PX.2.

10. Smith presented to Dr. Bradley Dworsky of Hinsdale Orthopaedics on January 17, 2011 for bilateral knee pain. Her left knee pain had since resolved. Her right knee pain had not diminished. She walked with a limp and could not bend her knee. Examination revealed that she was exquisitely tender over the medial joint line and mildly tender laterally. Smith had mild patellofemoral crepitation. The diagnosis was medial meniscal tear with pre-existing degenerative joint disease of the right knee. An MRI was recommended. PX.1.

11. Smith underwent an MRI of the right knee at Advanced Medical Imaging on March 3, 2011. The impression was fairly severe tricompartmental degenerative changes and a lateral meniscal tear. PX.1.

12. Smith was seen by Dr. Dworsky on March 14, 2011. Dr. Dworsky noted that the MRI showed a distinct horizontal tear of the lateral meniscus of the knee consistent with her symptomatology. The tear was traumatic in origin as Smith had described. Dr. Dworsky opined that Smith could attempt to ambulate with her condition, but she would have intermittent recurrence of sharp pain and discomfort. Dr. Dworsky recommended arthroscopic lateral meniscectomy of the knee to decrease her symptoms. PX.1.

13. Smith spoke with Samantha Smith, LPN at Hinsdale Orthopaedics on March 23, 2011. Per the medical record, Smith noted that she wanted to hold off on surgery as long as possible. Smith reported that she first wanted to lose weight. PX.1.

14. Smith presented to Dr. W.A. Earman of Orthospine Center on June 7, 2011 for a second opinion regarding her work injury. Smith reported that she was feeling better and her symptoms had improved. She still had occasional pain over the medial aspect of the knee. She has been increasing her activities. Examination revealed tenderness along the medial joint line. Dr. Earman noted that the MRI revealed degenerative changes of the knee as well as a degenerative tear located over the medial meniscus with significant narrowing of the medial meniscus. There was a possible tear of the posterior horn of the lateral meniscus that did not appear to be symptomatic. The impression was a significant degenerative change in the right knee with possible degenerative tears of the medial

meniscus of the right knee. Dr. Earman did not believe surgery would get rid of enough of her pain to require surgical intervention. Smith was going to attempt anti-inflammatory medication, a knee support, and a possible injection. RX.1.

15. Smith testified that she does not want to undergo surgery. T.34. She still uses a walker a few times a week. She will experience an ache every now and then. T.33. She tries to not let it get her down and she just goes about her day. She does not walk outdoors as much as she does not feel as steady. *Id.* She resigned at the end of May 2012. T.42. She has no future medical appointments and is not taking any prescription medication. T.43. She is 5'4" tall and weighs 260 pounds. T.42.

The burden lies with the claimant to establish the elements of her right to compensation. *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994). For accidental injuries to be compensable, a claimant must show that the injuries arose out of and in the course of employment. *Nabisco*, 266 Ill. App. 3d at 1106, 641 N.E.2d at 581. To arise out of one's employment, an injury must (1) have an origin in some risk connected with or incidental to the employment; or (2) be caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment. Dodson v. Industrial Comm'n, 308 Ill. App. 3d 572, 575-76, 720 N.E.2d 275, 278, 241 Ill. Dec. 820 (1999). Typically, an injury arises out of employment if, at the time of the occurrence, the employee was performing an act that he or she was instructed by the employer to perform, an act that he or she had a common-law or statutory duty to perform, or an act that the employee might reasonably be expected to perform incident to assigned duties. *Nabisco*, 266 Ill. App. 3d at 1106, 641 N.E.2d at 581. "In the course of" refers to the place, time, and circumstances under which the accident occurred. *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App. 3d 347, 349, 732 N.E.2d 49, 51, 247 Ill. Dec. 333 (2000). An injury that results from a hazard to which an employee would have been equally exposed apart from the employment or a risk purely personal to the employee is not compensable. *Nabisco*, 266 Ill. App. 3d at 1106, 641 N.E.2d at 581.

The purpose of the Act is to protect employees against hazards and risks that are peculiar to the nature of the work they do. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 605, 137 Ill. Dec. 658 (1989). The mere fact that duties take the employee to the place of injury and that, but for the employment, the employee would not have been there is not sufficient to give rise to the right to compensation. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63, 541 N.E.2d 665, 669, 133 Ill. Dec. 454 (1989).

The evidence establishes that the parking lot was open to and used by members of the general public. While the parking lot was also used by employees of the Park District, there is no evidence establishing that the Park District instructed their employees to park in that lot. Rather, employees were free to park anywhere in the lot, park in the street, or park in the Park District's other parking lot. Thus, the employees and members of the general public were exposed to the same risk.

17IWCC0462

By Smith's testimony, the Park District plowed and salted the lot prior to the start of the work day. She testified that it continued to snow and described the snow as very wet. Smith, however, was unsure as to whether the Park District continued to plow the lot throughout the day, and no evidence was offered establishing that the Park District attempted to clear the lot during the day. The Commission finds that the accumulation of snow in the parking lot represented a natural accumulation as there was no evidence that Respondent created or contributed to a hazard. As the lot was open to the general public, Smith's fall resulted from a hazard to which she and the general public were equally exposed. Thus, the Commission finds that Smith's injury did not arise out of her employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 13, 2016 is hereby reversed. Petitioner's claim for compensation is therefore 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: JUL 21 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 6-6-17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

SMITH, CHER
Employee/Petitioner

Case# **11WC019917**

17IWCC0462

MANHATTAN PARK DISTRICT
Employer/Respondent

On 6/13/2016, 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 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2122 McNAMARA PHELAN McSTEEN LLC
RON S FLADHAMMER
3601 McDONOUGH ST
JOLIET, IL 60431

0507 RUSIN & MACIOROWSKI LTD
LINDSAY A BEACH
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION CORRECTED DECISION

Cher Smith
Employee/Petitioner

v.

Manhattan Park District
Employer/Respondent

Case # 11 WC 19917

17IWCC0462

An *Application for Adjustment 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 M. Ory**, Arbitrator of the Commission, in the city of **New Lenox**, on **February 8, 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **December 13, 2010,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** sustain an accident that arose out 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 **$21,663.20**; the average weekly wage was **$416.63**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

ORDER

Medical Benefits

Respondent shall pay the bills totaling **$3,151.93**, subject to the fee schedule and pursuant to §8 and §8.2.

Permanent Disability

Respondent shall pay the sum of **$253.00** week for a period of **32.25** weeks, as provided in **§8 (e) 12**of the Act, because the injuries sustained caused **15% loss of use of the right leg..**

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

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

Christine Moy

06/10/2016

Signature of Arbitrator — Date

ICArbDec p. 2

JUN 13 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cher Smith	)	
Petitioner,	)	
vs.	)	**No. 11 WC 19917**
Manhattan Park District	)	
Respondent.	)	**17IWCC0462**
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox on February 8, 2016. The parties agree that on December 13, 2010, 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 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 $21,663.20, and that her average weekly wage was $416.63

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental 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 injury.
3. Whether respondent is liable for the unpaid medical bills.
4. The nature and extent of petitioner's injury.

FINDING OF FACTS

Petitioner testified that she was hired by respondent in March, 2007. She was originally the receptionist and worked her way up to program coordinator. Her job as program coordinator involved setting up programs for children and teenagers.

Petitioner testified she worked in respondent's administration building, which was an old farmhouse. There were nine parking spots at the administration building; eight employees worked at this building. Petitioner testified the administration building parking lot was mainly used by employees, although occasionally the parking lot was used by the public. There was very little interaction with the public at the administration building. Petitioner testified she was advised by the Executive Director, Julie Popp, that the lot next to the administration building was an employee parking lot. Respondent owned another building with a large parking lot located down the block from respondent's administration building. Petitioner only used this larger lot to park when the administration building parking lot was being repaved.

Petitioner testified that on December 13, 2010, she arrived at work at 8 A.M. Petitioner understood the administration building parking lot was owned and maintained by respondent. Petitioner understood the parking lot had been plowed before petitioner arrived that morning by Bob Gainos, respondent's superintendent of maintenance. The lot and walk had been salted.

Petitioner was wearing tennis shoes and carrying a small bag or satchel with work papers in it, as well as a small handbag. Petitioner left at 4 P.M. It was dusk. She walked to her vehicle in the administration parking lot. As she put her hand on the driver's door she slipped and fell down on both knees with legs underneath, falling to her right. Petitioner testified she fell on wet snow. Petitioner screamed and co-worker Vicky came to her aid. An ambulance was called. Petitioner testified that the firefighters were also sliding around when they came to petitioner's aid. Petitioner felt pain in her right knee and right foot.

Julie Popp, respondent's executive director, testified in behalf of respondent. Popp had been respondent's executive director for 16 years. She had known petitioner for four years. Popp did not witness the accident but came outside immediately afterward to find petitioner was on the ground. Popp did not see any snow accumulation on the ground. Popp testified that the lot where petitioner fell was used by the public. There is a 40-space lot down the street at the program center that is also used by the public. The employee handbook did not direct petitioner to park in the administration lot.

Petitioner was taken via ambulance to Silver Cross Hospital. According to the emergency record she slipped and fell on ice. She complained of an ankle injury. X-rays of petitioner's right ankle and leg were negative for fractures. The diagnosis was right ankle and knee sprain. She was referred to orthopedic surgeon, Dr. Dworsky. (PX.2)

Petitioner first saw Dr. Dworsky on January 17, 2011. Petitioner's complaints to Dr. Dworsky was limited to her right knee. Petitioner indicated to Dr. Dworsky that the right knee pain had not diminished in four weeks. X-rays showed significant arthritic changes in three compartments with osteophyte formation. However, she had a very well preserved joint space equal both medially and laterally. Dr. Dworsky diagnosed a medial meniscal tear with preexisting degenerative joint disease of the right knee. An MRI was ordered. (PX.1)

An MRI of March 3, 2011 reportedly showed severe tricompartmental degenerative changes and a lateral meniscal tear. She returned to Dr. Dworsky on March 14, 2011 to discuss the results of the MRI. Dr. Dworsky believed the tear was traumatic in nature and recommended arthroscopic lateral meniscectomy. Petitioner called Dr. Dworsky's office on March 23, 2011 for a prescription of Naproxen as she was trying to hold off on surgery until she lost weight. (PX.1)

Although petitioner denied seeking a second opinion from Dr. Earman, who had performed her left knee replacement, the records of Dr. Earman reflect that she did see Dr. Earman on June 7, 2011 for a second opinion. Dr. Earman noted degenerative changes of the right knee and possible tear of the posterior horn of the lateral meniscus which appeared not to be symptomatic. (RX.1)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator found the petitioner to be credible.

In support of the Arbitrator's decision with regard to whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator makes the following finding:

The Arbitrator finds petitioner's sustained an injury which resulted from the work accident that arose out of and in the course of petitioner's employment with respondent on December 13, 2010. The Arbitrator considered the following facts in reaching this decision.

The parking lot was owned and maintained by respondent. Although it was used by the public occasionally, it was mainly used by employees as it was adjacent to respondent's administrative office where petitioner and the other employees worked. For this reason, the Arbitrator finds petitioner was in the course of her employment when she slipped and fell on December 13, 2010.

The other issue considered by the Arbitrator was whether the accident arose out of the petitioner's employment with respondent. The Arbitrator notes the parking lot was maintained by respondent. It was not a natural accumulation of ice and snow as respondent had plowed and salted the parking lot. The Arbitrator also notes petitioner's testimony that the firefighters, who came to petitioner's rescue, were also slipping. The facts as presented indicate petitioner was exposed to a risk greater than that of the general public and thus her injury arose out of her employment with respondent.

Therefore, the Arbitrator finds petitioner was injured in an accident which arose out of and in the course of her employment with respondent on December 13, 2010.

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 finding:

As a result of the work accident, the Arbitrator finds petitioner sustained a sprained left ankle, that had resolved, and an injury to her right knee. Dr. Dworsky determined that although petitioner had pre-existing severe tricompartmental degenerative changes she also had a lateral meniscal tear that was acute. Dr. Earman found petitioner had a possible lateral meniscal tear, but it appeared to be asymptomatic as of June 7, 2011.

Based upon the foregoing, the Arbitrator finds petitioner sustained a tear of the lateral meniscus and a resolved sprained ankle as a result of the work accident of December 13, 2010.

In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, having found in favor of petitioner on the liability and as there does not appear there are any issues on the reasonableness and necessity of the medical treatment rendered, awards the following bills, to be paid in accordance with §8 and 8.2:

Manhattan F.P.D $950.00

Silver Cross Hospital -$1,330.45

Associated Radiologists - $37.00

EM Strategies LTD $419.00

Hinsdale Orthopaedics $298.00

Orthospine Center $80.00

Prescriptions $37.48

In support of the Arbitrator's decision with regard to the nature and extent of injury, the Arbitrator finds the following:

Petitioner sustained a sprained ankle that had resolved. Her treating physician, Dr. Dworsky, found petitioner had a torn lateral meniscus in petitioner's right knee which requires arthroscopic surgery. Although petitioner has been reluctant to have the surgery, the condition remains. The Arbitrator therefore finds petitioner's work injury has resulted in a 15% loss of use of the right leg, and awards 32.25 weeks permanent partial disability at $253.00 per week pursuant to §8 (e) 12 of the Act.

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

Terrence Shanahan,

Petitioner,

vs.

NO. 11WC 26651

17IWCC0450

Dykstra Concrete,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 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.

17IWCC0450

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: JUL 18 2017
SJM/sj
o-6/29/17
44

Stephen J. Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHANAHAN, TERRENCE
Employee/Petitioner

Case# **11WC026651**

17IWCC0450

DYKSTRA CONCRETE
Employer/Respondent

On 7/1/2016, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JAMES M BRYNES
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0450

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terrance Shanahan
Employee/Petitioner

v.

Dykstra Concrete
Employer/Respondent

Case # **11** WC **26651**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **6/7/2016**. 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. xx 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. xx Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **6/24/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$1,312.00**; the average weekly wage was **$1,640.00**. SEE DECISION

On the date of accident, Petitioner was **53** 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 **$282,706.49** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$282,706.49**.

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

ORDER

Respondent shall pay Petitioner temporary total disability/maintenance benefits of $1093.33 /week for 258-4/7 weeks, commencing June 25, 2011 through June 7, 2016.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 6/8/16, of $786.67/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay reasonable and necessary medical services of $ 2,790.75 , as provided in Sections 8(a) and 8.2 of the Act. The respondent shall have a credit for bills paid by respondent prior to the award.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 Carolyn Doherty — **6/30/16** Date

ICArbDec p 2

JUL 1 - 2016

FINDINGS OF FACT

On June 24, 2011, the 52 year old Petitioner, Terrance Shanahan, was employed by the Respondent, Dykstra Concrete, as a cement mason. At that time, the Petitioner had worked for the Respondent for 4 days. The Request for Hearing form reflects that the parties stipulated to the issues of accident, notice and causal connection at trial. ARB EX 1. Petitioner testified that he graduated from high school in 1975. After he graduated he began working as a cement mason. He worked as a cement mason from the time that he graduated from high school in 1975 until his injury on June 24, 2011. He does not have any other specialized skills or further education.

The Petitioner testified that, as a cement mason, his job duties included pouring and finishing concrete. The job also required lifting, climbing ladders and scaffolds. Petitioner was exposed to walking on uneven surfaces, such as mud, debris, dirt, and various surfaces on a construction site. For the 11 years before his accident, the Petitioner was a member of the Local 11 Cement Mason's Union. He testified that, as a member of the union, his base salary was $41.00 per hour. As a cement mason it was usual for him to work for more than one employer per week; during some weeks he could work for up to five different employers. He testified that he received jobs when he was contacted by the union's business agent, Anthony Frescura, Jr., and sent out to various worksites.

The Petitioner testified that his regular work week was working 5 days per week, 8-10 hours per day. This was full-time work. He would earn overtime pay if he worked on Saturdays or Sundays. As a cement mason, he was required to be available to work 5 days per week, and sometimes 6- to 7-days per week. He testified that if it was raining he was still required to show up to the job site.

The Petitioner suffered an injury to his right eye approximately 30 years ago. This injury caused a punctured globe and detached retina of his right eye. (PX 1). He testified that, as a result of this injury, he had diminished vision in his right eye and problems with depth perception. Before his injury, he relied on his left eye as his "dominant eye." Since his 2011 injury, his right eye has further deteriorated.

Petitioner testified that he began working for the Respondent the week of June 24, 2011. He testified that he worked for 4 days that week and was ultimately injured on June 24, 2011. He worked for the Respondent for 32 hours and earned $41.00 per hour before the undisputed accident on 6/24/11.

On June 24, 2011, the Petitioner was hammering a nail while at work for the Respondent. The nail flew up and struck him in his left eye. He was transported by ambulance to Silver Cross Hospital. (PX 1). He treated at the Silver Cross Emergency Room and was diagnosed with hypema (eye) post-trauma. *Id.* Mr. Shanahan followed up with Dr. Rassouli of the Spectrum Eye Institute on June 24 and again on June 25, 2011. On that date, he noted that his pain had decreased, but he was noticing a blurry spot in his central vision. He was diagnosed with possible macular edema, possible glaucoma, a conjunctive laceration, hyphema and a retinal tear of the left eye. (PX 2) Dr. Rassouli performed optical coherence tomography of the left eye and referred him for further treatment of the retinal tear. (Id.)

Dr. Joseph Civantos performed focal laser eye surgery on the Petitioner's left eye on June 25, 2011. (PX 4). He appreciated hyphema and traumatic iritis on the left eye. *Id.* An eye exam revealed visual acuity of 20/100 in the Petitioner's left eye. *Id.* Dr. Civantos ordered the Petitioner off work at this time. *Id.* The Petitioner continued to treat with Dr. Civantos. *Id.* On July 14, 2011, Dr. Civantos diagnosed decreased visual acuity of the left eye of

20/400 vision. *Id.* He noted that the Petitioner can only read stop signs approximately 10 feet away and that it took "awhile" for the Petitioner's eyes to focus. *Id.* The Petitioner reported that he was not driving. *Id.*

As of July 28, 2011, Dr. Civantos noted that the Petitioner's hyphema had resolved but that the Petitioner continued to have unexplained decreased 20/400 visual acuity in his left eye. *Id.* He recommended that the Petitioner undergo neuro-ophthalmic treatment to identify any optic nerve pathology causing the decreased vision. *Id.*

The Petitioner presented to Dr. Thomas Mizen, a board-certified ophthalmologist at Rush University. Dr. Mizen performed Optic Nerve OCT, testing on the Petitioner's eye in January 2012. PX 3. The test results were normal. *Id.* He also performed a multifocal ERG test on the Petitioner's retinas in February 2012. *Id.* These test results were also normal. *Id.* He referred the Petitioner back to Dr. Civantos. *Id.*

The Petitioner returned to see Dr. Civantos in April 2012. (PX 4). On April 30, 2012 Dr. Civantos opined that the Petitioner's clinical examination is stable and opined that he reached maximum medical improvement with no further intervention planned. *Id.* Petitioner's vision was 20/25 is the right eye and 20/400 in the left eye. PX 4. He issued the following permanent restrictions.

> [L]ight duty dues not accurately summarize his visual limitations. He can perform heavy lifting or strenuous effort. The problem is that with the decreased vision in his left eye, he has decreased depth perception and impaired balance. I reviewed some of the requirements of his job description. One of the concerns is the need to work at a high elevation. Because of the decreased depth perception and the issues with balance, I would be concerned about the risk of a fall. I do not think he should work in an environment, which would require him to be on scaffolding or otherwise in a situation where a fall could have severe consequences. In addition, he would not be able to perform any job that required a commercial driver's license. His vision does meet the requirements for a regular passenger license, so he can drive a passenger car. (PX 4 and 5).

The Petitioner continued to treat with Dr. Civantos and Dr. Mizen for his injury throughout 2012. (PX 3, 4). They did not change his work restrictions or document improvement with his vision. *Id.*

The Petitioner entered letters from Local 11 business agent, Anthony Frescura, Jr., regarding the Petitioner's permanent work restrictions. (PX 6). In this letter, Mr. Frescura notes:

> According to the member, Mr. Shanahan, has decreased depth perception and issues with balance. He is restricted from being on scaffolding or in a situation where a fall could occur. He also cannot perform any job that requires a commercial driver's license.
>
> The job duties of a cement mason require that he be able to climb ladders and scaffolds to reach elevated positions on buildings. It also requires climbing into holes and using ladders and other structures during concrete pours. The job also requires walking on uneven surfaces, such as mud, debris, dirt, and various surfaces on a construction site.

> There is no light duty on our trade. I cannot refer Mr. Shanahan to a job site. These restrictions cannot be accommodated. If we refer Mr. Shanahan for work he has to be able to perform all the duties of a cement mason. With these restrictions he is not able to perform the full duties of a cement mason. (PX 6).

An additional letter was provided by Art Sturms, business manager at Local 11. (PX 7). He indicates "As a cement mason it is virtually impossible to work with a visual impairment. Not only would it not be productive, but more importantly it is extremely unsafe." *Id.* He detailed job requirements making full visual abilities necessary such as working with extreme measurement tolerances and the need for excellent hand eye coordination. PX 7.

The Petitioner participated in vocational rehabilitation with David Patsavas, M.A., C.R.C. of Independent Rehab Services, Inc. (PX 8). He began vocational rehabilitation services on January 27, 2013. *Id.* Mr. Patsavas reported that the Petitioner had a work history of 37 years in the Concrete industry with membership in the Operators, Plasters and Cement Masons International Association Local 11. *Id.* Petitioner reported that while in the cement industry he worked as a cement mason, concrete supervisor, construction superintendent and estimator. Petitioner also reported being self employed in the concrete industry from 1982 to 1999 doing residential and light commercial cement work and that he employed between 8 – 10 people. He poured concrete in the morning and handled bidding in the afternoon. He handled his own pay roll. The Petitioner indicated that he had no computer skills but would be open to a return back to school for possible retraining and obtaining computer skills. *Id.* He was interested in a sales-type position. *Id.*

The transferable skills analysis dated January 27, 2013 which yielded 21 jobs as excellent and 128 jobs as good to moderate options for Petitioner.

Mr. Patsavas noted that if Petitioner was unsuccessful at returning to employment as a Supervisor in the concrete industry then he would require, at a minimum, entry-level computer skills training to apply for management and/or supervisory positions outside of the concrete industry. *Id.* At the conclusion of the initial vocational assessment, Mr. Patsavas recommended a labor market survey as well as coordination for computer classes. *Id.*

A Labor Market survey was completed on February 28, 2013. PX 8. Mr. Patsavas indicated that the survey revealed that a stable labor market exists for the Petitioner. *Id.* The labor market survey notes that Mr. Shanahan had experience not only as a concrete mason, but as a supervisor, superintendent, and estimator. He also had approximately 17 years of self-employment in the cement finishing business, which involved both concrete work and bidding on jobs for his company. It was felt that if he could not return to work as a supervisor or estimator in the concrete industry, a viable and stable labor market existed for him outside the industry, including such positions as Shipping and Receiving Clerk, Distribution Clerk, Coordinator positions and positions in Distribution, Maintenance, Warehouse, Estimating, Paving, Maintenance Coordinator and Dispatching. (Id.) Mr. Patsavas estimated that most of the entry level positions in such fields pay between $10.00 and $15.00 per hour. PX 8.

The Petitioner attended further vocational rehabilitation services in July and August 2013. *Id.* Mr. Patsavas indicated that the Petitioner attended all of the recommended classes in computer training, but had difficulties comprehending some of the materials. *Id.* The Petitioner continued vocational rehabilitation services with Mr. Patsavas. *Id.* On November 15, 2013, Petitioner had completed his keyboarding class and was set to begin receiving job lead via email and was "expected to follow up with those job leads." PX 8. On January 31, 2014, the Petitioner received a telephone call from Guardian Security for a security guard position. *Id.* However, the

job required reading tags underneath trailer in order to check in trucks. *Id.* Because of the Petitioner's sight, he was not considered for the job. *Id.* Mr. Patsavas recommended that research be conducted regarding a computer that the Petitioner could utilize for job search activities. *Id.*

In February 2014, Mr. Patsavas again documented his vocational rehabilitation efforts. *Id.* He noted that the Petitioner continues to be provided assistance in completing online applications but reported no positive responses during the past month. *Id.* He recommended that the Petitioner's vision be evaluated by the Chicago Lighthouse for the Blind to enable him to work independently on a computer, completing online applications, email correspondence, and prepare him for work in an environment that utilizes the computer. *Id.* On April 4, 2014, Mr. Shanahan returned to see Mr. Patsavas. *Id.* He noted that the Petitioner completed his course in Microsoft Excel and was provided with enhancements to his computer screen so that he could complete assignments. *Id.*

Mr. Patsavas reported that the Petitioner attended a job fair on April 11, 2014 at Joliet Junior College. *Id.* He made contact with several employers and provided copies of his resume. *Id.* He did not receive any job offers. *Id*

The Chicago Lighthouse for the Blind evaluated the Petitioner on April 25, 2014. *Id.* The Lighthouse recommended for the Petitioner to use a laptop computer, Zoom Text Screen Magnifier, Large Print Keyboard, Microsoft Office Home and Student, a printer with a USB cable, and a VisioBook S. *Id.* The Petitioner testified that these resources were provided by the workers' compensation carrier.

On October 16, 2014, the Petitioner presented to Dr. James Cutler for an eye-care consultation. The Petitioner reported that his vision had changed and was getting worse. The Petitioner reported the decreased vision to Mr. Patsavas. (PX 8). Mr. Patsavas recommended that the Petitioner apply for a transporter position at Marianjoy Hospital *Id.* He also advised the Petitioner to identify hiring opportunities online at Indeed, Monster, Career Builder, and Simply Hired. *Id.* He noted that the Petitioner's typing speed is still significantly slow. *Id.*

Petitioner continued to submit online applications through email leads provided by the counselor. The counselor also checked Petitioner's email account for responses but no responses were found or documented. It is not clear from the records whether Petitioner submitted his independent job search efforts or follow-ups to the counselor although requested to do so. PX 8. Petitioner continued to report no positive response to applications submitted. PX 8.

In February 2015, Mr. Patsavas recommended that direct contact be made to employers in Petitioner's local geographical area due to the lack of success from online applications. Mr. Patsavas updated his reporting on the Petitioner's vocational rehabilitation on March 27, 2015. *Id.* Mr. Patsavas noted that direct, yet unsuccessful, contact was made with employers in New Lenox, including Sam's Club, PetCo, and K-Mart. *Id.* He opined that the Petitioner made efforts to increase his skills on the computer by working on a daily basis. *Id.* However, the Petitioner continued to experience difficulty in becoming independent on the computer and felt that he would not be successful for a position requiring him to be on the computer for the majority of the day. *Id.* Although the computer improved his life, he was unable to retain and recall information and could only conduct basic computer-related activities. *Id.* Petitioner and the counselor decided to focus on jobs that do not require a significant amount of computer work so they agreed to focus on position in custodial work, stocking, loading and unloading and retail work that did not require a computer.

The Petitioner again met with Mr. Patsavas on June 27, 2015. *Id.* Mr. Patsavas noted that the Petitioner continued to apply with several employers but was unsuccessful at finding employment. *Id.* The Petitioner reported increased difficulties and bouts of mood swings and depression. *Id.* At this time, Mr. Patsavas opined

that, given the Petitioner's lack of transferrable skills, visual limitations, and lack of formal computer training, the Petitioner may continue to have difficulties in identifying full-time employment opportunities. *Id.* The Petitioner expressed his motivation to return back to some type of gainful employment, even at a minimum wage capacity. *Id.* He recommended that the Petitioner find a volunteer-type position in order to prove his ability for job tasks to potential employers and gain some practical work experience. *Id.*

In July 2015, the Petitioner began to volunteer at St. Mary Magdalene church in New Lenox, IL. *Id.* He reported that this opportunity provided him with a sense of purpose and improved his overall mood. *Id.* Despite the volunteer position, Mr. Patsavas opined that his lack of transferable skills, lack of formal computer training, and visual limitations may continue to present difficulties in full-time employment. *Id.*

The Petitioner met with Mr. Patsavas at the last time on September 4, 2015. *Id.* He reported that the Petitioner continued to volunteer at St. Mary Magdalene church. *Id.* The Petitioner expressed a decline in his overall mood with increased levels of anxiety and depression of the past few months. *Id.* He indicated that he felt his vision is declining and that this caused additional stress. *Id.* Mr. Patsavas noted that the Petitioner was participating in Job Placement Activities since June 2013 but was unable to fully grasp the computer training that was provided to him. *Id.* The Petitioner was not able to demonstrate the abilities to utilize the computer in a way that would transfer into a work environment. *Id.* Mr. Patsavas documented that the Petitioner made contact with local employers with a few interviews during the past few years. *Id.* These interviews were unsuccessful. *Id.* He opined that the Petitioner fully cooperated with Vocational Rehabilitation efforts. *Id.* Finally, he stated:

> Numerous job openings in [the Petitioner's] local area have been identified as potential employment opportunities for him, however, [the Petitioner] has not been offered any jobs to date. Job placement efforts with [the Petitioner] have been unsuccessful and training opportunities have not proven to be effective given his visual impairment, lack of transferable skills and inability to comprehend computer technology. *Id.*

Based on these opinions, Mr. Patsavas terminated vocational rehabilitation. *Id.*

With regard to his job search efforts, Mr. Shanahan testified that he "applied for a bunch of jobs," although he did not provide specific information concerning the nature of his contact with potential employers. He testified that he met with the vocational counselor at least once per month, sometimes twice, and at each meeting, the counselor would provide a list of job leads. He agreed that he was expected to contact the prospective employers set forth in the list of job leads on his own, apart and independent from any assistance from the counselor. He also agreed that he was to keep a written job log, setting forth the dates that he contacted potential employers, who he spoke with and the results of these contacts. The idea was that he would report back to the counselor the following month with the job log that outlined his independent job search activities. This expectation was noted in the records from Independent Rehabilitation Services. (PX 8) Despite being aware of the expectations of him, he testified that he did not keep any documentation of his job search activities, as he expected that his counselor would keep such records. The records from Independent Rehabilitation Services contain no job search logs prepared by Mr. Shanahan or any other documentation of the nature of his independent job search efforts, other than whatever took place during the meeting with the vocational counselor. (Id.)

The formal vocational rehabilitation program was suspended as of September 4, 2015. Mr. Shanahan testified that he has not made any effort to find work since that date.

At trial, the Petitioner testified regarding his vision in his left eye. He testified that he can see "hand signals." He explained that his vision cannot be rated as a "20/20"- or "20/40"-vision. When he closes his right eye and looks out of his left eye, he can see some motion out of his eye. His right eye has deteriorated since his injury.

The Petitioner currently volunteers at St. Mary Magdalene church. He helps to move desks and chairs. He testified that he volunteers "whenever the priest needs me." He wants to be there every day. He said, "I feel good when I go there."

He testified about his activities of daily living. He attempts to read using his VisioBook. He uses the computer to follow drag-racing. He does the dishes and listens to music.

On cross-examination, the Petitioner testified that he met with vocational rehabilitation counselors every two weeks from January 2013 through September 2015. At these meetings he would report on leads and contact employers between meetings. He testified that he did not keep a job-search log because of his vision problems and that the vocational rehabilitation counselors maintained that information. He has not looked for work since September 2015.

The Arbitrator also heard testimony from Anthony Frescura, Jr. Mr. Frescura is a business agent for Local 11 Area 161 in Will and Grundy County. He testified that he was the business agent in 2011 and worked with the Respondent at that time. The Respondent was a signatory to the union's collective bargaining agreement. PX 14.

Mr. Frescura testified that he was familiar with the regular work-week of a cement mason. A cement mason was a full-time position. The members had to be available from Monday to Friday. A regular work-day was from 7:00am through 3:30pm or 8:00am through 4:30pm. If the cement mason worked on Saturdays of Sundays they would earn overtime. The masons were also entitled to overtime if they worked more than 8 hours in a single week-day.

He further testified that a member must be available 5 days per week, sometimes 6, or even 7 days per week when needed. In the event of rain or inclement weather, the worker was expected to appear at the job site and would earn two-hour's pay. If weather clears up, they will get paid once they put their tools on and they perform work. Cement mason work is sequenced with other trades in the construction industry. If there was any delay in the scheduling of construction work, the worker still must be available. The Respondent did not cross-examine Mr. Frescura.

The Respondent called one witness, Dave Stuursma. Mr. Stuursma testified that he was the owner of Dykstra Concrete and had owned the company for 22-years. As part of his daily job duties he would estimate the cost of jobs, order materials, and direct cement finishers/masons.

He testified regarding payroll records of other employees. Mr. Stuursma testified that he would hire cement masons at an as-needed basis, particularly if he was in a different county. He testified that a cement mason had no guarantee of hours; different sized projects would last for a different number of days. He further testified that the Petitioner worked for four, eight-hour days, 32 hours, before his accident.

On cross-examination, Mr. Stuursma testified that cement masons were expected to be available for work at least five-days per week, Monday through Friday. He testified that cement masons' regular work-week was a five-day, 40-hour work week. The cement masons were expected to work from 7:00am through 3:30pm or 8:00am through 4:30pm.

CONCLUSIONS OF LAW

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

A. In support of the Arbitrator's Decision relating to (G) the Petitioner's Earnings, (K) What temporary benefits are in dispute TTD and (N) Is Respondent due any credit the Arbitrator finds as follows:

The Arbitrator notes that based upon the entirety of the record at trial, Petitioner's regular work week as a cement mason was a 40-hour week and that the Petitioner earned $41.00 per hour. The Petitioner was required to be available five-days per week for an eight-hour day; sometimes weekends included. Therefore, the Petitioner's AWW was as follows: $41.00 x 40 hours per week = $1,640.00 per week. This finding is supported by Petitioner's testimony, and the testimony of Mr. Frescura the Local 11 business agent and by Mr. Stuursma, the owner of Respondent Dykstra who agreed that he expected the cement masons he hired to be available for work at least five-days per week, Monday through Friday. He testified that cement masons' regular work-week was a five-day, 40-hour work week. The cement masons were expected to work from 7:00am through 3:30pm or 8:00am through 4:30pm. Petitioner testified that he was always available to work 5 days per week. Accordingly, the Arbitrator finds that Petitioner's average weekly wage was $1,640 and his TTD rate was $1,093.33. Lastly, the Arbitrator notes Petitioner's arguments made on the record regarding the binding nature of Respondent's "stipulation" made years before this trial that the AWW was $1,640 and the TTD payments made by Respondent based on that rate. However, the Arbitrator's finding here was based on the evidence submitted at trial thereby making Petitioner's "stipulation" argument moot.

Noting that Respondent paid Petitioner TTD of $1,093.33 per week based on the AWW of $1,640, the Arbitrator further finds there was no overpayment of TTD benefits as claimed by Respondent at trial. The parties have stipulated that the period of the Petitioner's temporary total disability is not in dispute. They agree that Mr. Shanahan has not worked since the date of the accident on June 24, 2011 and has been temporarily totally disabled or entitled to maintenance since that date to the date of the hearing on June 7, 2016, a period of 258-4/7 weeks. Petitioner was owed TTD commencing 6/25/11 as stipulated by Respondent and was paid at the correct rate. ARB EX 1. The Arbitrator further finds that Respondent shall receive credit for TTD paid. ARB EX 1.

B. In support of the Arbitrator's decision relating to (L) the Nature and Extent of the Petitioner's Injury, the Arbitrator finds as follows:

The Petitioner testified that he participated in vocational rehabilitation with Independent Rehabilitation Services from January 27, 2013 through September 4, 2015. He testified that he took various computer classes at Joliet Junior College. He testified that he was also afforded the benefit of services through the Chicago Lighthouse for the Blind and was also provided with new computer equipment and other assistive devices to assist in his ability to read and access the internet and check his email. He met with the vocational counselors on a regular basis, who assisted in preparing a resume, providing hundreds of job leads, and assisting in filling out online job applications.

The records from Independent Rehabilitation Services also make it clear that Mr. Shanahan had an obligation to conduct independent job search activities, specifically utilizing the new computer equipment and reading device that he was provided with by Chicago Lighthouse for the Blind. The reports repeatedly state that he was to provide job logs or otherwise to "document all of his employer contacts and provide those to the office of Independent Rehabilitation Services." (PX 8) Mr. Shanahan admitted on cross-examination that the purpose of

the job leads provided by the vocational counselor was to encourage him to contact prospective employers on his own and report his progress back to the counselor at the next meeting. Mr. Shanahan admitted that in fact, he did not keep track of his contacts by way of a written job log or other documentation. While the records from Independent Rehabilitation Services contain hundreds of job leads with potential employers, there is no written documentation to establish that Mr. Shanahan in fact took advantage of the job leads provided to him; no list of employers contacted by Mr. Shanahan, no list of when any contacts took place, no documentation of whom he may have spoken to and no documentation of any effort Mr. Shanahan took on his own volition to find work within his restrictions. Petitioner simply testified that he thought the logs and records were kept by Independent Rehabilitation Services because he could not use the computer to keep track.

Mr. Shanahan testified as to one interview he attended with a potential employer, which involved reading tags on semi-trucks. Mr. Shanahan determined that he would not be capable of performing such work and thus it does not appear that the interview ever resulted in a job offer. No evidence was offered as to whether Mr. Shanahan inquired as to possible accommodation for this position.

The Arbitrator specifically notes that David Patsavas of Independent Rehabilitation Services performed a labor market survey and set forth the results in his report of February 28, 2013. In that report, he stated the opinion that a viable and stable labor market exists for Mr. Shanahan, even given his education, experience and physical restriction. He set forth a variety of occupations which he believes Mr. Shanahan is capable of performing and noted that the average entry level position in such occupations pays on average from $10.00 to $15.00 per hour.

Based on the above, the Arbitrator finds that the Petitioner is not permanently and totally disabled. The labor market survey from 2013 establishes that a viable and stable labor market existed for him as of that time. The Arbitrator notes that he was given the tools from his vocational counselor to engage in a quantitative job search but the record is devoid of evidence that he properly availed himself of those resources to engage in a successful qualitative job search. There is no medical opinion that Petitioner is incapable of working in any capacity but only that he cannot return to his pre-injury employment as a cement mason.

The Arbitrator finds that the Petitioner is instead entitled to wage differential benefits pursuant to Section 8(d)1 of the Act. Based on the labor market survey, it is reasonable to find that he would be capable of earning $12.50 per hour in alternative employment, had he properly availed himself of the significant resources provided. Over the course of 40 hours, this would amount to a sum of $500.00. In comparison, the current wage for a Local 11 cement mason is $42.00 per hour. (PX 20) This calculates as $1,680.00 over the course of 40 hours. This results in a difference of $1,180.00 per week and a wage differential rate of $786.67.

J. Medical Services

At trial, Respondent stipulated to liability for unpaid medical bills. Petitioner submitted the following bills as unpaid bills. Respondent shall pay the following medical expenses pursuant to Sections 8 and 8.2 of the Act. To the extent any of the following bills have been paid prior to trial, Respondent shall receive credit for amounts paid.

ASSOCIATED RADIOLOGISTS OF JOLIET	6/24/2011	6/24/2011	$240.00	$240.00
EM STRATEGIES	6/24/2011	6/24/2011	$477.00	$477.00
RUSH UNIVERSITY MEDICAL CENTER	6/25/2011	2/21/2012	$2,073.75	$2,073.75
TOTALS			**$2,790.75**	**$2,790.75**

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRYAN FRIEMAN,

Petitioner,

vs.

NO: 11 WC 33020

17IWCC0446

STATE OF ILLINOIS/PINCKNEYVILLE CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner 5% loss of use of the left hand and 7.5% loss of use of the right hand under Section 8(e) of the Act. The Commission hereby modifies the Arbitrator's Decision to find the Petitioner to be permanently partially disabled to the extent of 10% loss of use of the left hand and 10% loss of use of the right hand.

The Arbitrator considered the factors in Section 8.1(b) of the Act to determine the nature and extent of Petitioner's condition, and the Commission relies upon same. The Commission, however, disagrees with the weight the Arbitrator placed on the evidence of Petitioner's disability, and believes that additional PPD is required.

17IWCC0446

The Arbitrator concluded that Petitioner's evidence of disability at arbitration, namely his continued complaints and limitations, were somewhat corroborated by the treating medical records and placed lesser weight on this factor in determining permanency. However, the record demonstrates that an updated EMG/NCV, dated March 7, 2016, indicated severe bilateral sensory motor median neuropathies across the carpal tunnels with axonal involvement. While the ulnar nerve studies were similar to a previous study, the median nerve studies had deteriorated. (PX4). Petitioner's treating physician, Dr. George Paletta, stated that given this study, he believed that even with surgical treatment, Petitioner would have some residual symptoms and incomplete recovery. (PX3).

Dr. Paletta's prognosis was consistent with Petitioner's complaints at arbitration following bilateral carpal tunnel releases in May 2016. While Petitioner did experience an improvement in his condition following surgery, including resolution of his pre-operative symptoms and complaints of numbness, he nonetheless continued to have tenderness at the surgical incision. (PX3). At the November 15, 2016 arbitration, Petitioner continued to experience shooting pain in his palms as well as weakness in his hands. He also experienced pain and stiffness in his fingers when he bent them. (T.15). Petitioner testified that he continues to hunt, but no longer works on cars because it hurts to turn wrenches, and "it's hard to pull on them to get enough strength to loosen them or tighten them." (T.17-18). Petitioner stated that he takes Ibuprofen a couple of times a week as needed for pain. (T.16).

As of November 15, 2016, Petitioner was at maximum medical improvement, had no further doctor's appointments or therapy for his hands, and was able to work with no restriction. (T.16; PX3).

Based on the totality of the evidence, the Commission modifies the Arbitrator's Decision to find Petitioner to be permanently partially disabled to the extent of 10% loss of use of the left hand and 10% loss of use of the right hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 11, 2017, is hereby modified as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $667.69 per week for a period of 38 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the left hand and 10% loss of use of the right hand.

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

17IWCC0446

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: JUL 14 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/pm
D: 7-11-17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRIEMAN, BRYAN
Employee/Petitioner

Case# **11WC033020**

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

17IWCC0446

On 1/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 11 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Bryan Frieman
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # 11 WC 33020

Consolidated cases: N/A

17IWCC0446

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **November 15, 2016**. By stipulation, the parties agree:

On the date of accident, **September 12, 2011**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$57,866.00**, and the average weekly wage was **$1,112.81**.

At the time of injury, Petitioner was **46** years of age, ***married,*** with **0** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$667.69**/week for a further period of **23.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **5% loss of use of the left hand and 7.5% loss of use of the right hand.**

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

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

Melinda M. Price-Gillivan
Signature of Arbitrator

1/3/17
Date

JAN 11 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Bryan Frieman
Employee/Petitioner

Case # 11 WC 33020

v.

Consolidated cases: N/A

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

17IWCC0446

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes that at the time his repetitive injuries manifested, Petitioner was a 46-year-old Correctional Officer for Respondent. He testified that he began working for Respondent at Menard Correctional Center and later transferred to Pinckneyville Correctional Center, where he realized he sustained work-related bilateral carpal tunnel syndrome as a result of his work as a Correctional Officer for Respondent at its facilities. By way of procedural history, the claim was disputed and heard on Petitioner's § 19(b) Petition on November 13, 2014 after which findings were rendered in favor of Petitioner. The 19(b) Arbitration Decision was thereafter appealed by Respondent. In its Decision and Opinion on Review, the Commission affirmed the Arbitrator's findings that Petitioner's work as a Correctional Officer at Menard Correctional Center and Pinckneyville Correctional Center led to the development of his work-related bilateral carpal tunnel syndrome, and the award of prospective medical care, including but not limited to the recommended surgical intervention. (PX7).

Petitioner testified that despite the improvement from surgery and post-operative therapy, he continues to have symptoms from his injuries. He testified that he has shooting pains in the palms of his hands when he puts his palms down on a surface. He testified that if he puts pressure on his palms, "it hurts pretty good." He also testified to a loss of strength in his hands and stiffness and aching in his fingers.

Petitioner testified that he now spends most of his time driving a transfer bus, vans and vehicles for Respondent. He testified that the wheel of the transfer bus vibrates. When asked what part of his job hurts his hands the most, he responded that opening the bus doors and cargo compartments "sends a zing to [his] hands." He also testified that he had to get down on his "elbows and knees" rather than his hands and knees to inspect the bus. He testified that he no longer works on vehicles because it is too difficult and painful to turn wrenches to loosen or tighten bolts. He testified that he takes Ibuprofen for his symptoms.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Dr. Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 21, 2015, at which time it was noted that he had been seen back in 2010 for complaints of bilateral wrist pain as well as numbness and tingling. It was noted that Petitioner returned with ongoing symptoms involving both hands, that he

still worked for the corrections department and that he currently drove a prison bus. It was noted that Petitioner stated that he still got numbness and tingling involving the first three fingers and part of the fourth finger, and that he also continued to have nocturnal symptoms. It was noted that things had gotten worse but at best stayed the same, that he had tried night splints with no improvement in nocturnal symptoms and that the previous EMG and nerve conduction studies demonstrated bilateral carpal tunnel syndrome. The impression was that of chronic symptomatic carpal tunnel syndrome. A new EMG and nerve conduction studies were recommended, and it was noted that if these demonstrated continued electrophysiologic abnormalities consistent with carpal tunnel syndrome then Dr. Paletta would recommend Petitioner undergo a carpal tunnel release. Petitioner was issued a work slip, allowing him to return to work full duty effective December 21, 2015. (PX3).

The records of Dr. Paletta reflect that an EMG/Nerve Conduction Study review was performed on March 7, 2016, at which time it was noted that the studies were completed by Dr. Phillips on March 7, 2016. It was noted that the impression was that of (1) severe bilateral carpal tunnel syndrome with interval deterioration since the last EMG and nerve conduction study; (2) underlying diabetes. It was noted that Dr. Paletta opined that given the severity of involvement at the carpal tunnels, the progression of his carpal tunnel involvement since the last EMG and his underlying diabetes, the potential was high that even with surgical treatment Petitioner would likely have some residual symptoms and incomplete recovery. (PX3).

The records of Dr. Paletta reflect that Petitioner was seen on May 23, 3016 for an initial post-operative visit status post carpal tunnel release left wrist. It was noted that overall Petitioner was doing well and that his pain had been under control. It was noted that Petitioner was not currently taking any pain medication. It was noted that Petitioner was to initiate physical therapy. It was noted that Petitioner wanted to go ahead and do the right side, and it was recommended that they go ahead with the right side next week after he had completed one week of therapy so they could make sure he had a good usable hand. A work slip was issued on that date, allowing Petitioner to return to work with restrictions. At the time of the June 20, 2016 visit, it was noted that Petitioner returned for follow-up of both hands and that he was status post bilateral carpal tunnel releases. It was noted that overall Petitioner was doing well and that he denied any numbness and tingling in the median nerve distribution of the right hand. It was noted that with respect to the left wrist, Petitioner could continue with self-directed exercises at that point. It was noted that Petitioner would start physical therapy on the right side. A work slip was issued on that date, allowing Petitioner to return to work with restrictions. (PX3).

The records of Dr. Paletta reflect that Petitioner was seen on August 15, 2016 for continued follow-up of both his left and right carpal tunnel releases. It was noted that overall Petitioner was doing quite well and that his pre-operative symptoms had resolved. It was noted that Petitioner still noted a little bit of tenderness at the surgical incisions if he pushed up on a hard surface such as a chair rail, but overall he was pleased with how it was doing. It was noted that Petitioner had had an excellent outcome, and that he could continue full duty without restriction or limitation. It was noted that Petitioner required no additional treatment, follow-up or therapy and that he was at maximum medical improvement. It was noted that Dr. Paletta reassured him that the tenderness at the surgical incision sites typically disappeared within 3-6 months after surgery. A work slip was issued on that date, allowing Petitioner to return to work full duty. (PX3).

The medical records of Dr. Phillips were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on March 7, 2016 for bilateral upper extremity EMG and nerve conduction studies. The impression was that of severe bilateral sensory motor median neuropathies across the carpal tunnels with axonal involvement; the median nerve studies have deteriorated since last obtained; the ulnar nerve studies are similar. It was noted that many diabetic patients with this pattern would benefit from carpal tunnel decompressions. (PX4).

The medical records of Orthopedic Ambulatory Surgery Center of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent (1) left wrist exam under anesthesia; (2) left wrist carpal tunnel release on May 3, 2016 for pre- and post-operative diagnoses of (1) left wrist pain; (2) left carpal tunnel syndrome. The records further reflect that Petitioner underwent (1) right wrist exam under anesthesia; (2) right wrist carpal tunnel release on May 31, 2016 for pre- and post-operative diagnoses of (1) right wrist pain; (2) right carpal tunnel syndrome. (PX5).

The medical records of Pinckneyville Community Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent therapy for the right hand for the timeframe of July 26, 2016 through August 9, 2016. At the time of the August 8, 2016 visit, it was noted that Petitioner stated that he did not have any numbness or tingling but it felt like it was still very weak. The records further reflect that Petitioner underwent therapy for the left hand for the timeframe of June 1, 2016 through June 9, 2016. (PX6).

The IWCC Decision and Opinion on Review dated October 22, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Decision and Opinion on Review found various exhibits and testimony to be inadmissible hearsay, but despite having found specific testimony inadmissible and striking same from record, affirmed the Arbitrator's decision, which found that Petitioner met his burden of proof in establishing that he sustained accidental bilateral repetitive trauma compression neuropathies that arose out of and in the course of his employment with Respondent, which were causally related to his current condition of ill-being. (PX7).

The TriStar Bilateral EMG/NCS Authorization was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The TriStar Bilateral Carpal Tunnel Release Authorization was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The TriStar Hand Therapy Authorization was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

CONCLUSIONS OF LAW

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

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she continues to be employed by Respondent as a Correctional Office and was placed under no permanent restrictions from Dr. Paletta. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 46 years old on his date of accident. Given the younger age of Petitioner and the fact that his treating physician, Dr. Paletta, has placed him under no restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that despite the improvement from surgery and post-operative therapy, he continues to have symptoms from his injuries. Petitioner testified that he has shooting pains in the palms of his hands when he puts his palms down on a surface. Petitioner testified to a loss of strength in his hands and stiffness and aching in his fingers, and that he no longer works on vehicles because it is too difficult and painful to turn wrenches to loosen or tighten bolts. At the time of the August 15, 2016 visit with Dr. Paletta, it was noted that overall Petitioner was doing quite well and that his pre-operative symptoms had resolved. It was noted that Petitioner still noted a little bit of tenderness at the surgical incisions if he pushed up on a hard surface such as a chair rail, but overall he was pleased with how it was doing. It was noted that Petitioner had had an excellent outcome, and that he could continue full duty without restriction or limitation. It was noted that Petitioner required no additional treatment, follow-up or therapy and that he was at maximum medical improvement. It was further noted that Dr. Paletta reassured him that the tenderness at the surgical incision sites typically disappeared within 3-6 months after surgery. (PX3). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records at the conclusion of his treatment with Dr. Paletta. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **5% loss of use of the left hand and 7.5% loss of use of the right hand** as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAWRENCE WILLIAMS,

Petitioner,

vs.

NO: 11 WC 34038
11 WC 37451

ILLINOIS CEMENT COMPANY, LLC.,

17IWCC0461

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of LaSalle County. Per the remand order dated October 4, 2016, Judge Joseph Hettel reversed the Commission's March 9, 2015 Decision. Judge Hettel found the Commission's Decision finding that Petitioner, Lawrence Williams, failed to prove an accident on May 9, 2011 and that he failed to prove that a causal connection existed between the accident and his cervical condition was against the manifest weight of the evidence. The matter was remanded to the Commission for further findings of fact on the issues of temporary total disability (TTD), maintenance, the reasonableness and necessity of the medical expenses, the nature and extent of the disability, whether Petitioner established that he was entitled to an odd lot permanent and total disability award, and whether penalties and attorney's fees are appropriate.

Procedurally, Williams filed two Applications for Adjustment of Claim. The first, case number 11 WC 37451, alleged a date of accident on July 29, 2010. The second, case number 11 WC 34038, alleged a date of accident on May 9, 2011. The matters were consolidated for trial before Arbitrator Granada on May 28, 2014. The Arbitrator found that Petitioner's condition was, in part, causally related to the June 29, 2010 accident. He further found that Petitioner failed

to prove an accident arising out of and in the course of his employment on May 9, 2011 and that his cervical condition was not casually related to the alleged May 9, 2011 incident. The Arbitrator denied Petitioner's claim for TTD and maintenance relative to the May 9, 2011 claim. The Arbitrator awarded medical expenses relative to the left elbow epicondylitis stemming from the July 29, 2010 accident only and denied medical expenses related to the cervical condition. Petitioner was awarded 10% loss of use of the left arm as a result of the July 29, 2010 accident.

Both parties filed a Petition for Review to the Commission. The Commission affirmed and adopted the Decision of the Arbitrator on March 9, 2015.

The Petitioner appealed to the Circuit Court. A hearing was held before Judge Hettel on August 25, 2016, and a record of same was made. During the hearing, the Judge noted there was no question in his mind that there was an accident on May 9, 2011. Judge Hettel noted that while there was some discrepancy as to when the accident actually happened, he was convinced that it did happen. The Judge noted that Williams reported the accident on June 20, 2011 and his version of the accident was consistent with his witness' testimony. The Judge took issue with Respondent's expert noting that Dr. Kern Singh originally found causal connection on November 1, 2011 and only after prompting by Respondent found no causal connection.

The Court noted that the May 9, 2011 injury caused Petitioner's particular complaints. The Judge noted that Dr. Kube related Williams' condition to the alleged May 9, 2011 accident. Dr. Singh, Respondent's expert, initially made similar findings. It was Judge Hettel's opinion that there was enough evidence for Petitioner to overcome the manifest weight of the evidence standard. Therefore, the matter was remanded to the Commission to address all issues, and comment on the so called independent witness.

The Circuit Court initially issued a Remand Order from the bench, by a scant minute Order. The Order was to be supplemented by the transcript of the Court's comments from the bench. That Remand Order was entered August 25, 2016.

Thereafter, Judge Hettel held a telephone conference with the parties on September 22, 2016 resulting in a second Order dated October 4, 2016. The Judge noted that he retained jurisdiction, and amended, amplified and clarified his August 25, 2016 Order. Specifically, Judge Hettel, by his new written Order, dated October 4, 2016, reversed and remanded the matter back to the Commission noting that the Commission's finding that Petitioner failed to prove an accident and causal connection between his cervical condition and the May 9, 2011 accident was against the manifest weight of the evidence.

Though the Commission is of the belief that Petitioner failed to prove that an accident occurred on May 9, 2011 or that Petitioner sustained an injury to his cervical spine on any alleged date, it now must set aside its prior findings and conclusions. Based upon the directive from the Circuit Court, the Commission is required to find that Williams sustained an accident

arising out of and in the course of his employment on May 9, 2011 and that his cervical condition is causally related to said accident.

The Commission finds that Petitioner reached maximum medical improvement (MMI) as of January 8, 2013 and failed to prove that he is permanently and totally disabled. The Commission awards TTD benefits through January 8, 2013. The Commission finds that Williams sustained 20% loss of use of the man-as-a-whole. The Commission denies Petitioner's request for penalties and attorney's fees. In support thereof, the Commission, for reasons stated below, finds the Petitioner not credible and finds the opinion of Dr. Singh persuasive.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Lawrence Williams testified that he has a high school education and has 23 years of experience in quality control. He began working as a quarry truck driver for the Illinois Cement Company on November 26, 2001. He would drive between the plant and quarry. T.1427. He stated that there are a lot of ruts in the quarry, which would cause his truck to vibrate. *Id.* According to the job task sheet for a quarry driver, drivers were responsible for checking the vehicle's condition. It also noted that the quarry floor could be rough due to weather related conditions. PX.5.

2. On July 29, 2010, Williams tripped and fell landing on his outstretched left arm. T.1428.

3. Williams underwent a Section 12 examination with Dr. Eric Ortinau on January 14, 2011. Dr. Ortinau noted that Williams' left elbow complaints were related to his July 2010 accident. In the narrative from the insurance company to the doctor, they noted Williams was a ranch hand at the Cedar Creek Ranch and they did not think that Williams would delve into that information. The insurance company noted that Williams was listed as a ranch hand on the Ranch's website. PX.10.

4. Williams underwent an MRI of the left elbow on January 24, 2011 at Illinois Valley Community Hospital that revealed lateral epicondylitis. PX.14.

5. Petitioner underwent a Section 12 examination with Dr. John Fernandez of Midwest Orthopaedics Hand and Shoulder Center on February 15, 2011. It was noted that Williams worked as a part-time ranch hand for Cedar Creek Ranch. Dr. Fernandez diagnosed Petitioner with left elbow lateral epicondylitis. He noted there were no problems with Williams' arm prior to the July 21, 2010 incident and, as such, this incident was either completely related to or it aggravated the lateral epicondylitis. Williams could work but should restrict significant repetitive activities and use under

17IWCC0461

20 pounds of force. His condition was not permanent and would go away. Dr. Fernandez recommended two cortisone injections. PX.22.

6. According to the City Center Physical Therapy report dated March 17, 2011, Williams reported some intermittent tingling in his left forearm and hand which had been present for 4 to 5 days. It extended from his elbow down to his hand and his forearm felt heavy. PX.21.

7. Williams was treated by Dr. Robert Mitchell of Illinois Valley Orthopedics on March 24, 2011 for his left elbow pain. He had made excellent progress with occupational therapy. There was no complaint of neck or spine pain. He did, however, complain of occasional numbness and tingling in his whole hand. The heaviness of his upper extremity had decreased. No issues were detected with his musculoskeletal and neurological review of systems. The physical examination revealed that Williams was neurovascularly intact to his left upper extremity. He had full active and passive range of motion of his shoulder. He had no tenderness over the lateral epicondyle. He could return to regular work. The assessment was resolving left lateral epicondylitis. It was explained to Williams that it was possible for his condition to return and he would require another injection. He was to continue with anti-inflammatories. PX.23.

8. Williams alleged that on May 9, 2011, he was shoveling material onto a conveyor when his elbow began to swell and he had pain up into his neck and down into his fingers. He stated the incident aggravated everything. T.1433. He continued to work. Williams stated that he contacted Dr. Mitchell, but could not get an appointment until July 19, 2011, or until 70 days later.

9. Mr. John Olson testified that he worked with Williams on May 9, 2011. He stated that Williams was shoveling heavy, wet clinker material from the lower pit onto a conveyor belt at shoulder height when he experienced a shocking pain to his left arm. PX.45. pg.929. He could see Williams was in pain. *Id.* Mr. Olsen testified that Williams slipped and fell on snow at work a few weeks prior to the May incident, but did not make any physical complaints. PX.45. pg.933.

10. Williams testified that he was off work for vacation from May 31, 2011 to June 12, 2011. T.1434.

11. Williams presented to Dr. Mitchell on June 28, 2011 for recheck of his left elbow pain. It was noted that Williams had returned to regular duty. It was further noted that on May 11, 2011, Williams was shoveling and when he lifted the shovel, which was rather heavy, up high to his head, he felt a burning sensation to his lateral epicondyle. He had pain with soreness and swelling. He tried taking Lodine for 2 weeks without relief. Review of his systems revealed no aching muscles or joints, no back pain,

swollen joints, headaches, dizziness, or numbness. The examination revealed full active and passive range of motion of his shoulder. He had tenderness over the lateral epicondyle with palpation with a small amount of swelling. He had pain with resistance to wrist extension and supination over the lateral epicondyle. He had a negative Phalen's sign, a positive median nerve compression test, and positive Tinel's in the median nerve distribution. There was no numbness in the ulnar nerve distribution. The assessment was left elbow lateral epicondylitis. He was given work restrictions and an injection into the left elbow. PX.23.

12. On July 19, 2011, Williams reported some improvement in his left elbow since his injection. However, he had continued numbness and tingling to his left upper extremity. He was able to drive but noticed numbness after a while, even with sitting. His pain was 7 to 8 out of 10. He would experience a sharp burning pain continuing to his left elbow with numbness that would shoot down to his finger when he lifted his arm. There were no issues detected with his neurological and musculoskeletal review of systems. Examination revealed that he was neurovascularly intact to his left upper extremity. He had minimal tenderness over the lateral and medial epicondyle. He had a positive Tinel's at the medial epicondyle and at the median nerve distribution of the carpal tunnel. He had a negative Phalen's. He had full supination and pronation, and no pain with flexion and extension. An EMG was recommended. The assessment was left elbow lateral epicondylitis. PX.23.

13. Williams underwent an EMG with Dr. Thomas Szyrnke on August 4, 2011. The EMG revealed double crush of the left upper extremity, mild left carpal tunnel syndrome, and left C7 radiculopathy. There was some slowing of the ulnar nerve through the left cubital tunnel. PX.23.

14. On August 11, 2011, Dr. Mitchell reviewed the August 4, 2011 EMG and recommended an MRI of the left upper extremity. He also referred Williams to Dr. Richard Kube. Petitioner complained of paresthesias in the left upper extremity and radiating pain from his shoulder and neck. Examination revealed a positive Tinel's, Phalen's, and median nerve compression testing on the left. He had a negative Tinel's at the elbow and a questionable Spurlings maneuver. A referral to a spine surgeon was recommended. PX.23

15. Williams underwent an MRI of the cervical spine on August 25, 2011 at Illinois Valley Community Hospital. The MRI revealed a central disc bulge at C3-C4 that caused central canal and mild neural foraminal narrowing. At C5-C6, there was a central disc bulge and endplate osteophyte formation that contacted and deformed the cord. At C6-C7, there was an asymmetric disc bulge to the left that caused some central canal and left neural foraminal narrowing. PX.14.

16. Williams was seen by Dr. Richard Kube on August 30, 2011. Per the "new patient: cervical spine" form, Williams indicated that his chief complaint was neck pain and arm pain with numbness. He also indicated back pain. He indicated that his problem had been present for 13 months and was recently worsened over the last 3 to 4 months. The initiating factor was a fall on his extended left arm. Dr. Kube noted that Williams originally had an event where he fell on his outstretched hand resulting in hand numbness and tingling. His symptoms improved a little bit with respect to the elbow pain after the injection. The hand numbness and tingling continued.

17. Dr. Kube noted Williams then had a secondary event 6 months ago when he was shoveling loads from the ground to over his head. He experienced a shock and burn sensation down the left arm. His elbow pain returned and the numbness and tingling increased. He had some pain shooting up from the hand to the elbow at that time. Per the record, "this has gone on since despite some non-operative intervention, but predominately not a lot of it happening since that secondary moment." Examination of the neck revealed decreased extension. Dr. Kube diagnosed Petitioner with cervicalgia, degenerative disc disease, spinal stenosis and brachial neuritis.

18. Dr. Kube provided Petitioner with restrictions consisting of sedentary work activities, lifting up to 10 pounds only, no overhead work or floor to waist lifting, rare bending and twisting, no prolonged sitting or standing position, and no vibration. Dr. Kube noted that the imaging studies of the cervical spine revealed some loss of disc height at C5-C6 with some cervical spondylolysis and mild foraminal stenosis to moderate foraminal stenosis. Dr. Kube noted that the MRI revealed significant stenosis at C5-C6 and C3-C4. An annular tear at C5-C6 and the anterior/posterior canal diameter was only 8mm which was frank canal stenosis as the spinal cord should occupy 10 mm. PX.26.

19. Williams underwent a Section 12 examination with Dr. Kern Singh on December 1, 2011. Williams complained of neck pain that was a 2 to 9 out of 10. His pain travelled to his left upper extremity and into his index finger and thumb. He had not worked since August 22, 2011. His pain was increased with sitting and standing, and decreased with laying down. He was able to sit, stand and walk indefinitely. Examination revealed a positive Spurling's maneuver on the left. Dr. Singh reviewed the August 25, 2011 MRI and noted that it revealed a degenerative disc osteophyte complex at C5-C6, and left greater than right foraminal narrowing at C5-C6 and C6-C7. The EMG revealed left sided C7 radiculopathy, mild left carpal tunnel and a suggestion of double crush syndrome.

20. Dr. Singh diagnosed Williams with degenerative disc disease at C5-C6 and C6-C7. Dr. Singh opined Williams sustained an aggravation of an underlying degenerative cervical condition resulting in upper extremity radiculopathy. Dr. Singh provided

Williams with light duty work restrictions. It was Dr. Singh's opinion that Williams' symptoms were emanating from his cervical spine at C5-C6 and C6-C7. He did not believe Williams was suffering from median nerve compression. Williams' symptoms could be explained by his C5-C6 and C6-C7 nerve root irritation. Dr. Singh noted that the C5-C6 nerve root also formed the median nerve in the distal extremity, which would explain Williams' carpal tunnel syndrome. An anterior cervical discectomy and fusion at C5-C6 and C6-C7 was recommended and was related to his work injury. RX.1.

21. Dr. Singh authored an addendum on December 19, 2011 following his review of the records from Dr. Ortinau, Dr. Mitchell and Dr. Fernandez, and his re-review of the August 25, 2011 MRI. Based on his review of those medical records, Dr. Singh found no evidence to suggest Williams' symptoms occurred prior to July 19, 2011. Given the delay in the symptoms, his condition was related to his degenerative condition and not aggravated by his work injury. Dr. Singh noted that the MRI revealed degenerative changes. Given the long gaps in treatment, it appeared there was no causal connection between Williams' current symptoms and his need for surgical intervention relative to his cervical spine and his July 29, 2010 and May 11, 2011 accident. RX.1

22. Dr. Mark Lorenz performed a C5-C6 anterior cervical fusion on March 20, 2012. There was a central disk herniation significantly compressing the thecal sac that was removed.

23. According to the Medical Examination report for Commercial Driver Fitness Determination dated August 8, 2012, Williams did not meet the standards for his license. Williams reported that he had lifting restrictions of 25 pounds maximum, no overhead lifting, a 6 hour work day, he could drive a truck, but no shoveling or jack hammer work.

24. Williams underwent an FCE on August 24, 2012 that was performed by Lucas Schultz at ATI Physical Therapy. Williams was capable of working in the medium demand level and could lift 63 pounds occasionally from the floor to the chair and 43 pounds above shoulders bilaterally. Williams met the level for his job duties as a truck driver. PX.31.

25. Williams testified that he advised the CDL office that he had a 25 pound lifting restriction. T.1490. After learning of the FCE restrictions, however, he never went back to the CDL office to get his CDL approved so that he could return to work as a truck driver. T.1493.

26. Williams underwent a Commercial Driver Fitness Determination on September 12, 2012. It was noted that Williams was released per the FCE. Williams met the standards, but required periodic monitoring. He was qualified for 1 year only.

27. On November 12, 2012, Williams presented to Illinois Valley Community Hospital complaining of neck pain with exacerbation as the result of quarry driving. He began driving around November 6, 2012 or November 7, 2012. His pain radiated to his left arm. Williams was provided with added restrictions of no quarry driving plus the permanent restrictions per the FCE. PX.14.

28. On November 27, 2012, Dr. Lorenz stated Williams could return to modified work on November 27, 2012 with no lifting greater than 30 pounds occasionally, no vibrational exposure, and no shoveling. PX.14.

29. Dr. Singh authored another addendum on "January 8, 2012" indicating Williams met his job demand per the FCE and could return to work without restriction. He was unsure as to the treating physician's arbitrary restrictions as they did not correlate with the FCE that revealed a full and valid effort was given. RX.2. The Commission notes that the date of January 8, 2012 is an obvious error as all the records referred to by Dr. Singh in his report are dated after January 8, 2012. The date of the report should be January 8, 2013.

30. On April 25, 2013, Dr. Mitchell authored a letter to "Whom It May Concern." He noted Williams was diagnosed with double crush syndrome, mild carpal tunnel, and left C7 radiculopathy. His C7 radiculopathy was related to this May 11, 2011 accident. PX.23.

31. Vocational expert, Mr. Bob Hammond prepared a vocational report on June 20, 2013 at the request of Petitioner's attorney. He opined that Williams could work at the minimum wage level, but he would likely not be hired. PX.32.

32. Vocational expert, Ms. Natalie Maurin conducted a vocational rehabilitation review and labor market survey on December 30, 2013 at the request of the Respondent. Based on Dr. Singh's restrictions, Williams was employable at an entry level wage of $12.58 per hour and $17.35 per hour if he targeted so-called no touch positions. He could earn more with advancement. RX.10.

33. Williams submitted his job log showing that he applied for numerous jobs, the vast majority of which were not hiring. See PX.37. He testified that he applied for work at approximately 200 places of employment, and has not received a job offer. Williams testified that he is ready, willing and available for work. T.1442.

34. Williams testified that he experiences some tingling and pain in his arm that will shoot to his neck and down his arm. T.1446. He cannot do all the things he used to be able to do. *Id.* He stated that driving in the quarry causes him pain. T.1505. He avoids activities that cause vibration or bouncing. T.1505.

35. On cross-examination, Williams stated that he did not have any neck complaints following the first injury. T.1449. He stated that the shoveling incident made his neck worse. T.1452. He was previously diagnosed with chronic back pain on September 5, 2006, nearly four years prior to the alleged accidents.

36. Williams testified that his son owns the Cedar Creek Ranch, which has a Kawasaki ATV. He does not now ride on the ATV for more than 10 minutes at one time. It does not cause vibration to the extent of the quarry truck and does not cause an increase in his pain complaints. T.1507. While on an ATV, he travels gradually over ditches. *Id.* It is not the same jostling he experiences while driving in the quarry truck. It is gentle. T.1508. He has ridden on the ATV 10 times in 2014. He usually gets a ride on the ATV across the creek so he can walk for exercise. T.1513.

37. Williams also testified that he renewed the license for his 16 foot silver craft boat in April 2012. He stated that riding in a boat does not bother his neck. T.1510. The vibration and movement is not as serious as what he experiences while driving the quarry truck. *Id.* He does not go across waves and fishes in a gate locked lake community only. T.1511. He is, however, able to drop off and load the boat at the dock. *Id.*

38. Williams testified that he assists his son at the Cedar Creek Ranch. He painted a 120 foot by 10 foot section of decking, which took 10 hours over several days. T.1515.

39. Mr. Rick Struglinski was deposed on May 7, 2014 and is employed by Illinois Cement. RX.12. He saw Williams on a ladder painting a wood beam at the Gunsmoke Bar. RX.12. pg.1407.

40. On cross-examination, he stated that Williams was lifting a paintbrush only. RX.12. pg.1408. He did not observe Williams driving a vibrating vehicle. *Id.* He was not aware of Williams' medical restrictions. RX.12. pg.1409.

41. Dr. Mitchell is board certified in orthopedic surgery and was deposed January 29, 2014. PX.24. Dr. Mitchell thought Williams had some underlying radiculopathy in the cervical spine, which was work-related. PX.24. pg.421. He opined Williams had work-related injuries consisting of lateral epicondylitis, mild carpal tunnel syndrome, cubital tunnel syndrome, and double crush syndrome. PX.24. pg.432.

42. Dr. Mitchell opined that the May 11, 2011 injury contributed to the progression of Williams' already underlying problems for which he had sought treatment. PX.24. pg.437. He stated that the cubital and carpal tunnel, and lateral epicondylitis were caused by the first accident. He would defer to Dr. Kube regarding the cervical issues. PX.24. pg.438. However, the cervical condition could have been aggravated by the second accident.

43. On cross-examination, Dr. Mitchell stated that his treatment prior to May 9, 2011 did not reveal any cervical spine issues serious enough to warrant treatment. PX.24. pg.449. He did not see any definitive signs of cervical radiculopathy during his first visit following the May 9, 2011 incident. As of April 11, 2013, he was of the opinion Williams could work full-duty. PX.24. pg.450. Dr. Mitchell stated that the mild cubital and carpal tunnel would resolve with anti-inflammatory medication. Williams did not sustain any permanent impairment or permanent loss of function as a result of the cubital tunnel, carpal tunnel, or epicondylitis. PX.24. pg.453. But for the Order of the Circuit Court, the Commission would have considered Williams at MMI as of the date of Dr. Mitchell's comments.

44. Dr. Kube is board certified in spine surgery, orthopedic surgery and independent medical examinations, and was deposed March 9, 2012. PX.27.pg.560. He diagnosed Williams with neck pain along with degenerative disc disease, spinal stenosis, and radiculopathy. There was some indication of double crush syndrome and carpal tunnel.

45. Dr. Kube stated that the May 2011 event aggravated his underlying cervical stenosis and led to radicular pain that Williams continues to experience. The radiculopathy was diagnosed on the EMG. PX.27. pg.571. This event caused the need for the surgery. PX.27. pg.572.

46. On cross-examination, Dr. Kube stated that if there was an absence of complaints after the May 11, 2011 accident for a significant period of time, it would cause him to question that portion of his opinion. PX.27. pg.580. Dr. Kube formed his opinion based on the history Williams provided to him. PX.27. pg. 581. Dr. Kube testified that he did not review any records from Rezin Orthopedic Group from December 2010 through his visit in August 2011. PX.27. pg.576. He had no records of contemporaneous complaints from March 1, 2011 through May 10, 2011. PX.27. pg.577.

47. Dr. Lorenz is board certified in orthopedics and was deposed September 24, 2012. PX.30. He performed a surgery upon Williams on March 20, 2012. Williams had a C5-C6 disk herniation with myelomalacia. The surgery revealed a disk herniation that was primarily central at C5-C6 with some fairly significant indentation of the cord.

There was also some stenosis in the foramen on that side, in part spur, and in part disk. PX.30. pg.682. Postoperatively, the shoulder pain was gone as was the numbness and pain going down the left arm. *Id.* Williams had some mild neck aches more toward the right, which were not present prior to surgery. Dr. Lorenz returned Williams back to light duty work on July 9, 2012 and limited his exposure to vibration in addition to the FCE restrictions. The restrictions were permanent.

48. Dr. Lorenz opined there was a causal connection between the accident, his condition, and the need for surgery. His epicondylitis was primarily due to a diskogenic issue in the cervical spine and the fall was a competent cause for the disk herniation. PX.30. pg.689. He stated that the May 2011 event was causally related to his cervical condition. *Id.* The disk herniation was directly related to the fall and the underlying degenerative disk disease was aggravated by the fall. PX.30. pg.691.

49. On cross-examination, Dr. Lorenz stated that he was unaware of the May 2011 shoveling incident. T.693. He noted the FCE indicated Williams could perform truck driving duties. Dr. Lorenz stated that he never saw a job description for Williams' job duties. T.700.

50. Dr. Singh is board certified and was deposed May 31, 2012. He diagnosed Williams with degenerative disc disease at C5-C6 and C6-C7. He opined that Williams sustained an aggravation of his underlying degenerative cervical condition that resulted in upper extremity radiculopathy. RX.1. pg.960. He recommended an anterior cervical discectomy and fusion at C5-C6 and C6-C7.

51. Dr. Singh authored a report on December 19, 2011 after reviewing additional medical records. Those records affected his opinion in that there was a gap between Williams' complaint of neck and upper arm pain. His original opinion changed as Williams' complaints did not begin until July 2011. RX.1. pg.962.

52. In regards to the first accident on July 29, 2010, Williams did not have complaints consistent with radiculopathy, and was diagnosed with lateral epicondylitis. RX.1. pg.963. Regarding the May 2011 accident, in light of Williams' delay in seeking treatment for his arm symptoms and his radicular complaints, Dr. Singh found no causal connection. Williams' complaints were related to his underlying degenerative discogenic condition. RX.1. pg.964. His condition was not aggravated by his work accident. Dr. Singh stated that he would have expected complaints to begin within 2 to 6 weeks after the event. The first neck symptoms were not reported to Dr. Mitchell until June 28, 2011, or approximately one year later. RX.1. pg.965.

53. On cross-examination, Dr. Singh noted that left arm pain can be a symptom of left radiculopathy. If Williams had numbness, tingling, or pain in his left arm and neck

pain following the alleged second accident, those findings would be consistent with an accident, depending on the timing of the symptoms. RX.1. pg.970. If, however, Williams had left trapezius pain and paresthesia in the left hand shortly after the work accident, that likewise could affect Singh's opinion. RX.1. pg.973.

54. Mr. Hammond was deposed November 1, 2013. He contacted some of the places where Williams stated he applied for work, and they confirmed that Williams did apply for a position. PX.33. pg.764. However, they could not accommodate his restrictions. Hammond opined Williams could not go back to work as a truck driver due to the vibration. He was a semi-skilled worker that could read and maintain logs. PX.33. pg.767. He had no computer experience and was 70 years old. The vocational guidelines state that training and education is not something to be utilized with somebody over 60 years of age. Williams did not have any transferrable skills based on his age, education and experience. PX.33. pg.773. While Williams could work, he would not find a job. Williams would earn between $8.35 and $9.00 per hour. PX.33. pg.776. Williams sustained a significant loss of earnings. PX.33. pg.778.

55. Ms. Natalie Maurin is a certified rehabilitation counselor and was deposed February 7, 2014. She completed a labor market survey and noted Williams had a strong work history. She focused on the restrictions placed by Dr. Singh per the FCE. RX.10. pg.1319. Williams' restrictions met the job requirements at Illinois Cement. Williams would have been able to return to his prior position. RX.10. pg.1320. Maurin opined Williams was employable in the truck driving industry. RX.10. pg.1322. Based on the labor market survey, Williams was capable of earning $12.85 per hour and $17.35 for no touch driving. He could command a wage in excess of those minimum wages based on his experience. His age would present an obstacle to his hire. RX.10. pg.1335. However, Williams would have an advantage over a younger applicant with less experience. RX.10. pg.1336.

56. On cross-examination, Maurin stated that she was not provided with a job description. She did not know what the road conditions were in the quarry. She was not provided with a copy of Dr. Lorenz' work restrictions imposed on Williams. RX.10. pg.1345. Exposure to vibrations would be relevant in her consideration as to whether a person has the ability to be a truck driver. *Id.* She was not given any information that Illinois Valley Community Occupational Clinic would not certify his DOT certificate to continue his CDL license. RX.10. pg.1359.

Based upon the totality of the record, the Commission finds petitioner lacks credibility. The Commission further finds the opinion of Dr. Singh persuasive and finds that Williams reached MMI as of January 8, 2013. Williams further failed to prove that he is permanently and totally disabled. The Commission awards Williams 25% loss of use of the man-as-a-whole.

In resolving disputed issues of fact, including issues related to causation, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

The Commission finds that Petitioner is not credible. His actions run counter to his alleged disability such that the Commission has serious doubts as to the significance of his alleged disability and his is inability to find work.

Following the May 9, 2011 accident, Williams continued to work and then went on vacation from May 31, 2011 through June 12, 2011. While Williams' ability to continue to work has no impact on its credibility determination, the Commission is troubled by the fact that he went on a two week vacation. When he received treatment following his vacation, there was no mention of the May 9, 2011 accident or any complaints relative to his neck. Rather, his complaints were strikingly similar to his complaints made prior to May 9, 2011.

It was not until Williams saw Dr. Kube on August 30, 2011 that he finally mentioned the May 9, 2011 incident. That record, however, indicated that Williams had neck pain, among other issues, and numbness and tingling for 13 months. While he did report an increase 3 months prior, the record further indicated that while this has "gone on since despite some non-operative intervention, predominately not a lot of it has gone on since the secondary moment." By the record, the Commission notes that Williams' symptoms pre-dated the May 9, 2011 accident. The Commission is left to speculate as to whether the alleged May 9, 2011 accident caused a temporary aggravation to Williams pre-existing condition, or whether some other event after the alleged accident truly aggravated his condition.

Thereafter, Williams underwent a C5-C6 anterior cervical fusion on March 20, 2012. It was noted there was a central disc herniation significantly compressing the thecal sac, which was removed. Dr. Kube and Dr. Lorenz both opined that the surgery was causally related to the work accident. Based upon the directive from the Circuit Court resolving accident and causal connection in favor of Williams, the Commission finds that the fusion was causally related to the accident.

Subsequent to the fusion, the Commission is troubled by Williams' actions. On August 8, 2012, Williams underwent a Commercial Driver Fitness determination. He did not meet the standards for his license. Williams then underwent an FCE that was valid and revealed that he met the demands of his job as a truck driver. Williams then met the standards for his job duties per the Commercial Driver Fitness Determination. He returned to work for a few days in November 2012, but complained that driving aggravated his condition. Dr. Lorenz then provided restrictions of no lifting greater than 30 pounds, no vibration exposure and no shoveling. Dr. Singh then, on January 8, 2013, authored a report indicating that Williams could work without

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restrictions as he was unsure as to the arbitrary restrictions from the treating physician as they did not correlate with the FCE.

The Commission is troubled by the admissions of Williams, which the Commission finds undercut the severity of his subjective complaints. Williams admitted that he rides an ATV. Per his testimony, he only rides the ATV for 10 minutes and it does not cause vibration to the extent of the quarry truck nor does it increase his pain complaints. He also only goes over ditches gradually.

Williams also testified that he renewed his 16 foot silver craft boat license in April 2012. Per his testimony, riding in the boat does not bother his neck as he does not go over waves and he fishes in a gate lock lake. He is also able to drop off and load the boat at the dock.

Williams further testified that he painted a 120 foot by 10 foot section of decking at his son's ranch. Furthermore, information provided by the insurance company indicated that Williams was listed as a ranch hand on his son's website for Cedar Creek Ranch.

The Commission is not persuaded by Williams' testimony that he is only able to perform the above events as they are relatively mild and do not cause him pain. The Commission finds it inconceivable that Williams is able to ride an ATV, load and unload his boat to go fishing, and paint as those events do not aggravate his condition, but he is unable to work as his work activities cause him too much pain. The Commission finds the above activities inconsistent with his claimed level of disability.

Based upon the Commission's belief that Williams' is not credible and the Commission's doubt as to Petitioner's claimed level of disability, the Commission finds the opinions of Dr. Lorenz and Dr. Kube not persuasive. There is no indication in the medical records that Williams informed his doctors that he was able to ride an ATV without issue, or trailer and unload his boat to go fishing, or that he was capable of painting. As Dr. Kube and Dr. Lorenz did not have an accurate understanding of Williams' true level of disability, the Commission finds their opinions not persuasive.

During his deposition, Dr. Kube admitted that his opinion was based largely on Williams' subjective statements. Dr. Kube testified that, if there was an absence of complaints after the accident, it would make him question his opinion. Dr. Kube also did not review all of the medical records. Additionally, Dr. Lorenz admitted that he did not review the job description for Williams and was not aware of the shoveling incident.

Without a complete understanding of Williams' activity level outside of work and what his job duties entail, the Commission is left with little option but to afford little weight to those opinions. Accordingly, the Commission finds the opinion of Dr. Singh more persuasive. Dr. Singh's opinion on January 8, 2013 was that Williams could work full-duty per the FCE. The FCE represented a valid effort on the part of Williams.

The Commission affords no weight to Williams' subjective testimony regarding his alleged neck pain and resulting restrictions when he attempted to return to work in November 2012 following the FCE. The Commission notes that Williams' neck pain is not bothered whatsoever during his recreational activities; however, when tasked with work activities by an employer, he suddenly experiences pain that precludes him from work.

Accordingly, the Commission finds Williams reached MMI as of January 8, 2013, the date of Dr. Singh's report. The Commission awards medical expenses through January 8, 2013 only.

A claimant is temporarily totally disabled from the time an injury incapacitates her from work until such time as she is as far recovered or restored as the permanent character of her injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118, 561 N.E.2d 623, 149 Ill. Dec. 253 (1990). The dispositive test is whether the claimant's condition has stabilized, *i.e.*, whether she has reached MMI. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759, 800 N.E.2d 819, 279 Ill. Dec. 531 (2003). In determining whether a claimant has reached MMI, a court may consider factors such as a release to return to work, and medical testimony or evidence concerning the claimant's injury, the extent thereof, and, most importantly, whether the injury has stabilized. *Mechanical Devices*, 344 Ill. App. 3d at 760. Once an injured claimant has reached MMI, the disabling condition has become permanent and she is no longer eligible for TTD benefits. *Archer Daniels Midland Co.*, 138 Ill. 2d at 118. The time during which a claimant is temporarily totally disabled presents a question of fact to be determined by the Commission, and the Commission's decision will not be upset on review unless it is against the manifest weight of the evidence. *Archer Daniels Midland Co.*, 138 Ill. 2d at 119-20.

Based upon Dr. Singh's finding that Williams was capable of working full-duty as of January 8, 2013, the Commission finds Williams is entitled to TTD through January 8, 2013 only.

An employee need not be reduced to complete physical incapacity to be entitled to PTD benefits. *Ceco Corp. v. Industrial Comm'n*, 95 Ill. 2d 278, 286, 447 N.E.2d 842, 845, 69 Ill. Dec. 407 (1983). Instead, a PTD award is proper when the employee can make no contribution to industry sufficient to earn a wage. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342, 357, 310 Ill. Dec. 18 (2007). "The focus of the Commission's analysis must be upon the degree to which the claimant's medical disability impairs his employability." *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534, 668 N.E.2d 21, 24, 217 Ill. Dec. 836 (1996). A person is not entitled to PTD benefits if he is qualified for and capable of obtaining gainful employment without seriously endangering his health or life. *Interlake, Inc. v. Industrial Comm'n*, 86 Ill. 2d 168, 176, 427 N.E.2d 103, 107, 56 Ill. Dec. 23 (1981).

The Commission finds that Williams failed to prove that he is permanently and totally disabled. Based upon the opinion of Dr. Singh and relying upon the FCE, the Commission is of the opinion that Williams was capable of performing his work duties. The FCE revealed that Williams met the demands of his job duties as a quarry truck driver. Dr. Singh reviewed the valid

FCE and noted that Williams was capable of returning to work. The sole limitation to Williams' ability to work is his desire. The evidence establishes that Williams is in no way limited from enjoying his recreational activities of fishing and riding his ATV. His disability only impacts his ability to work. The Commission finds that his disability did not impair his employability as the FCE revealed he was capable of returning to work. Williams failed to prove that he is unable to work.

The odd-lot category for purposes of a PTD award arises when a "claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability." *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159, 1163, 50 Ill. Dec. 710 (1981). In these situations, the claimant can establish that he is entitled to PTD benefits under the "odd-lot" category by proving the unavailability of employment to persons in his circumstances. *Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill. App. 3d 191, 204, 904 N.E.2d 1122, 1133, 328 Ill. Dec. 612 (2009).

The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market." *Westin Hotel*, 372 Ill. App. 3d at 544, 865 N.E.2d at 357. If the claimant establishes that he fits into the odd-lot category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.*

The Commission finds that Williams failed to prove that he is permanently and totally disabled under the odd-lot theory. The Commission has reviewed the opinions from vocational expert Bob Hammond and Natalie Maurin. The Commission is not persuaded by the cursory review of the record and opinion of Mr. Hammond. Mr. Hammond finds Williams essentially unemployable based upon his age, education and skill level. The record reveals that Mr. Hammond provided no meaningful assistance to Williams other than providing the pre-determined opinion that Williams is unemployable.

The Commission does not believe that Williams put forth a diligent but unsuccessful job search. After reviewing the job search log, the Commission finds Williams' efforts not credible. The job search logs demonstrate that Williams applied for a number of jobs, knowing that the employers were not hiring. The logs also indicate that a number of employers could not accommodate the work restrictions imposed by Dr. Kube or Dr. Lorenz. The Commission finds the FCE restrictions and Dr. Singh's opinion relative to Petitioner's ability to work more persuasive than the restrictions from Dr. Lorenz and Dr. Kube.

17IWCC0461

Because of this, the Commission finds Williams failed to prove that because of his age, skills, training, and work history, he is not able to be regularly employed in a well-known branch of the labor market.

The Commission finds that Williams' sustained a 25% loss of use of the man-as-a-whole, pursuant to Section 8(d)(2) of the Act. As a result of the accident, Williams underwent a C5-C6 cervical fusion. As a result of the fusion, Williams underwent an FCE giving him permanent restrictions albeit restrictions that did not preclude him from his job duties as a quarry truck driver. Accordingly, the Commission finds Williams sustained a 25% loss of use of the man-as-a-whole.

The Commission declines to award penalties and attorneys' fees in this matter. The Respondent's defense of this matter was not unreasonable or vexatious as they had a good faith objection to liability based upon the opinions as stated by Dr. Singh and Williams' significant lack of credibility.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $735.05 per week for 80-3/7 weeks, commencing August 25, 2011 through January 8, 2013, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $661.54 per week for a period of 100 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 25% loss of use of the man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses relating to the cervical spine through January 8, 2013 under §8(a) of the Act, and subject to the medical fee schedule.

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

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

17IWCC0461

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: JUL 20 2017

MJB/tdm
D: 5-22-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Filbrun,

Petitioner,

vs.

NO. 11WC 36342

Sangamon County Sheriff,

17IWCC0423

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 25, 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.

17IWCC0423

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.

JUN 30 2017

DATED:
SJM/sj
6/8/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FILBURN, JANSON
Employee/Petitioner

Case# **11WC036342**

SANGAMON COUNTY SHERIFF
Employer/Respondent

17IWCC0423

On 7/25/2016, 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 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5757 MARTIN J HAXEL PC
2651 S FIFTH ST
SPRINGFIELD, IL 62703

0507 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821-7047

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JASON FILBRUN,
Employee/Petitioner

Case # 11 WC 036342

v.

Consolidated cases: N/A

SANGAMON COUNTY SHERIFF,
Employer/Respondent

17IWCC0423

An *Application for Adjustment 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 Springfield, on May 23, 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 Vocational Rehabilitation expenses

FINDINGS

On 4-25-11, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $47,035.12; the average weekly wage was $904.52.

On the date of accident, Petitioner was 33 years of age, single, with 1 child under 18.

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

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

Respondent shall be given a credit of $51,169.71 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $51,169.71.

ORDER

Petitioner failed to prove his current condition of ill-being is causally related to the work accident of April 25, 2011.

Respondent shall pay Petitioner temporary total disability benefits of **$603.01/week** for **41 1/7 weeks**, commencing **April 26, 2011** through **February 7, 2012** as provided in Section 8(a) of the Act. Respondent shall receive a credit for benefits paid in the amount of $51,169.71.

Respondent shall pay Petitioner permanent partial disability benefits of **$542.71/week** for **37.5 weeks** because the injuries sustained caused the **7.5% loss of the person as a whole** as provided Section 8(d)2 of the Act.

Respondent shall pay compensation that has accrued from **April 25, 2011** through **June 12, 2012** 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 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

July 19, 2016
Date

JUL 25 2016

Jason Filbrun v. Sangamon County Sheriff, 11 WC 36342

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner has been employed as a correctional officer for the Sangamon County Sheriff's Department since 2001.

Petitioner received chiropractic treatment with Dr. Dana Oliver, a chiropractor, on March 11 and 12, 2010. (PX 16)

Petitioner presented to Dr. Oliver on March 25, 2010 regarding neck, mid back, and headache complaints. Petitioner reported headaches off and on for years and midback pain for about a year. He described the pain as "deeply sore." He took two Darvocet the night before in order to sleep. He denied any recent trauma or injury. He had a mild auto accident in 2001 with chiropractic care thereafter. He underwent left ankle surgery in 2001 after stepping in a hole playing volleyball. He underwent left knee surgery in 2006. Petitioner displayed moderate hypertonicity with tenderness associated with the cervicothoracic musculature. He had distorted muscle tone and mobility of the ribs around T6-8. Upon questioning, Dr. Oliver noted, "he thinks he may have fractured and separated his ribs on the left about a year ago when he had a situation with a prisoner." Petitioner received care at that time. Petitioner had cervical range of motion but it was uncomfortable. Dr. Oliver's assessment was intersegmental joint dysfunction and he was provided treatment and exercises to perform at home. (PX 16)

Petitioner treated with Dr. Oliver on March 29, 2010 and received a body pillow. (PX 16)

Petitioner returned to Dr. Oliver on April 8, 2010. According to her note, "mornings [are] bad, afternoon ok, nighttime sucks." Petitioner's headaches were gone. (PX 16) Petitioner returned on April 12, 2010. Thoracic spine and left rib x-rays were taken on April 12, 2010. The impression was a fractured T9 vertebra with anterior wedging of the vertebral body. It was unclear whether the fracture was acute or subacute. (PX 16)

Dr. Oliver wrote a note to Dr. Florence on April 14, 2010 noting she had seen Petitioner for five visits and that after the third visit his neck pain and headache had resolved but he continued to experience midback pain with no improvement. Dr. Oliver referred him for diagnostic films and was sending the reports to Dr. Florence as she had advised Petitioner to follow up with her. (PX 16)

On May 5, 2010 Petitioner was examined by Dr. Joseph Williams with the chief complaint of a thoracic compression fracture. Petitioner had been referred by Dr. Florence. Petitioner gave a history of

being seen by his chiropractor as "he had pain in his back at times." He complained of a headache that had become fairly severe. He denied any recent injury. While being evaluated by the chiropractor, it was determined that he had a compression fracture at T9 and the chiropractic treatment was ended. Petitioner did recall a motor vehicle crash in the year 2000 when he was rear-ended but he had not sought any medical attention. He could not recall any other more specific injuries. Petitioner was noted to be working as a deputy for the Sheriff's Department. On physical examination, Petitioner had mild tenderness to the thoracic spine at T9. X-rays were taken and indicated a compression fracture at T9 with mild kyphosis. There was also some sclerosing of the endplates consistent with a chronic fracture. Dr. Williams' diagnosis was a T9 compression fracture and chronic neck axial pain. He ordered an MRI of Petitioner's cervical and thoracic spines as he was concerned about the fracture given Petitioner's age and lack of identifiable injury. (PX 3)

On May 13, 2010 Petitioner underwent a thoracic spine MRI as ordered by Dr. Williams. A Schmorl's node formation at T6-7 through T12-L1 was noted with anterior wedging of the T8, T 9, and T10. Given Petitioner's age, it was believed the finding might relate to sequellae of prior Scheuermann's Disease. Mild disc bulges at multiple levels with near ventral cord abutment at T8-9 was also noted. (PX 3; RX 3) Petitioner's cervical spine MRI revealed disc protrusions at C4-5 and C5-6. (PX 3)

Petitioner returned to Dr. Oliver for chiropractic treatment on July 8, 2010. According to the note, "Doesn't know anything yet – neck and low back. No new injury." (PX 16)

Petitioner returned to see Dr. Williams on July 21, 2010 with ongoing pain complaints in his thoracic region. Dr. Williams noted that Petitioner continued to complain of occasional pain consistent with intercostal radiculopathy. No acute findings were noted by the doctor and he recommended physical therapy. It appeared to the doctor that Petitioner had Scheuermann's Disease which was now symptomatic in regard to axial thoracic back pain. He was to return in six weeks. (PX 3)

Petitioner received chiropractic treatment with Dr. Oliver on July 22, 2010 (Scheuermann's is noted) and July 29, 2010 ("Back hurts.") (PX 16)

Petitioner followed up with Dr. Williams on August 24, 2010. He reported participating with chiropractic manipulations but denied any significant relief of his symptoms. Dr. Williams felt Petitioner had a questionable chronic compression fracture of T9. Petitioner was also describing some radiating pain on the left hand side. On physical examination Petitioner displayed mild tenderness to palpation of the thoracic spine. The doctor's assessment was chronic thoracic back pain with a compression fracture at T9

and Thoracic Degenerative Disc Disease. He recommended a physical therapy evaluation and a consultation with Dr. Smucker. Petitioner was to return in four weeks. (PX 3)

Petitioner returned to Dr. Oliver on September 27, 2010 who noted his "mid-back hurts a lot." He had been diagnosed with Scheuermann's. (PX 16)

On October 1, 2010 Petitioner was examined by Dr. Paul Smucker at the request of Dr. Williams due to complaints of persistent thoracolumbar pain. Petitioner gave a history of having experienced a blow to his back in March of 2010 followed by pain. He denied any prior history of similar complaints. Petitioner reported never having a day where he was fully comfortable. His pain was located midline with no radiation. An MRI showed findings consistent with Scheuermann's Disease. Petitioner was unaware of any family history of a similar problem nor had previous physical examinations with the sheriff's department or air force shown any type of spinal deformity. Petitioner reported some relief with pain pills but primarily the use of hot water. Petitioner acknowledged prior chiropractic therapy and traditional physical therapy without relief. On exam he had tenderness to palpation of the thoracic spine. Dr. Smucker reviewed Petitioner's thoracic MRI noted it revealed what appeared to be a significant compression of T9. There were no T2 changes suggestive of edema. Multi-level disc disease with thinning was evidence through most of the thoracic discs. There was some anterior angulation at T8-9 with a small disc protrusion that appeared to be abutting the ventral cord at T8-9. Dr. Smucker's impression was thoracolumbar pain and multi-level vertebral compressions which might be secondary to Scheuermann's Disease. Dr. Smucker recommended an updated MRI with "STIR images" as such images had not been included with the earlier MRI. Petitioner was to return thereafter. (RX 4)

The updated MRI was performed on October 6, 2010. It was read as showing moderate chronic wedge compression deformity ofT9 contributing to mild to moderate spinal canal stenosis. Mid to lower thoracic degenerative endplate irregularity with degenerative loss of disc height was also noted. The findings noted that there was chronic moderate wedge deformity of T9 which contributes to kyphosis and "Perhaps this represents an old fracture." There was no evidence of a recent fracture. (PX 1; PX 4; RX 5)

Petitioner did not follow up with Dr. Smucker as he had been advised to do. (PX 4)

Petitioner underwent chiropractic treatment on February 21, 23, and 28, 2011. She imposed a lifting restriction due to his low back pain and it was to remain in effect until he was re-evaluated. As of February 28, 2011, Dr. Oliver noted "Not bad at all." His work restrictions were lifted. (PX 16) As of March 3, 2011 Petitioner advised he would call Dr. Oliver. (PX 16)

On April 25, 2011, Petitioner was involved in an accident at work. Petitioner reported to the emergency room at St. John's Hospital that day. According to the emergency room records Petitioner had complaints of mid-back and right knee pain. He reported being shoved by an inmate into a steel door frame. Petitioner's mid back and right knee hit the door frame. A related history of a fracture at T8,9, and 10 was noted. X-rays taken on April 25, 2011 revealed old compression fractures at the T8, T9, and T10 levels of the thoracic spine. The x-rays did not reveal any evidence of a new compression. Some joint effusion in the suprapatellar bursa was noted on the knee x-ray. Petitioner was diagnosed with a contusion of the right knee and contusion of the thoracic spine. He was told to rest and use ice and heat to the areas of pain and to see his family doctor the next day for a recheck and release back to work. (PX 9; RX 6)

As instructed, Petitioner reported to his primary care physician, Dr. Nicole Florence, on April 26, 2011. Petitioner provided a consistent history of the work accident. Petitioner told her about his prior thoracic spine fracture and that it had healed on its own. Petitioner also complained of right knee pain associated with the altercation – primarily stiffness and decreased range of motion. Dr. Florence diagnosed Petitioner with a thoracic strain and took Petitioner off work for a week, believing he could return to work on May 3rd. (PX 2)

On May 5, 2011, Petitioner returned to Dr. Florence with complaints of knee pain and ongoing back pain. Dr. Florence referred Petitioner to Dr. Joseph Williams. He was switched to Ultam since the Tylenol with codeine wasn't helping. He was to remain off work until seen by Dr. Williams. (PX 2)

On May 11, 2011, Dr. Williams examined Petitioner. He noted significant paraspinal muscle spasms and noted "His complaints and physical findings are somewhat impressive." He diagnosed Petitioner with an acute thoracic strain as well as thoracic compression fractures and a possible new thoracic compression fracture. He ordered an MRI study which was performed May 16, 2011. (PX 3)

The MRI revealed the compression deformities which were thought to be chronic because there was no edema within the compressed vertebrae. Additionally, there was no spinal stenosis or thoracic disc herniations. (PX 3; RX 7)

Dr. Williams next prescribed medications and advised Petitioner to undergo a course of physical therapy. (PX 3)

Petitioner had his physical therapy evaluation on May 31, 2011 at Midwest Rehab. Petitioner reported increasing pain after being slammed into a door on April 25, 2011. Petitioner described problems standing, bending, and sleeping due to pain. He described feeling his best when hunched in a flexed position and often rotating to the right and leaning to the right to alleviate his symptoms. Petitioner also

reported a previous injury occurring approximately a year before that resolved with rest and medication. Petitioner expressed the desire to return to his normal job duties and have less pain although he was concerned about being able to do so given he had had his second injury in as many years. Petitioner's job was noted to be that of a corrections officer with typical duties including transporting inmates to and from court dates. He was not presently working since Respondent had no light duty. Petitioner was observed as walking guardedly with very little trunk movement when standing and walking. He also demonstrated a high degree of pain behaviors such as holding his breath with movement. Goals and exercises were discussed. (PX 7)

Petitioner underwent therapy on June 2, 2011 reporting no change. (PX 7)

Petitioner had therapy on June 6, 2011 and reported his mid back was very sore as was his low back but the former was worse. (PX 7)

Petitioner attended therapy on June 8, 2011 reporting today was a "bad day" but recalling no "offending activity." Petitioner reported relief while doing the modalities but, otherwise, ongoing pain. He had purchased a Swiss ball at home to do lower truck rotation there. (PX 7)

Petitioner continued to attend physical therapy on June 13, 2011 and June 17, 2011. (PX 7)

On June 21, 2011, Petitioner returned to Dr. Williams reporting no improvement with the physical therapy program. Dr. Williams ordered a bone scan. (PX 3)

Petitioner underwent a nuclear bone scan on July 12, 2011. It showed no abnormal radiotracer uptake associated with compression deformities within the thoracic spine. Findings included some slight thoracic kyphosis. (RX 8)

Petitioner underwent a Physical Therapy Re-evaluation at Midwest Rehab on July 22, 2011. Subjectively, Petitioner reported ongoing and constant thoracic spine pain which would shoot down into his low back. He denied any radicular complaints. Petitioner was noted to not be wearing his TENS unit and he explained that insurance had just sent him additional electrode pads so he had been using them sparingly. Petitioner felt heat helped more than ice and he had difficulty finding a comfortable position. Petitioner reported his back popped a lot and if he flexed his trunk, his back would catch. He acknowledged understanding that it would all heal with time but was "tired of hurting." Petitioner had returned to work four hours a day at a light duty level. He could not take pain medication at work and his chair was bad. He expressed the desire to return to work but didn't think he could do so with the amount of pain he had. Petitioner's Modified Oswestry Low Back Pain Disability Questionnaire score was a 66%

which indicated "crippled." Petitioner also displayed some guarding and pain behaviors such as facial grimacing and holding his breath. (PX 7)

Petitioner was taken off work as of July 22, 2011. (PX 7)

Petitioner returned to physical therapy on July 25, 2011 reporting ongoing pain and complaints. At the July 27, 2011 therapy session, Petitioner reported some tailbone pain which the therapist told him could be from moving more or the stretches. The therapist observed that Petitioner was attending therapy with an erect posture but facial grimacing. When Petitioner was questioned about standing straight, he replied, "I'm not working." (PX 7)

Petitioner cancelled his physical therapy scheduled for the first week in August due to a staph infection in his tailbone. At his August 8, 2011 therapy session he was standing up straighter and his thoracic spine, while tight, wasn't throbbing. Sleeping was still rough. (PX 7)

At his August 10, 2011 therapy session Petitioner reported feeling like someone was kicking him in the back or he was having a throbbing headache. He did not wish to perform some of the upper extremity exercises at that visit. (PX 7)

Petitioner continued with therapy. On August 15, 2011 he reported not having any pain pills and not sleeping more than 3.5 hours per day. His back felt like someone was constantly squeezing in on it. (PX 7)

Petitioner presented to therapy on August 17, 2011 reporting he was very sore. He had showered at home on August 16, 2011 and felt something catch in his back and his muscles "seized up." He lost his balance and fell on his right side. His back had been hurting ever since and was reportedly at an "8/10" level of pain. Dr. Williams' office was contacted and Petitioner was told he could stop physical therapy for a while if he thought it would help. Petitioner was going to talk to the doctor. (PX 7)

Dr. Williams re-examined Petitioner on August 19, 2011. Petitioner reported falling in the shower on August 16, 2011 and that since then, his pain had been "slightly worse." Physical therapy had been placed on hold per Petitioner. X-rays were taken with no acute findings. Dr. Williams wanted a second opinion with Dr. Keith Bridwell, especially concerning the possibility of surgery. Petitioner was given Tylenol #3 to take in the interim. He was taken off work pending the second opinion. Further recommendations were to follow. (PX 3)

Petitioner was evaluated by Dr. Buchowski on September 27, 2011, upon referral of Dr. Williams, due to his thoracic back pain. Petitioner reported that his symptoms initially began in September or

October of 2010 when he struck his back on the underside of a desk. Subsequently his symptoms were worsened when he was shoved into a steel door frame hitting his back on the door frame (April of 2011). Petitioner reported sharp, aching, moderate to severe pain in his thoracic spine since that time. He rated the pain as "6/10." His primary complaint was pain as he identified no other problems with motor tasks or upper/lower extremity issues. Petitioner had tried physical therapy, exercise, massage, TENS Unit and narcotic pain medications with minimal improvement in his symptoms. Petitioner reported being unable to work. A physical examination was performed and an MRI from October 11, 2010 was reviewed. Dr. Buchowski's impression was thoracic back pain secondary to a work-related injury in October of 2010 and subsequently in April of 2011. Dr. Buchowski recommended continued non-operative treatment in the form of an evaluation with a physiatrist to maximize all non-operative treatment. He also recommended a new MRI scan as the one he had seen was over a year old or that he be provided with the one Petitioner indicated had been done in the last six months. The doctor noted, "I believe that the patient's current symptoms are casually and directly related to his work related injury. He does appear to have Scheuermann's disease, which almost certainly predated his existing symptoms; however, I believe that the work related injury exacerbated the underlying condition." (PX 5, p. 2) Dr. Buchowski felt Petitioner could work with the following restrictions: no lifting, pushing, and pulling over 20 lbs.; no bending/ no twisting; and frequent standing/walking breaks. The doctor further indicated that Petitioner should be allowed to take pain medication as needed for pain relief. He acknowledged the restrictions could make working for Respondent difficult. The doctor expressed optimism at getting Petitioner back to his normal state of being without resorting to surgery. He wished to see him again. (PX 5)

Petitioner was under video surveillance on September 30, 2011. He was photographed walking in and out of a door onto a porch where he would stand, walk, and lean on the porch railing. He was smoking cigarettes and talking on a phone. (RX 16)

Petitioner returned to see Dr. Smucker on October 14, 2011, approximately one year after his first visit wherein Dr. Smucker had treated him for injuries sustained the previous March. At that time, Dr. Smucker diagnosed Petitioner with Scheuermann's Disease with an exacerbation of pain related to his work accident. Dr. Williams had subsequently referred him to Dr. Buchowski at Washington University who had recommended that he be re-evaluated by a physiatrist. Hence, the appointment with Dr. Smucker. Petitioner related being very fit in the past and working as a correctional officer. He expressed frustration by his persistent thoracic pain as he was unable to exercise in any meaningful way and had gained 35 pounds. He had tried working in a light duty position but was failing at that because there was no way for him to lie down. Petitioner reported being unable to stand up straight at any time and related that his back felt like there was a slab of concrete on each side of midline and a pounding aching pain in

the midline amplified with any significant activity. Petitioner was taking six Tylenol #3 per day which didn't really help with the pain and made him feel fuzzy. Dr. Smucker's physical exam and diagnosis remained unchanged from the 2010 visit. He had no further recommendations for care. Physical therapy had not helped. He did not think Petitioner was going to improve with anything that he had at his disposal. If there was a chance surgery could help, Dr. Smucker felt it should be explored. Dr. Smucker took Petitioner off work as he couldn't even do light duty work. He was prescribed different medication. Dr. Smucker also noted that the compression fractures were felt to be chronic in nature. (PX 2; PX 4)

At the request of Respondent, Petitioner was evaluated by Dr. Patricia Hurford on November 8, 2011. Petitioner provided Dr. Hurford with a history of his accidents – both in 2010 and 2011. Petitioner told her that after the March 2010 injury he was able to resume his prior activities but to a lesser extent. He was unable to play softball and required more frequent breaks. He was only able to run up to three miles per day versus the five miles he had run before the March 2010 accident. Petitioner described "significant difficulty dealing with pain" since his April 25th injury. He described constant pain and the need to use Tylenol #3 every four hours along with Nabumetone. Petitioner mentioned cold and damp weather aggravated his pain and he didn't believe he could return to full duty work. The day of his visit with Dr. Hurford he stated he was primarily sedentary or bedridden due to significant pain complaints. On physical exam Petitioner was noted to have an increased thoracic kyphosis with painful extension. Dr. Hurford noted there were no acute deformities identified on Petitioner's diagnostic studies; however, moderate thoracic kyphosis and compression deformity at T8 – was noted with disc space narrowing particularly between the T9 – T10 vertebral bodies. She did not render any opinions at that time due to the lack of Petitioner's pre-accident medical records; however, she recommended he stop smoking and decrease his reliance on bedrest and narcotic analgesics. (RX 10)

After reviewing Petitioner's medical records, Dr. Hurford prepared an addendum report dated November 21, 2011. (RX 11) After describing Petitioner's medical treatment, Dr. Hurford commented that assuming Petitioner's history was accurate and he was pain-free and active as of April 25, 2011 and did not require pain medications or other treatment for his thoracic spine, it would be reasonable to assume that the altercation did result in an exacerbation of pain symptoms. She made it clear the underlying condition of the spine was not produced by the events which occurred April 25, 2011.

Dr. Hurford also commented that Petitioner has significant dysfunction and pain-coping abilities. She felt Petitioner was treating himself with excessive inactivity due to his reported intolerance of most activities of daily living. Dr. Hurford concluded Petitioner's inactivity would lead to more chronic and severe pain complaints due to a combination of deconditioning and limited distraction techniques.

Additionally, she felt Petitioner was aggravating his condition with excessive tobacco use and pain medications. Dr. Hurford recommended that Petitioner exhaust all conservative measures, including injections, bracing and modified activities to improve his symptoms. She felt her review of Petitioner's entire records suggested a pattern of pain and dysfunction that was developing in 2010 and extending into his recent injury and subsequent treatment. Cognitive behavioral techniques and work with a physician that he could trust and respect would likely result in the maximum benefit to Petitioner. She felt Petitioner had done very little to help his current situation and approached any thought of increased activity with skepticism due to perceived pain results. (RX 11)

On December 13, 2011 at the request of the Work Comp Case Manager, Petitioner was examined by Dr. Salvacion at the Spineworks Pain Center. Petitioner gave a history of a work-related injury going back to May of 2010 when he hit his back on a desk. Then, on April 27, 2011 while scuffling with an inmate he was "slammed" in to a steel door frame on his back with continued pain and spasming thereafter. Petitioner's treatment with Dr. Williams and Dr. Buchowski was noted with Petitioner having been sent to Dr. Smucker for epidural steroid injections which Dr. Smucker was unwilling to consider. Therapy had provided only limited benefit. Petitioner described his pain as a constant aching with spasms, as though being kicked in the middle of his back. Nothing helped with the pain and it worsened with activity. On physical examination Petitioner's spasms were noted as well as his tilted posture to the left which the doctor felt was due to the spasms. Very limited range of motion in the thoracic and lumbar spine secondary to pain was also evident. The doctor's impression was thoracic compression fractures, myofascial pain, and thoracic degenerative disc disease. Petitioner was to be scheduled for a trial of thoracic epidural steroid injections and he was given a prescription for baclofen and tramadol. Petitioner was taken off work for thirty days. (PX 6)

Petitioner returned to Dr. Florence on December 14, 2011, having last seen her on May 5, 2011. Petitioner was there for a routine clinic follow-up but requesting pain medication. Petitioner reported originally getting hurt at work in April and being seen by Dr. Williams and, more recently, a thoracic surgeon who felt surgery should wait until Petitioner was older. That doctor had referred him to Dr. Smucker who didn't want to do further injections. Petitioner had just seen Dr. Salvacion who was going to be giving him an injection. Petitioner advised the doctor he was able to do activities of daily living, with limitation, but unable to work. Her assessment was chronic pain due to trauma and a closed fracture of the thoracic vertebra with spinal cord injury. Petitioner was given a Fentanyl patch. (PX 2)

On January 17, 2012 Dr. Salvacion performed a thoracic epidural steroid injection on Petitioner. (PX 6)

On February 8, 2012, Petitioner returned to work for Respondent in a light-duty capacity. (PX 14)

The parties stipulated that Petitioner was temporarily totally disabled from April 26, 2011 through February 7, 2012. (AX 1)

Petitioner returned to see Dr. Williams on February 27, 2012 having been previously seen in St. Louis by a spine surgeon who recommended continued conservative measures. Petitioner was noted to be using a 25 microgram Fentanyl patch. His bilateral leg pain was resolved completely. His primary pain complaints were on the right and left sides at the apex of his kyphosis within the thoracic spine. Petitioner was noted to be working albeit at a sedentary position. Dr. Williams noted that Dr. Smucker declined to provide Petitioner with any injections; Dr. Salvacion did some but they only provided a small amount of relief. Petitioner expressed the continued desire to "get his life back." Dr. Williams documented his lengthy discussion with Petitioner confirming he told him the MRI changes had probably been present for years. Surgery would be an option but Petitioner didn't wish to pursue it as he understood even with surgery he would have pain. Dr. Williams noted, "I have discussed the need to treat the underlying depression. I have contacted Dr. Florence and we have had a discussion while [Petitioner] was in the office. This discussion focused specifically on his current state, as well as his need for narcotics and his depression." Dr. Florence wanted Petitioner to come right over to his office so she can begin talking with him about depression and the treatment options. Dr. Williams was of the opinion that Petitioner could ultimately see a return to full activity without surgery and wasn't convinced Petitioner would have a good outcome, even with surgery, as he would still require pain medication. They discussed the risk of addiction and tolerance issues with fentanyl. Dr. Williams wanted to begin decreasing Petitioner's work restrictions and have Petitioner meet with Dr. Florence to address his options for depression. He also wanted to see Petitioner wean off the need for narcotics. (PX 3)

Petitioner did not go right over to Dr. Florence's office as there is no office note for any such visit. (PX 2)

Petitioner presented for another physical therapy evaluation on March 6, 2012. Again, he was seen at Midwest Rehab. Petitioner had undergone two epidural injections with Dr. Salvacion and noted marked relief. Dr. Williams had ordered additional physical therapy. Petitioner described his least amount of pain in the previous week as a "0" with the worst being a "6". Petitioner described intermittent pain about his mid-back but no upper or lower extremity symptoms as the pains down his legs resolved entirely after the injections. Petitioner described being unlimited in regard to standing or walking but admitted he had not "pushed it." If he sat for more than an hour or mopped his kitchen floor he had increased pain. He could not identify any other aggravating factors stating, "I always hurt, it's just not as painful as it had been." (PX 7) Petitioner's Modified Oswestry Low Back score was 334% which meant moderate disability. Petitioner was currently working with light duty restrictions performing sedentary/desk duties. He wished to "get his life back." On exam, Petitioner exhibited increased thoracic kyphosis, most notably at T6, as well as forward head posturing and anterior tipping of bilateral scapulae. His posture was, otherwise, unremarkable. (PX 7)

As of March 9, 2012 Petitioner had walked three miles and denied any new complaints at his therapy session. (PX 7)

At the March 9, 2012 therapy session Petitioner reported his stretching exercises were going okay. Upper extremity strengthening exercises hurt but didn't cause pain. (PX 7)

When Petitioner reported to therapy on March 14, 2012 he stated he was hurting that day and described it as an "Advil type hurt." He focused more on the lower back. (PX 7)

As of March 16, 2012 Petitioner was telling the therapist that he hurt but was not in pain. He had walked approx. six miles the day before. (PX 7)

Petitioner attended physical therapy on March 20, 2012. He reported that he "hurt like hell, but [wasn't] in pain." He had walked 5 ½ miles the day before and jogged ½ mile. That was his first attempt at jogging in eleven months. (PX 7)

Dr. Florence re-examined Petitioner on March 21, 2012. Petitioner reported he "hurts but is not in pain, there is a huge difference from where I was to where I am now". Petitioner had recently started Cymbalta for depression and it was helping. Emotionally, Dr. Florence noted Petitioner's comments, to wit, "I'm not happy, I don't want to eat my gun anymore but I'm not where I was." Petitioner's diagnoses now included depression, chronic pain due to trauma, allergic rhinitis, a closed fracture of the thoracic vertebra, mid back pain, nicotine dependence, and a thoracic sprain. He was taking Cymbalta, Fentanyl, and Ibuprofen. A nasal spray was added for his rhinitis. She did not fill out an off work slip. (PX 2)

As of March 23, 2012 Petitioner told the therapist he was walking six miles a day and had tried jogging one day and that was it. (PX 7)

Petitioner attended physical therapy on March 26, 2012. He was still working restricted duty. His Fentanyl dosage had been decreased by Dr. Florence and he was having a difficult time. Petitioner had increased his Cymbalta. His arms were described as being "squeezed" and his legs "binded up." Petitioner hadn't walked over the weekend. (PX 7)

Petitioner returned to see Dr. Williams on March 27, 2012. Petitioner reported doing better and making some improvements in physical therapy. He still complained of a constant ache but no real pain. He was decreasing his use of Fentanyl and had recently been started on Cymbalta. The doctor noted he and Petitioner had a lengthy discussion regarding Petitioner's findings and subjective complaints. The doctor did not feel a surgical solution would be in Petitioner's best interests and he agreed. They also discussed how depression can affect one's back pain and vice-versa. He was again encouraged to decrease his need for the fentanyl patch. Dr. Williams told Petitioner to sue nonsteroidal anti-inflammatory medication, if tolerated. Petitioner was given restrictions of no lifting, pushing, or pulling more than 25

lbs., no repetitive bending, twisting or stooping, and no climbing of ladders, crawling, or squatting. (PX 3)

At the March 28, 2012 therapy session Petitioner reported soreness and that his lifting restriction had been changed from 20 lbs. to 25 lbs. Petitioner was to continue therapy and had been ordered to add aquatic exercise. (PX 7)

At therapy on March 30, 2012 Petitioner denied any new complaints. (PX 7)

Petitioner attended physical therapy on April 3, 2012 reporting he had walked 4 miles at Washing ton Park. He had also been greeted by a friend with a pat on the back with resulting pain. Aquatic exercises were initiated. (PX 7)

Petitioner continued with physical therapy in April and May of 2012 and progressed to Work Hardening in May of 2012. (PX 7) Petitioner continued to work restricted duty.

Petitioner began taking classes on-line with Argosy University as of April 10, 2012. From April 10, 2012 through May 14, 2012 he took a "Skills for Success" class and received a "C+". (PX 13)

Petitioner returned to Dr. Florence on May 1, 2012 reporting an improvement in his depression since his last visit. He reported good social support and compliance with his medications. He denied any problems with lower leg numbness and weakness. His symptoms were primarily in the area of his thoracic and low back and included pain and stiffness. Hydrocodone was added to Petitioner's medications and he was advised to wean off the patch. Dr. Florence did not complete an off work slip. (PX 2)

Petitioner returned to Dr. Williams on May 8, 2012. Dr. Williams noted that Petitioner had been diagnosed with Scheuermann's Disease and seen by a surgeon in St. Louis who suggested that he try to avoid surgery as well. Petitioner reported physical therapy was resulting in some improvement in both strength and flexibility. Petitioner was decreasing his use of the Fentanyl patch but complaining of some pain. He reported some difficulty with sleeping; otherwise, overall he was doing better. Dr. Williams' assessment was chronic thoracic back pain and Scheuermann's Disease. Summarily, he described Petitioner as doing "somewhat better." He had a very lengthy discussion with Petitioner regarding his symptoms noting it would be difficult to suggest a more aggressive approach at this point. Petitioner was not showing any neurologic dysfunction. He mainly had pain. Dr. Williams expressed concern about the amount of pain medication Petitioner was requiring and felt a Fentanyl pain patch appeared somewhat excessive. He wrote, "I am very concerned given his young age and the use of this Fentanyl, that he will

develop a dependency. This will only make matter worse. I do feel there is a component of depression at play here." Petitioner was given the following restrictions: No climbing of stairs or ladders; No lifting over 25 lbs.; No pushing or pulling over 25 lbs.; no work requiring repetitive bending of his lumbar spine; and no repetitive twisting or stooping. Petitioner was to undergo work hardening. (PX 3)

Having completed one class on-line on May 14, 2012 Petitioner next signed up for "Interpersonal Effectiveness", a psychology class at Argosy. (PX 13)

Petitioner presented to Dr. Florence on May 29, 2012 in follow-up for his myofascial pain syndrome. Petitioner reported doing well and stating he was put on Vicodin to help with any withdrawal symptoms from reducing the duragesic patch. Petitioner was in work hardening and felt he needed the patch. He was taking the Vicodin as needed and not even on a daily basis. His diagnosis of depression remained. Petitioner had started work hardening therapy with noted discomfort but getting through it as able. She described his back pain as stable. He denied any depression, irritability, sleep problems, or decreased appetite. She indicated Petitioner was doing well with his goals. (PX 2)

Petitioner's work hardening was completed on June 12, 2012. Petitioner was noted to be functioning between the light and medium physical demand level. Petitioner expressed the desire to return to work, full duty, at his previous job but was unsure whether he could tolerate the weight levels. He would also like to be able to manage his pain without pain medication. Petitioner was reportedly taking a class and thought he would continue going to school. He acknowledged his understanding that if he couldn't return to his previous job he would or could be moved within the state. Petitioner was to be seen by Dr. Williams that day. (PX 7)

Petitioner returned to Dr. Williams on June 12, 2012 regarding his chronic thoracic back pain. Petitioner had undergone work hardening with some improvement in his symptoms. Petitioner was currently working and tolerating his activity. He denied any worsening symptoms although he still required a rather significant amount of narcotic pain medication. Petitioner's neurologic exam showed good strength in his lower and upper extremities bilaterally. His gait was normal and his lumbar and thoracic spines were soft and supple. Dr. Williams' assessment was thoracic kyphosis secondary to Scheuermann's Disease, thoracic degenerative disc disease; and chronic thoracic back pain. At this visit Petitioner specifically requested that he not have any interaction with inmates as he had a fear of dealing with them and having further problems with pain. Dr. Williams felt such a restriction was reasonable given his symptoms and his history. He issued it as a permanent restriction and noted Petitioner was at maximum medical improvement (MMI) and released from care. They discussed the use of an FCE. No

physical restrictions were imposed. (PX 3) Petitioner would not return to see Dr. Williams until November 24, 2014. (PX 3)

Petitioner completed his "Interpersonal Effectiveness" class on June 18, 2012 and received an "A." (PX 13) He next took an English class entitled "English Review I." (PX 13)

On June 25, 2012 Respondent sent Petitioner a letter regarding Respondent's need to return Petitioner's position to full duty. Per the Sheriff's Office Rules and Regulation, Petitioner had been allowed to work on a light duty assignment after his April 25, 2011 accident. As of August 8, 2012 Petitioner had been performing that light duty assignment for six full months. Respondent had become aware that Petitioner's condition prevented him from returning to full duty on a permanent basis. Therefore, his light duty position would be ending on August 8, 2012. Respondent was notifying Petitioner in advance to allow him an opportunity to rehabilitate and return to full duty on/before August 9, 2012. In the event he couldn't return to full duty Petitioner was advised he might wish to consider applying for IMRF Disability Benefits. (PX 14)

Petitioner had a routine follow-up visit with Dr. Florence on July 17, 2012 for chronic pain. He reported some depression having recently put his grandmother in hospice and having been recently terminated from his job due to his restrictions stemming from his injury. Disability forms were given to him. Petitioner remained unable to work, according to Dr. Florence. (PX 8)

Petitioner completed his English class on July 23, 2010 and received credit for the class. (PX 13)

On August 1, 2012 Petitioner's attorney sent a fax to "Gabby Bennett" confirming their conversation of two weeks earlier when a request was made for payment of maintenance benefits. "Client is looking for work and going to school and, therefore, would request voc rehab." (PX 15)

In a Health Status Form dated August 1, 2012 Dr. Florence indicated Petitioner should remain off work through August 8, 2012. (PX 12)

Petitioner began an English Review II class on August 2, 2012. (PX 13)

Petitioner's employment with Respondent was terminated as of August 9, 2012.

Petitioner returned to Dr. Florence on September 4, 2012 regarding cramping in his right hand and bilateral moderate lower leg pain. He could attribute his symptoms to no known event. Testing was ordered. She did not comment on Petitioner's ability to work. (PX 8)

Petitioner completed his English Review II class on September 5, 2012 and received credit for the class. (PX 13)

As of September 6, 2012, Petitioner was enrolled in a Math Review class on-line. (PX 13) He completed the class on October 10, 2012 and received credit. He then began an Information Literacy and Communication Class which ended on November 14, 2012. Petitioner received an "A" in the class. (PX 13) Beginning on November 15, 2012 Petitioner enrolled in Composition I and Introduction to Business in a Technology World. (PX 13)

Dr. Florence met with Petitioner again on November 19, 2012 regarding a medications check. Petitioner was off the pain patch. He also reported worsening symptoms but his complaints focused on arthralgia, joint stiffness, and myalgia. Dr. Florence advised Petitioner his symptoms could wax and wane. (PX 8)

Petitioner finished his two on-line classes on December 19, 2012 and received a "B+" and "B" respectively. (PX 13) He then began a finance class entitled "Foundations of Building Wealth." It ended on January 30, 2013 and Petitioner received an "A." (PX 13) His next class was General Education Mathematics. (PX 13)

Dr. Florence saw Petitioner on February 19, 2013 for a routine check of his back pain. (PX 2) She completed a temporary disability claim form indicating Petitioner was still unable to work as a result of his work accident. She did not know when he might be able to return to work. (PX 2)

Petitioner received an "A-" in his general math class that ended on March 6, 2013. He then began "Critical Thinking and Problem Solving." (PX 13) That class ended on April 10, 2013. He received a "B-." (PX 13)

Petitioner did not take any classes on-line as of April 11, 2013. (PX 13)

By fax dated April 23, 2013, Petitioner's attorney sent a request to "Gabby" stating, "Please find forthcoming education info. (I was mistaken, it is online). As you can see, he is completing his requirements. When I made oral demand I did not realize educ. Expense. Demand is [deleted] and any related reasonable bills to date. Maintenance benefits would continue until settlement check is sent." Five pages were faxed[1]. (PX 15)

[1] But not included in PX 15

Dr. Florence again saw Petitioner on May 24, 2013. He was complaining of constant episodes of moderate symmetrical bilateral lower and bilateral mid back pain. She noted limited range of motion due to pain. (PX 2)

Petitioner signed up for Composition II at Argosy University on-line as of May 30, 2013. He completed the class on July 3, 2013 and received a "C+." (PX 13) His next class was Ecology and Environmental Sustainability." (PX 13)

Dr. Hurford evaluated Petitioner a second time July 31, 2013 for an updated independent medical evaluation. Petitioner described his pain as "5-6/10" on an average along with swelling and spasms in his mid- thoracic spine. Petitioner reviewed his treatment since the first IME with the doctor. He reported being terminated from his job and going to school full-time studying accounting and business management. Dr. Hurford reviewed additional records and concluded Petitioner had a history of chronic thoracic level pain symptoms and an exacerbation as a result of a steel door frame contusion/strain injury. Dr. Hurford felt Petitioner's symptoms did not lead to any acute fractures of his thoracic spine and that he had exhausted all additional options for treatment of his condition. She felt he needed ongoing pain management treatment but not as a result of his injury at work in 2011. She felt the work restriction imposed by Dr. Williams was not due to the work accident but was due to his inability to deal with pain symptoms that pre-existed the 2011 work accident. She felt Petitioner was at maximum medical improvement and needed no permanent restrictions as a result of the 2011 work accident. (RX 12)

Dr. Hurford reiterated her belief that Petitioner had a pre-existing pattern of pain and dysfunction that developed as early as 2010 and possibly sooner. She noted the exacerbation of Petitioner's symptoms did not lead to any acute fractures of the thoracic spine. She believed Petitioner needed ongoing pain management, but it was not for the April 25, 2011 work accident. She believed any additional treatment was for his pre-existing thoracic-level symptoms and Scheuermann's disorder.

Dr. Hurford attributed the restriction imposed by Dr. Williams of avoiding inmate contact to be based solely on Petitioner's inability to deal with pain symptoms which pre-existed the April 25, 2011 event. She determined Petitioner was at maximum medical improvement for the April 25, 2011 work injury. She also noted Petitioner did not require any restrictions in his activities as a result of the April 25, 2011 incident. (RX)

Petitioner's Ecology class ended on August 7, 2013. He received a "B." The next class was Macroeconomics. (PX 13)

Dr. Hurford prepared another report dated August 12, 2013 based upon her review of the written job description for Petitioner. She concluded there were no limitations in Petitioner's ability to return to his previous position as a corrections officer. (RX 13)

On August 26, 2013 Petitioner presented to Dr. Florence for a three month follow-up for back pain and depression. Petitioner reported ongoing issues with his workers' compensation case resulting in increased stress with finances. She noted that Petitioner had gained weight due to more pain and vice versa. He remained temporarily disabled. Dr. Florence noted that Petitioner was asking for another pain injection as soon as possible as his pain was better controlled when he received consistent injections; however, they appeared on hold due to unpaid workers' compensation bills and needed to be addressed because the issue was disrupting his treatment and exacerbating his pain. A chronic pain consult with Dr. Chad Johnson was to be considered. (PX 2)

Petitioner's economics class ended on September 11, 2013 and Petitioner earned a "B+" in the class. He next took Diversity and World Cultures through October 16, 2013 and received an "A-." From October 17, 2013 through November 20, 2013 he took Business Law and Corporate Ethics, earning an "A." Petitioner would continue taking classes on-line as reflected in PX 13. H received A's and B's in the classes. (PX 13)

Dr. Florence continued Petitioner's temporary disability as of September 3, 2013 and continued relating it to his work accident. (PX 2)

Petitioner saw Dr. Florence on December 2, 2013. He had undergone a weight gain of 30 lbs. (PX 2) He remained temporarily disabled on account of the work accident. (PX 2)

On February 19, 2014, Petitioner participated in a functional capacity evaluation. (RX 15) Petitioner testified he was in pain and felt nauseous at the time of the FCE, but the therapist refused to allow him to perform the exam on another day. The FCE report indicates Petitioner was pleasant and voiced a willingness to participate fully in the testing. The FCE report makes no mention of Petitioner being ill or of requesting that the evaluation be performed on a different day. The FCE makes numerous references to Petitioner's participation being self-limited. The report indicates Petitioner self-limited his performance before objective signs of maximum effort could be observed. The FCE report also reflects several inconsistencies with Petitioner's performance. Petitioner demonstrated a limited range of motion when performing unilateral heel raises in that he could only lift his heels between ½ of an inch and 1 inch from the floor. However, when Petitioner was walking, he demonstrated excessive plantarflexion/heel raise range of motion to propel himself forward. Petitioner also demonstrated limited trunk mobility when

walking, but he had more mobility during the physical assessment of his range of motion. The FCE report indicated Petitioner put forth less than full effort during testing of the spine and extremities. He also reported he could only sit for 15-20 minutes, but he could drive for 45 miles which was thought to take between 40 and 60 minutes. The therapist noted Petitioner sat for 23 minutes while providing his subjective history, and he did not shift his weight or struggle to do so. The therapist also commented that Petitioner reported an ability to walk for 15-30 minutes, but he complained of pain after only walking for four minutes. The written pain questionnaires revealed Petitioner had a high level of perceived disability. He self-reported ability below a sedentary physical demand level, but despite his self-limiting behavior, he still demonstrated ability greater than a sedentary physical demand level. The therapist performing the FCE concluded that because of Petitioner's self-limiting performance, his true abilities and true limitations were undetermined on the functional capacity evaluation. (RX 15)

Petitioner saw Dr. Florence on March 3, 2014 reporting back pain. He denied any leg numbness or weakness. Petitioner was currently able to do activities of daily living without limitation but was limited in his ability to do housework, engage in sports, or work. He was going to school on line. Dr. Florence discussed with Petitioner that he is unable to do his previous job as a corrections officer. Given the fact he was able to go to school which was sedentary she felt he should be able to perform a sedentary job at this point, even part-time. She noted the "Functional assessment was inconclusive and reviewed." (PX 2)

On March 12, 2014 Dr. Florence completed a Social Security Medical Assessment Form. Dr. Florence noted that she had begun treating Petitioner on April 26, 2011 and had last seen him March 3, 2014. She described his prognosis as "poor." His current symptoms included chronic pain and limited lifting, sitting, and walking. She felt his symptoms, including pain, limited his ability to concentrate and pay attention up to fifty percent of the day. She felt he was capable of low stress jobs. She also felt he could perform sedentary work. She didn't think he could engage in heavy lifting, pushing or pulling. (PX 2)

The deposition of Dr. Williams was taken on May 20, 2014. Dr. Williams testified that he is a board certified spine surgeon. He first began treating Petitioner on May 5, 2010 due to back pain and headaches. Dr. Williams suspected a T9 compression fracture and ordered MRIs. It was Dr. Williams' understanding that Petitioner was receiving some chiropractic treatment. He himself referred Petitioner to Dr. Smucker. Petitioner went on to see Dr. Smucker on October 21, 2010; however, Dr. Williams had no further visits with Petitioner between August 24, 2010 and May 11, 2011. (PX 1, pp. 1-9)

Dr. Williams testified that when he saw Petitioner again on May 11, 2011 Petitioner reported a work accident on April 25, 2011 with resulting thoracic back pain that required him to go the emergency room at St. John's Hospital. Dr. Williams suspected a new compression fracture and ordered another MRI. That was done on May 16, 2011 and showed a compression deformity at T6, a possible compression deformity at T9, and mild compression deformities at T8 and T10. Dr. Williams testified that Petitioner was not a surgical candidate because he wasn't convinced Petitioner's fractures were acute ones but, even if they were, he thought they should heal without the need for surgery. (PX 1, pp. 9-11)

Dr. Williams testified that Petitioner has Scheuermann's Disease, a disease which affects the thoracic spine as one has an increase in the curvature of one's thoracic spine, making it more prominent than what is deemed normal. It often develops in adolescence and represents a growth failure of the normal thoracic vertebral body. Dr. Williams further testified that one can have Scheuermann's Disease and no subjective complaints. Dr. Williams never thought Petitioner was a malingerer and, for the most part, he found Petitioner's subjective complaints valid. (PX 1, pp. 11-12, 13)

Dr. Williams was of the opinion that Petitioner's work accident on April 25, 2011 aggravated his pre-existing condition in his thoracic spine but he couldn't state "with certainty" whether that would be permanent. (PX 1, p. 12) Dr. Williams explained that, by history, Petitioner had an exacerbation and experienced more pain. By that same approach if he assumed Petitioner was still in pain that could lead one to conclude it was permanent. However, based upon the mechanism of injury and his previous history and condition of his spine, one wouldn't expect it to be permanent. (PX 1, pp. 12-13) When asked if his opinion would change if medical records around April 25, 2011 showed Petitioner occasionally took Tylenol 3 with codeine for pain, the doctor replied, "No." (PX 1, p. 14) Dr. Williams was asked if he would concur with the independent medical examination doctor who wrote, "Presuming that Mr. Filbrun's history is accurate and that he was pain free and moderately active up until April 25, 2011…it would be reasonable to assume that the altercation did result in exacerbation of pain symptoms" and Dr. Williams agreed. When also asked if he agreed with that same doctor's opinion that the work-related accident may have exacerbated his underlying Scheuermann's Disease, the doctor agreed. (PX 1, pp. 14-15)

On cross-examination Dr. Williams agreed that the curvature of the spine in Scheuermann's Disease would be like that of a hunchback. (PX 1, p. 15) He testified that he had reviewed all of Petitioner's MRIs and there wasn't much change from one to another. He felt it reasonable that the accident did not result in any objective changes to Petitioner's spine. When asked if the compression fractures didn't worsen as a result of the accident, the doctor testified that would be accurate adding "If

this in fact is Scheuermann's, they weren't really compression fractures to start with." (PX 1, p. 16) Dr. Williams didn't have a one hundred percent opinion if Petitioner had no fractures. He would need to read through the medical records because the history was vague but he thought Petitioner described an injury in which he was coming up and had a separate injury besides the one on the 25th of April. That injury, which he thought involved meeting resistance with a desk or something, could be somewhat more consistent with a compression fracture mechanism of injury. In the end, compression fractures and Scheuermann's Disease can look alike. (PX 1, p. 17)

Dr. Williams further testified that given Petitioner's age he would think it would take a fall or some higher energy injury to cause a compression fracture; however, it would not take as much energy to aggravate a Scheuermann's Disease. (PX 1, p. 18) Dr. Williams testified that Petitioner had symptoms related to the condition back in May and June of 2010 and either his symptoms improved or else he knew there was nothing else that could be done and didn't seek any follow-up care. If there isn't anything objective showing up on the MRI then one relies upon his subjective complaints. It can be fine one minute and then there's an injury and it flares up. That's a common complaint with a chronic condition. (PX 1, p. 19)

Dr. Williams agreed that one of his diagnoses when he first saw Petitioner was an acute thoracic strain and that would be consistent with his pain complaints. In order to distinguish between a thoracic strain and an aggravation of the underlying condition it would depend upon the length of time the symptoms occurred. (PX 1, pp. 19-20)

Dr. Williams thought Petitioner was, for the most part, legitimate in his complaints. He had some concerns that Petitioner was taking too much medication and it was approaching the point he thought Petitioner was drug seeking. Dr. Willliams testified that he believes Petitioner has pain but he questions his ability to deal with the pain. (PX 1, pp. 20-21) Based upon Petitioner's description of the accident Dr. Williams didn't think there was a lot of energy imparted to his spine. He would have expected Petitioner's symptoms to have resolved in a couple of months, not four or five months. (PX 1, pp. 21-22)

Dr. Williams testified that he ordered a bone scan in July of 2011 and it was negative, thereby suggesting a chronic problem and not an acute one. He explained that the wedging and "compression fractures" appeared to have been there for a long time. (PX 1, p. 23) Dr. Williams agreed that a fall, such as the one Petitioner had in the shower in August of 2011, could cause an aggravation of Petitioner's underlying condition. It didn't need to be blunt trauma. If Petitioner complained of an increase in his back pain after the shower incident, he would attribute it to the shower incident. (PX 1, p. 24) Thereafter, the only way to distinguish whether Petitioner's symptoms were from the fall or the work accident would be

Petitioner's history. (PX 1, p. 24) Dr. Williams testified that Petitioner conveyed to him that his pain never improved after the April 25th injury. He did not remember Petitioner specifically telling him that his complaints improved after the shower incident. (PX 1, pp. 24-26)

Dr. Williams testified that there was nothing about Petitioner's back condition that would prevent him from walking. (PX 1, p. 26) Dr. Williams also testified that depression can manifest itself with body aches. He could not give an opinion regarding whether Petitioner's depression was contributing to his back pain as he isn't an expert in that area. He did recall calling Petitioner's primary care physician to discuss the matter with her. (PX 1, p. 27)

Dr. Williams' only restriction for Petitioner was to avoid inmate interaction. He did that because it was his understanding Petitioner's job posed the possibility of fairly frequent altercations with prisoners and since Petitioner has Scheuermann's Disease (or what he believed to be that condition) and had a history of multiple injuries to his spine, he probably wouldn't do well in that type of situation. (PX 1, p. 28) He further added that if he was correct in believing Petitioner has Scheuermann's Disease, he should probably avoid work as a laborer or in construction. He would need to use common sense with lifting. It would be difficult to distinguish between the need for restrictions and whether they were due to his underlying condition or an aggravation of that condition. Arguably, those restrictions (regarding the work environment) would be in place regardless of the accident. (PX 1, p. 29)

Dr. Florence re-examined Petitioner on June 3, 2014. Petitioner's diagnosis remained unchanged. Another temporary disability form was completed by the doctor. (PX 2)

Petitioner received his Associates Degree in Business Administration from Argosy University on June 25, 2014. (PX 13)

Petitioner again returned to Dr. Florence on September 5, 2014 regarding his chronic back pain and myofascial pain syndrome. He described himself as doing poorly. His diagnoses included a Vitamin D deficiency, thoracic sprain, myofascial pain syndrome, depression, and high risk medication use. Lab work was ordered. Dr. Florence completed a Disability Form and referred to the functional capacity evaluation for guidance in restrictions and when Petitioner could return to work. (PX 2)

Beginning September 12, 2014, Petitioner underwent a New Patient Evaluation with Mary Conklen, a nurse practitioner associated with Dr. Schenkelberg. According to the note, Petitioner had been referred by Dr. Florence for evaluation of his anger, anxiety and depression. Petitioner gave an onset date of about a year earlier when he realized that his life was not going to change. He had experienced a spinal injury from work in 2011 when he fractured vertebraes T2-9 and surgery was deemed too risky. Petitioner was

not happy, moody and irritable and was taking it out on his family. Petitioner had never seen a therapist before and had started to go back to school and was working on his Bachelor's Degree in business and marketing. Everything was going well until six months earlier. Petitioner was currently taking a semester off due to problems concentrating and his inability to work through his homework problems. Petitioner described himself as "stuck" and unable to get out. He stated that before "an injury" he was very active, liked to bowl, rode motorcycles, and played softball and volleyball. He denied any depression or anxiety before his injury. He was currently fighting to get SSI and waiting to go back to court. His workers' compensation claim was in arbitration and his ex-wife was taking him to court for child support. Petitioner had been married twice with children from both marriages. He reportedly had no income for child support. Petitioner indicated he was always tired as he couldn't sleep well and often would wake up due to pain and anxiety. He felt out of control because he couldn't do anything to change his physical situation. Petitioner was discontinued on Zoloft and a trial of Cymbalta was substituted. Gabapentin and Mirtazapine were added. He was scheduled to see Dr. Smucker for pain control on October 3, 2014. Petitioner had undergone acupuncture in the past which was extremely helpful but it wasn't currently covered by his insurance. (PX8)

Petitioner returned to see Dr. Smucker on September 15, 2014 upon referral of Dr. Florence. Petitioner's complaints included his mid-back, shoulders and arms. He denied any cervical pain but noted bilateral shoulder pain and numbness, tingling, and pain radiating down both extremities. Petitioner said the pain had been ongoing and unchanged for three years. Petitioner also reported that physical stress seemed to increase his symptoms and that warm water decreased the pain and paresthesia noted in the upper limbs. Petitioner was currently taking hydrocodone 7.5 mg. up to six times a day if needed. Dr. Smucker's assessment included Scheuermann's Disease, chronic thoracic pain with a two to three month history of bilateral upper extremity diffuse paresthesia and numbness, and possible cervical radiculopathy, peripheral neuropathy, or polyneuropathy. He recommended EMG testing and cervical and thoracic MRIs. (PX 4)

Petitioner returned to see Mary Conklen on October 24, 2014 expressing anger about everything and feeling, at times, like he could grab someone and beat their head against the wall. Petitioner felt his anger was due to his pain but noted his wife pushed his buttons. He was angry about all the things that he has lost because of his injury and now his wife treated him badly and looked down on him. He apparently yelled at someone in the Meijer parking lot the other day and his wife had to break it up. He was back to one class at school. Petitioner's diagnosis was Major Depressive Disorder and non-specific anxiety. Both individual and marital therapy was recommended as were relaxation exercises and whirlpool. (PX 8)

Petitioner returned to see Dr. Smucker on October 10, 2014 and they reviewed the diagnostic testing Petitioner had undergone. The EMG testing showed bilateral carpal tunnel syndrome, moderate to severe in nature. The cervical MRI showed mild cervical disc disease with mild spondylosis at C5-6 without canal or neural foraminal stenosis at any level. Petitioner's MRI of the thoracic spine revealed stable chronic wedge deformities at T8-9 and T10 compared to the MRI dated May 16, 2011. In addition to Scheuermann's Disease Petitioner was diagnosed with bilateral carpal tunnel syndrome and mild cervical degenerative disc disease. Dr. Smucker felt Petitioner should be referred back to a spinal surgeon and Petitioner expressed the desire to return to Dr. Williams. In the interim, splinting was continued and Petitioner was advised to continue taking the over-the-counter Advil. (PX 4)

Petitioner presented to Dr. Williams' office on November 24, 2014 having last been seen in June of 2012. Petitioner was being seen for cervical pain at Dr. Smucker's request. Petitioner was complaining of pain in his neck and hands. The pain occurred mostly during the day and was not exacerbated by anything in particular. Nothing helped the pain. Petitioner was noted to be taking Gabapentin, Norco 5, if needed, and Cymbalta. Petitioner denied any injury. He reported nocturnal pain. Petitioner had undergone an MRI on October 2, 2014 but no physical therapy nor had he seen a chiropractor. Petitioner reported undergoing an EMG. Petitioner's cervical range of motion was noted to be within normal limits for flexion, extension, lateral flexion, and rotation bilaterally. Dr. Williams' assessment was numbness, neck pain, and carpal tunnel syndrome. They discussed Petitioner's use of braces. Petitioner reported he was decreasing his activities. They discussed surgery but Petitioner was busy with school and family and worried about recovery time. Dr. Williams noted the need to see Petitioner again before surgery. (PX 3)

Dr. Florence examined Petitioner for a pre-op exam on December 2, 2014 before his carpal tunnel surgery. He was deemed medically ready for the procedure. His judgment and insight appeared normal along with his mood and affect. He was also noted to be living independently in a private residence with his family. (PX 2) He was again examined by her on February 18, 2015 for the same reason. (PX 2)

Petitioner underwent a left carpal tunnel release on January 2, 2015. (PX 3) Post-operatively, Dr. Williams examined Petitioner on January 12, 2015. Petitioner reported falling on his hand while he had his child in one hand and his dog knocked him over. He was progressing well with excellent pain control and no signs of infection. (PX 3) He was continuing to do well as of January 13, 2015. (PX 3)

Petitioner did not take any courses on-line between January 15, 2015 and March 4, 2015. (PX 13)

Petitioner's hand continued to heal albeit slowly. As of February 6, 2015 Dr. Williams felt they could proceed with the right side. Petitioner needed to use deep massage on the left hand. (PX 3)

On February 27, 2015 Petitioner underwent a right carpal tunnel release. (PX 3)

Petitioner returned to see Mary Conklen on February 27, 2015. Petitioner reported his pain was improving with the Fentanyl patch. His major concern was that he had never had any anger prior to his accident. He had been seeing Kelcey Short for therapy. Petitioner was on break from school but doing well with his classes. He was still very irritable and short-tempered. His 11 month old son was with him. (PX 8)

Petitioner returned to see Dr. Williams on March 3, 2015. He was doing well with excellent pain control. (PX 3)

Petitioner resumed classes on-line as of March 5, 2015. (PX 13)

Petitioner was re-examined by Dr. Williams on March 6, 2015 and was doing well. (PX 3)

Petitioner returned to see Dr. Florence on March 6, 2015 in follow-up for pain management stemming from an injury and chronic pain. Petitioner described his pain as dull and aching and a "3/10" on the pain scale. He denied any difficulty concentrating, sleeping or with his appetite. He did have some complaints of depression. (PX 2) His diagnosis was chronic paid due to trauma. He was prescribed a Fentanyl patch. (PX 2)

Dr. Williams re-examined Petitioner on March 13, 2015 reporting no problems. (PX 3) As of March 30, 2015 Petitioner expressed being pleased with his progress. He was going to attend physical therapy for a few visits to learn what he could do at home. (PX 3) That was Petitioner's last visit with Dr. Williams.

Petitioner withdrew from his Principles of Management Accounting class on April 8, 2015. He then began 21st Century Leadership and Beyond. His GPA at that time was 3.31. (PX 13)

On June 30, 2015, Petitioner again visited with Mary Conklen. He was neither depressed nor happy. His mood was midline. Petitioner was doing what he had to do and taking care of his kids. He was taking classes and his grade point average was a 3.98. Petitioner was studying business management and just about done with his bachelor's degree. He hoped to get his doctorate. Petitioner was still in litigation with his back and child custody issues. Petitioner described his relationship with his wife as difficult because he doesn't have a job and is frequently irritable and angry. Petitioner indicated he had issues with his wife in that she gave him mixed messages regarding her emotions and whether she loved him or wanted a divorce. Petitioner's sleep was described as sometimes difficult as he frequently worries at night about things he needs to do and his relationship. Petitioner was described as fully function as he was taking care

of the kids and going to school. His energy was adequate and he was reportedly staying active with his kids but somewhat limited by his back injury. (PX 8)

Petitioner's last class on-line was Principles of Management Accounting. It ended on July 22, 2015. Petitioner received an "A-." (PX 13)

Dr. Florence again examined Petitioner on September 8, 2015 due to Petitioner's back spasms. He reported constant back pain moderate in severity along with depression. He was given Adacel and Chantix. (PX 2)

Petitioner returned to see Mary Conklen on December 3, 2015 reporting his major concern that day was that he had failed his first class due to stress and problems at home. Petitioner had his twenty month old son with him. Petitioner reported spending most of his day with his son. He was continuing to take classes and trying to remain positive except for the stress at home. Petitioner didn't feel the medication had been especially helpful. Some adjustments were made after a discussion. (PX 8)

Petitioner again met with Mary Conklen on March 16, 2016. He reported taking a break from classes so he could get his head together. He was back in class and another baby was on the way (October). Petitioner was striving for a Master's Degree. He expressed missing his job and dreaming about it. He was having difficulty adjusting to a lack of income and having to stay at home with the kids. Petitioner's pain medications had been increased and so his pain was a little better. He was getting 4-5 hours of sleep. He just wasn't happy. Petitioner felt frustrated because it had been four years since a life altering event and he was seeing little progress. Petitioner was to return in four months. (PX 8)

Petitioner was under video surveillance on May 15, 2016, eight days before the trial proceedings. (RX 16) Petitioner was observed using a push mower without any apparent difficulty. He also used a leaf blower without any apparent difficulty. Petitioner is also seen dragging a bag of yard waste. Petitioner is then seen jumping a couple of times to pull Christmas lights off a large tree. He also climbed into the tree, carried a ladder, and climbed up the ladder all to retrieve the Christmas lights out of the tree. (RX 16)

Petitioner's case proceeded to arbitration on May 23, 2016. Two witnesses testified: Petitioner and James Wyse.

James Wyse testified for Petitioner. He is a correctional officer employed by the Sangamon County Sheriff's Department, a job he has had for approximately 19 years. As a guard in the county jail, he has daily interaction with the inmates.

Mr. Wyse testified that violent encounters with the inmates can happen at any time, spur of the moment. When a guard is working upstairs, Mr. Wyse estimated a guard will have 2 or 3 violent encounters per week with an inmate. He explained that the inmates are housed upstairs in the jail and the guards there mingle with the inmates. One never knows what is going to happen. While not every violent encounter may result in an injury the potential is there.

Mr. Wyse acknowledged that he has his own pending worker's compensation claim for an injury he is alleging was caused by an encounter with an inmate. It is currently on appeal.

On cross-examination Mr. Wyse admitted he did not see Petitioner's accident as he was not present. He further testified that prior to Petitioner's work accident Petitioner was fine and considered one of the more energetic officers. He agreed that the written job description of a correctional officer (RX14) requires the officer to ensure the safety of all persons in the jail. This includes restraining inmates in fight situations.

Petitioner testified that he was employed by Respondent for approximately ten years. His job as a corrections officer was terminated on August 9, 2012. As a corrections officer Petitioner was a guard inside the county jail. He worked the day shift.

Petitioner testified that on April 25, 2016 he was working as the booking officer but was relieving another officer in K Block so that he could take a lunch break. Petitioner testified that he was walking when an inmate stopped him to talk to him. He then told Petitioner he had forgotten what he wanted to walk about, turned around and walked away. Petitioner testified that when he went to go through the secure door, the inmate called out his name and when Petitioner turned around the inmate "smashed" him into the door frame. Petitioner testified that the inmate was 6'3" tall and weighed around 250 lbs. Petitioner further testified the middle of his back struck the doorframe. He described it as a "hockey check." Petitioner fell to the ground, got up, called for help, and then restrained the inmate by tasing him and using pepper spray. Petitioner testified that later in the day after he had calmed down and his adrenaline had gone away he began hurting a great deal and told his supervisor about it. He then went to the emergency room.

After the emergency room visit, Petitioner followed up with Dr. Florence, his family doctor of sixteen years. She referred him to Dr. Williams. Petitioner acknowledged receiving treatment for his thoracic spine prior to the April 25, 2011 work accident. Petitioner was treated by Dr. Oliver for headaches, neck pain, and a little bit of lower back pain/tension. He acknowledged problems with his neck, mid back, and lower back "to an extent." He thought it was more for the neck and headaches, however. While treating with Dr. Oliver, Petitioner continued working full duty at the jail although there

may have occasionally been some restrictions, but nothing serious. He also saw Dr. Williams and Dr. Smucker before the April 25th accident.

Petitioner also testified that during 2010 and 2011 he played in various sports leagues – softball, bowling, and volleyball. He rode with a motorcycle club and was usually at the gym every day. Petitioner testified that he has not been able to continue doing those activities since being injured at the jail nor has he attempted them because he is scared of making the thoracic part of his back worse.

Petitioner could not recall if he was taking pain medication prior to the work accident. There might have been some but it wasn't an everyday thing. He thought he took a lot of Advil. He also thought that he was working full duty although there might have been a few weeks of light duty.

Petitioner recalled the episode in the shower where his muscles contracted and spasmed and he kind of went into the fetal position. He couldn't remember how long his pain level increased after that episode.

Petitioner worked in a light-duty capacity for Respondent from February 8, 2012 through August 8, 2012. Petitioner was terminated effective August 9, 2012.

Prior to his termination but after receiving the June 2012 letter, Petitioner testified he met with the Sheriff in an effort to determine why he was not being allowed to return to work. Petitioner did not take any other action to return to the workforce.

Petitioner testified he did not look for any type of job after being discharged by Respondent. He only enrolled in classes at Argosy University which is an on-line university he heard about through his brother. He is studying business management and business psychology. Petitioner identified PX 13 as his transcript, billings, and associate's degree he received from Argosy. To date, he has incurred tuition and fees of $67,495.00. He did not know how much he had paid for as much if it has been through grants, loans and student aid. His payments would be reflected on PX 13, however. Petitioner estimated he has six to seven more classes to take before he'll get his Bachelor's degree. Petitioner testified that he didn't try to go to Lincoln Land or UIS because Argosy was more convenient and doesn't require him to go to a classroom or sit in one for hours on end. If he was having a bad day he could lie on the couch and read there.

Petitioner testified that he doesn't know what his career objective is. He is considering a Master's Degree or something in Human Resources or a desk job. He spends about 2-3 hours per day for each class but it's not five days in a row. Each class if five weeks long.

Petitioner did a semester at Lincoln Land Community College in 1996. He had no other post high school education. Before going to work for Respondent he worked at the Mansion View Inn as a banquet manager, worked loss prevention at K-Mart and Venture and changed oil at Jiffy Lube. He thought he earned between $7.00 and $10.00 per hour in those jobs.

Petitioner acknowledged undergoing an FCE in February of 2014. He testified that he didn't feel well on the day of the exam. He was in pain and nauseated. He didn't want to do it but he did what he could.

Petitioner recalled having about six injections for pain with Dr. Salvacion. He didn't think they were very successful.

Petitioner testified that after Dr. Williams released him he remained under Dr. Florence's care for pain management. He goes to her every three to six months depending on the situation. He is currently taking Fentanyl 25 mcgs. Every three days. At the time of arbitration he wasn't feeling too bad but he had just switched his patch.

At trial, Petitioner testified his symptoms are variable, and some days are better than others. He also testified he no longer engages in various activities including playing softball, bowling, playing volleyball, participating in a motor cycle club, or going to a gym on a daily basis. Petitioner's activity level depends on what his body feels like when he gets up that day. Some days he needs to take breaks or lie down.

Petitioner also testified that he sees Dr. Conklin for depression, anxiety and "issues." He was referred to Dr. Conklin by Dr. Florence. He takes anti-depressant medication from her. Besides the Fentanyl, Petitioner takes Advil for pain.

Petitioner acknowledged seeing the video surveillance. He agreed that it showed him cutting grass and pulling some Christmas tree lights out of a tree. He explained that he had to do it because his wife is pregnant and it is a high risk pregnancy. Normally, his wife mows the lawn because it's easier for her than him. At trial, Petitioner denied having any recollection of jumping to retrieve the lights. The Arbitrator notes that at approximately six minutes and ten seconds into the video, Petitioner is seen jumping.

On cross-examination Petitioner explained that he injured his back in 2010 when he was underneath a desk and the sergeant on duty goosed him and he came up underneath the desk and cracked his back. He never filed a workers' compensation claim because he didn't want his supervisor fired for sexual

harassment. He didn't recall undergoing two MRIs in 2010. He knew he was diagnosed with Scheuermann's Disease in 2010 and that it causes compression fractures or wedging of the spine. He understood that he had the condition before the accident occurred. He acknowledged that he twisted his knee in the April 25th accident but that was it. He didn't recall if there was bruising on his back.

Petitioner recalled telling the physical therapist about falling in the shower and that his symptoms were worse. He didn't recall telling the therapist or Dr. Williams that his symptoms improved after he fell.

Petitioner acknowledged that he returned to work on a light duty basis in February of 2012. Petitioner thought someone imposed some lifting restrictions on him but he couldn't recall who.

Petitioner acknowledged that he hasn't searched for other employment since being terminated in August of 2012. It is his understanding Mary Conklin is a psychiatrist. He understands that the doctors told him there were no changes in his spine from before and after that accident. Petitioner testified he was seen by Dr. Narla who recommended against injections. He agreed that in the last four years he hasn't had any updated x-rays.

The Arbitrator concludes:

Petitioner was not an altogether credible witness. He very much downplayed the nature of his treatment in 2010 with Dr. Oliver. His testimony focused on headaches and neck pain and "some problems" with his mid-back "to an extent." In contrast, Dr. Oliver's records indicate a clear history of mid-back ("deeply sore") symptoms for one year. When x-rays showed a fractured T9 vertebrae with anterior wedging of the vertebral body, he recalled possibly fracturing and separating his ribs about a year earlier in a "situation with a prisoner." (PX 16) Petitioner did not have just a few visits or minimal treatment for his mid-back in March of 2010 as he suggested at trial. He had chiropractic treatment and referrals to Dr. Williams and Dr. Smucker, both of which were done at the request of Dr. Florence, whose records during this time were not introduced into the record. That Petitioner continued to work during this time with, perhaps minimal lost time, doesn't mean he was not in pain. Records show he was using pain pills and hot water for pain relief. The Arbitrator further notes that during the time Petitioner treated for his mid-back between March and October of 2010 he said nothing about the March 2010 "blow to his back"/desk incident that occurred at work and which he didn't report to his employer, Respondent herein. Hence, during that time period, unlike after the April 25, 2011 accident, Petitioner wasn't pursuing a workers' compensation injury.

Prior to the April 25, 2011 accident Petitioner had been diagnosed with chronic thoracic back pain, a compression fracture at T9 and Thoracic Degenerative Disc Disease. It is also noteworthy that Petitioner did not follow up with Dr. Smucker in the fall of 2010 as he was instructed to do. Furthermore, no records of Dr. Florence pre-dating April 26, 2011 were introduced into the record.

X-rays taken on April 25, 2011 showed old compression fractures, not new ones. Petitioner was diagnosed with thoracic spine and right knee contusions at the emergency room. Dr. Florence diagnosed Petitioner with a thoracic strain. Upon referral, Dr. Williams felt Petitioner's complaints and findings were consistent with an acute thoracic strain, chronic thoracic compression fractures, and "possibly" a new thoracic compression fracture. He ordered an MRI that was negative for findings related to an acute injury.

The Arbitrator further notes that Petitioner was not entirely forthright and honest in his history to Dr. Buchowski. Contrary to his history provided, his thoracic back pain did not begin in September or October of 2010 "when he struck his back under a desk." They began in March of 2009 per his initial history to Dr. Oliver. It is also interesting to note that Petitioner didn't tell Dr. Buchowski he was asymptomatic prior to the April 25, 2011 accident. Rather, he stated that "his symptoms were worsened" thereby suggesting he was experiencing symptoms prior to April 25, 2011 and wasn't asymptomatic as he testified to at arbitration or to other providers. Furthermore, while Dr. Buchowski found Petitioner's symptoms causally related to his "work-related injury" the doctor didn't identify which work-related injury being referred to as Petitioner had discussed two injuries -- October of 2010 (which was the wrong date) and April of 2011.

Petitioner returned to see Dr. Smucker on October 13, 2011. Dr. Smucker's office notes indicate that Petitioner's physical examination and diagnosis remained unchanged from the 2010 visit. He had no further recommendations for Petitioner. He described the compression fractures as "chronic."

Petitioner was then examined by Dr. Hurford. As with other doctors, the history Petitioner provided is important. Petitioner told her of his March 2010 accident after which he was able to resume his prior activities but to a lesser extent. He acknowledged being unable to play softball and requiring more breaks. He could only run three miles per day whereas he had run five miles per day before March of 2010. This history is totally contrary to his arbitration testimony. Dr. Hurford noted no acute injuries. Her addendum and causation opinion was based on Petitioner's history of being pain-free and active as of April 25, 2011. Even then she felt Petitioner had suffered, at most, an exacerbation. She further noted Petitioner was impeding his own recovery through excessive inactivity, excessive smoking and pain medication. Surveillance video from September of 2011 is somewhat supportive of this as Petitioner is shown

standing on a porch, speaking on the phone, repeatedly smoking cigarettes. There is little, if any, sign of physical pain or discomfort. (RX 16)

Seven months after his last visit with Dr. Florence, he returned to see her in December of 2011 requesting pain medication. Petitioner would note, as he repeatedly would thereafter, that he could engage in activities of daily living with limitation but he nevertheless felt couldn't work.

Petitioner was released to return to light duty work as of February 3, 2012 and he did so. Between February 27, 2012 and June 12, 2012 Petitioner continued to treat with Dr. Williams. Injections helped very little. Dr. Williams repeatedly documented discussions with Petitioner regarding the chronic nature of his back condition. Dr. Williams noted Petitioner was depressed but never opined it was caused by the April 25, 2011 accident. Petitioner underwent physical therapy and, objectively, it appeared to be positive. The ongoing complaint was subjective back pain and aching.

Interestingly, Petitioner began taking on-line college classes while he was still on TTD and prior to his termination with Respondent. As of May and June of 2012 Dr. Williams' diagnoses were chronic thoracic back pain and Scheuermann's Disease. As of June 12, 2012 Petitioner was found to be functioning between the light and medium physical demand level. Dr. Williams released Petitioner to return to work at that time with only one permanent restriction and that restriction was given at Petitioner's request as he was worried about inmate contact in light of his back condition and multiple injuries. He was deemed at maximum medical improvement.

No doctor has opined that Petitioner needs any permanent physical restrictions as a result of the April 25, 2011 accident. No doctor has stated that Petitioner's depression was caused by the April 25, 2011 accident. When deposed, Dr. Williams testified that the restriction he imposed would have been appropriate regardless of the April 25, 2011 work accident.

Petitioner did not return to work for Respondent but it was not on account of the accident herein. No doctor has opined that Petitioner's inability to return to work was due to the April 25, 2011 accident. No doctor, or other expert, has opined that Petitioner needs vocational assistance as a result of the April 25, 2011 accident. The only doctor who has kept Petitioner off work since June 12, 2012 has been Dr. Florence, Petitioner's primary care doctor. However, this Arbitrator has not been persuaded, contrary to what might be stated in disability forms completed by the doctor, that Petitioner's inability to work since June 12, 2012 is the result, in whole or in part, of the April 25, 20111 accident. Dr. Florence is not an expert in orthopedics or depression. She has referred Petitioner to specialists in those areas. She has been treating Petitioner for a myriad of complaints and symptoms, problems and conditions – both physical

and mental. It is interesting that Petitioner was referred back to Dr. Williams for treatment of his bilateral upper extremity complaints in 2014. Absolutely no mention of any mid-back/thoracic problems was noted. Similarly, Petitioner has undergone a great deal of counseling with Mary Conklen and most, if not all of it, dealt with personal family issues and stressors at home.

The Arbitrator has serious questions about Petitioner's motivation herein. Petitioner has never returned to work for Respondent because he is fearful of further injuries to his thoracic spine, not because he cannot perform the job duties of a corrections officer. Given his underlying physical condition in his thoracic spine this fear can be understandable; however, it stems from an underlying chronic condition and not the April 25, 2011. With the foregoing in mind, the Arbitrator concludes as follows:

In support of the Arbitrator's Decision relating to (F), Is Petitioner's current condition of ill-being causally related to the injury?:

Petitioner failed to prove that his current condition of ill-being in his thoracic spine or right knee is causally related to his accident of April 25, 2011. Petitioner sustained an undisputed accident on April 25, 2011. The overwhelming majority of the evidence establishes Petitioner did not sustain any objective changes to his thoracic spine as a result of the work accident. Petitioner had two MRI studies of his thoracic spine performed prior to the work accident. They each showed wedging of the thoracic spine consistent with Scheuermann's Disease. X-rays taken on the date of the work accident did not reveal any acute findings. Similarly, an MRI taken of the thoracic spine May 16, 2011 did not reveal any acute pathology and a bone scan performed July 17, 2011 did not reveal any increased uptake or other evidence of an acute injury. The contusions diagnosed to Petitioner's right knee and mid-back resolved.

Dr. Joseph Williams, Petitioner's primary treating orthopedic surgeon, testified there were no objective changes in Petitioner's spine from before and after the work accident. Petitioner testified the symptoms in his mid-back worsened as a result of the work accident and have never resolved. However, Petitioner's testimony lacks credibility as discussed above. Petitioner's testimony and histories to various providers contained numerous inconsistencies leading to a reasonable conclusion that Petitioner is exaggerating his condition after this accident and not being upfront about the nature of his condition and/or injuries after the March 2010 work accident that he never reported. Petitioner testified that as a result of the work accident, he is no longer able to engage in various sporting activities. However, he admitted to Dr. Hurford that he stopped performing several sporting activities prior to the work accident due to an injury he sustained in 2010. Petitioner also told a nurse practitioner presumably in a psychiatrist's office that he sustained multiple fractures in his thoracic spine as a result of a work accident. Clearly, that information was not accurate.

Petitioner claimed he could not recall jumping up and down to retrieve Christmas lights from a tree in his yard 8 days before the trial, but the surveillance video admitted in evidence clearly shows Petitioner jumping up and down to retrieve Christmas lights from a tree. The surveillance video also shows Petitioner being somewhat active without showing any signs of pain or limitation.

Significantly, the functional capacity evaluation performed February 19, 2014 repeatedly notes inconsistencies between Petitioner's demonstrated capabilities and his actual capabilities. On the heel raise test and range of motion testing, Petitioner demonstrated significant limitations, but he was observed by the therapist performing similar activities without any limitation. Petitioner also reported to the therapist conducting the functional capacity evaluation that he could only sit for 15-20 minutes at a time. However, Petitioner acknowledged being able to drive for 45 miles which was thought to be between 40 and 60 minutes. Petitioner was also observed sitting without any difficulty for 23 minutes while providing his subjective history to the therapist. The therapist who performed the FCE ultimately concluded Petitioner's capabilities and limitations could not be determined based upon Petitioner's self-limiting performance during the FCE. Petitioner testified at trial that he was in pain and ill at the time of the FCE, but the FCE report makes no mention of Petitioner being ill or requesting that the exam be performed on a different day.

With respect to Petitioner's claim that he can no longer perform various sporting activities, he testified he has not even attempted any of those activities following the work accident because he is scared of making his condition worse. Consequently, he really cannot say whether or not he is capable of performing those activities.

There is also a question of whether Petitioner's fall in his shower in August 2011 severs the causal relationship between the work accident and Petitioner's current condition. Dr. Williams testified that the work accident aggravated Petitioner's spinal condition, but he was unable to state with any certainty whether the aggravation would be permanent. He also indicated Petitioner's symptoms increased following the fall in the shower, and Petitioner never reported that his symptoms improved following the shower incident. Similarly, Petitioner told Dr. Buchowski that his symptoms were "worsened" by the April 25, 2011 accident.

Based upon the complete lack of any change in the diagnostic studies and the overwhelming evidence that Petitioner did not sustain an acute injury to his spine, along with significant credibility issues, the preponderance of the evidence supports the conclusion that Petitioner suffered a thoracic strain or exacerbation of his underlying chronic thoracic spine condition as a result of the April 25, 2011 work accident. However, Petitioner was at maximum medical improvement as a result of those injuries by June

12, 2012. No doctor credibly and persuasively opined that Petitioner's depression was caused or aggravated by the accident of April 25, 2012. Finally, the Arbitrator notes that a chain of events analysis is inappropriate herein given Petitioner's pre-existing condition in his thoracic spine and the significant credibility issue regarding his condition pre-accident. Pursuant to the opinions of Dr. Williams and Dr. Hurford, the Arbitrator concludes Petitioner failed to prove his current condition of ill-being is causally related to the 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 adopts and incorporates herein the findings set forth above.

Petitioner submitted medical bills from Koke Mill Medical Associates consisting of charges from Dr. Nicole Florence. Petitioner also submitted charges from pharmacies relating to prescriptions filled by Petitioner and a bill from Memorial SpineWorks Pain Center for an injection performed by Dr. Salvacion.

The bills from Dr. Florence reflect Respondent paid for all of Petitioner's medical treatment incurred through the time he reached maximum medical improvement June 12, 2012. The remaining charges were from after Petitioner reached a point of maximum medical improvement and are therefore denied. Additionally, some of the charges from Dr. Florence are entirely unrelated to the work accident. The bills include charges for treatment relating to dermatitis, a flu shot, and sinusitis.

Petitioner's Exhibit 11 sets forth numerous prescription charges. Respondent's Exhibit 2 sets forth an itemization of payments made by Respondent including numerous payments to Pharmaceutical Technologies and to Injured Workers' Pharmacy.

Based upon the facts presented in this case, Respondent is liable for the payment of the prescription charges associated with the medications prescribed by Dr. Florence and Dr. Williams through June 12, 2012. Respondent is not liable for the payment of Petitioner's prescription medication after June 12, 2012.

Comparing Petitioner's Exhibit 11 with Respondent's Exhibit 2, it appears the charges from Injured Workers' Pharmacy have all been paid by Respondent including payments for prescriptions rendered after Petitioner's MMI date.

With respect to the charges from Walgreens and HyVee pharmacies, the charges total $132.20, and through Pharmaceutical Technologies, Respondent paid $523.83.

The charges from Dr. Salvacion correspond with an injection performed March 19, 2013.

Based upon Petitioner reaching maximum medical improvement in June 2012 and based upon the opinion of Dr. Smucker who indicated injections were not indicated, Petitioner's claim for the payment of Dr. Salvacion's charges is denied.

Based upon the foregoing, the Arbitrator concludes that Respondent has paid all appropriate prescription charges and Petitioner's claim for the payment of any additional prescription charges is denied.

In support of the Arbitrator's Decision relating to (K), What temporary benefits are in dispute? (TTD):

The Arbitrator adopts and incorporates herein the findings set forth above.

It is axiomatic that TTD benefits are to be paid until a claimant's work-related condition reaches a point of stability. When a claimant reaches maximum medical improvement that is commonly determined to be the point when TTD benefits shall terminate. However, a claimant is not entitled to TTD benefits if he returns to work in either a light-duty or full-duty capacity. Here, Petitioner returned to work in a light-duty capacity February 8, 2012. He continued working a light-duty capacity until he was terminated effective August 9, 2012.

While working in a light-duty capacity, Petitioner's primary treating orthopedic surgeon, Dr. Williams, imposed a permanent restriction preventing Petitioner from having contact with inmates. Dr. Williams also discharged Petitioner from care on June 12, 2012 and Petitioner did not return to see him again until over two and one-half years later for a completely different problem.

As Dr. Williams was Petitioner's primary treating physician, his discharge from care and imposition of permanent restrictions weighs heavily in favor of Petitioner being at maximum medical improvement as of June 12, 2012.

Petitioner did continue to receive medical treatment from Dr. Florence, his primary care physician after June 12, 2012. The treatment only consisted of Dr. Florence prescribing pain medications. Other than maintaining Petitioner's pain medications, there is no indication Dr. Florence provided any treatment intending to cure Petitioner's subjective complaints. While Dr. Florence completed disability forms for Petitioner and indicated his inability to work was due to the accident of April 25, 2011, the Arbitrator does not find those forms and information contained therein persuasive enough to support an award for ongoing TTD benefits. Dr. Florence is not a specialist in orthopedics or psychiatry. She treated Petitioner before April 26, 2011 for similar symptoms and complaints and did not address those in rendering her

"opinion" as arguably set forth in those forms. Furthermore, those forms contain no persuasive explanation as to the basis of her "opinions" as set forth in the forms. Dr. Florence was not deposed.

Following the discharge from care by Dr. Williams, Petitioner routinely complained of varying levels of pain in his back, but as indicated above, the Arbitrator finds the legitimacy of Petitioner's subjective complaints to be suspect.

The preponderance of the evidence establishes Petitioner returned to work in February of 2012, and he reached maximum medical improvement on June 12, 2012. Consequently, Petitioner's claim for TTD benefits after February 7, 2012 is denied.

In support of the Arbitrator's Decision relating to (K), What temporary benefits are in dispute? (Maintenance):

The Arbitrator adopts and incorporates herein the findings set forth above.

Petitioner alleges entitlement to maintenance benefits from August 10, 2012 through the time of trial May 23, 2016. Respondent contends Petitioner is not entitled to any maintenance benefits.

The Appellate Court has established maintenance benefits should be awarded to a claimant engaged in a prescribed rehabilitation program. *Nascote Industries v. Industrial Comm'n*, 353 Ill.App.3d 1067 (2004). Additionally, the Supreme Court of Illinois has held a claimant is entitled to rehabilitation where he sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. *National Tea Company v. Industrial Comm'n*, 97 Ill.2d 424 (1983). In contrast, rehabilitation awards have been deemed inappropriate where a claimant is not "trainable" due to age, education, training and occupation, or where a claimant has sufficient skills to obtain employment without further training or education. Other appropriate factors include the relative costs and benefits to be derived from the program. The Supreme Court of Illinois expressly stated the interest of the employer must be considered in determining an appropriate rehabilitation program. *Id.*

Here, Petitioner was discharged from care by Dr. Williams with no physical restrictions. The only restriction was that Petitioner was to avoid having contact with inmates. However, Dr. Williams testified the restriction would have been necessary even if the work accident had not occurred. Consequently, no restrictions were imposed as a result of the work accident.

No evidence was presented suggesting Petitioner does not have sufficient skills to obtain employment without further training or education. Petitioner is a high school graduate with a minimal amount of college education. In addition to his position as a correctional officer, Petitioner has worked in the automotive industry, worked in security, and he worked in management as a banquet manager.

Significantly, Petitioner did not make any attempt to return to the workforce after he was terminated by Respondent. Petitioner did not present any evidence establishing there is no stable labor market for Petitioner. Petitioner also did not present any evidence that he would suffer a decreased earning capacity as a result of the restriction to avoid contact with inmates.

When the lack of evidence presented by Petitioner is coupled with a questionable need for the restrictions imposed by Dr. Williams and the suspect legitimacy of Petitioner's subjective complaints, the Arbitrator finds Petitioner has failed to prove entitlement to maintenance benefits.

In support of the Arbitrator's Decision relating to (L), What is the nature and extent of the injury?:

The Arbitrator adopts and incorporates herein the findings set forth above.

As indicated above, the evidence establishes the most likely injury sustained by Petitioner was a thoracic strain and a temporary exacerbation of Thoracic Degenerative Disc Disease. Petitioner has continued to complain of symptoms and limitations as a result of the work accident. However, Dr. Williams did not impose any physical restrictions on Petitioner's activities. Dr. Hurford rendered an opinion Petitioner's condition is no longer related to the work accident and he does not need to have any restrictions on his activities as a result of the work accident. The surveillance video suggests Petitioner is capable of functioning at a higher level than he contends. Additionally, the Arbitrator finds Petitioner's subjective complaints in light of his testimony, the functional capacity evaluation and the surveillance video are suspect.

Based upon the foregoing, the Arbitrator finds Petitioner sustained permanent disability to the extent of 7.5% of a person as a whole.

In support of the Arbitrator's Decision relating to (O), Other: Vocational Rehabilitation expenses:

Petitioner is claiming entitlement to a reimbursement for the costs associated with Petitioner's online university courses.

As indicated above, the Supreme Court of Illinois has established a claimant is entitled to rehabilitation when a work injury causes a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. *National Tea Company v. Industrial Comm'n*, 97 Ill.2d 424 (1983). However, a claimant is not entitled to rehabilitation benefits when he has sufficient skills to obtain employment without further training or education.

Here, Petitioner's only restriction from his primary treating physician was to avoid contact with inmates and that restriction was not made necessary by the work accident. Dr. Williams did not impose any physical restrictions on Petitioner's activities. Similarly, Dr. Hurford rendered an opinion any limitations suffered by Petitioner are not due to the work accident.

Petitioner did not present any evidence establishing he will suffer from a decreased earning capacity as a result of the work accident. Additionally, Petitioner acknowledged he did not make any attempt to return to the workforce after being terminated by Respondent.

Petitioner is relying upon the imposition of a single restriction by Dr. Williams to avoid inmate contact to support a position that he is entitled to vocational rehabilitation and ongoing maintenance benefits. However, with there being no physical restrictions preventing Petitioner from returning to the workforce and with the only restriction being necessary even if the work accident never occurred, and with Petitioner not presenting any evidence that there is no stable labor market or that he will suffer from a decreased earning capacity, Petitioner has failed to prove entitlement to rehabilitation expenses.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Gilmore, Sr.,

Petitioner,

17IWCC0460

vs.

NO: 11 WC 40540

Hull Trucking of Mason City IL Inc,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

17IWCC0460

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: JUL 19 2017
o7/13/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0460

GILMORE SR, JOHN
Employee/Petitioner

Case# **11WC040540**

12WC018726

HULL TRUCKING OF MASON CITY IL INC
Employer/Respondent

On 12/12/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2593 GANAN & SHAPIRO PC
SARAH ANTRIM
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

17IWCC0460

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Gilmore, Sr.
Employee/Petitioner

v.

Hull Trucking of Mason City, Illinois, Inc.
Employer/Respondent

Case # 11 WC 45040

Consolidated cases: 12 WC 18726

An *Application for Adjustment 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 Peoria, on October 20, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ____

FINDINGS

On the date of accident, July 31, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $41,600.00; the average weekly wage was $800.00.

On the date of accident, Petitioner was 51 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $8,758.81 for other benefits, for a total credit of $8,758.81.

Respondent is entitled to a credit of $4,076.93 under Section 8(j) of the Act. Total amount in this case and 12 WC 18726.

ORDER

Respondent shall pay reasonable and necessary medical expenses, provided from August 7, 2011, through December 14, 2015, as identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Conclusions of Law attached hereto, Petitioner's petition for prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of $533.33 per week for 248 4/7 weeks commencing July 31, 2011, through May 5, 2016, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

December 9, 2016
Date

DEC 12 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 12 WC 18726, the Application alleged that on January 4, 2010, Petitioner was "injured at work" and sustained an injury to the "back and other parts of the body" (Arbitrator's Exhibit 4). As is later noted herein, at trial, Petitioner's counsel made a motion to change the date of accident to January 5, 2010, which was granted by the Arbitrator. In case number 11 WC 40540, the Application alleged that on July 31, 2011, Petitioner was "injured at work" and sustained an injury to the "back and other parts of the body" (Arbitrator's Exhibit 3). These two cases were previously consolidated for trial.

These cases were tried in a 19(b) proceeding and Petitioner sought orders for payment of temporary total disability benefits and medical as well as prospective medical treatment. In case number 12 WC 18726, Respondent disputed liability on the basis of accident, notice and causal relationship. In case number 11 WC 40540, Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner began working for Respondent sometime in 2004, as a truck driver. Prior to both of the accidents, Petitioner underwent three low back surgeries.

Petitioner had his first lumbar surgery performed in April, 1996. The medical records regarding that surgery were not tendered into evidence; however, when Petitioner was seen by Dr. Timothy VanFleet, an orthopedic surgeon, on July 9, 1999, Dr. VanFleet noted that Petitioner had undergone lumbar surgery in April, 1996, by Dr. Wacaser (Respondent's Exhibit 6).

When Dr. VanFleet saw Petitioner on July 9, 1999, he diagnosed Petitioner with cervical radiculopathy and lumbar spondylosis. Dr. VanFleet treated Petitioner for several years for low back symptoms. On December 3, 2003, Dr. VanFleet performed back surgery which consisted of a bilateral discectomy at L4-L5. Following surgery, Dr. VanFleet ordered physical therapy and subsequently released Petitioner to return to work without restrictions on February 6, 2004 (Respondent's Exhibit 6).

Petitioner subsequently had low back surgery performed on December 11, 2006. At that time, Petitioner's treating physician was Dr. Brian Russell, a neurosurgeon. The surgery consisted of fusions at the L4-L5 and L5-S1 levels (Respondent's Exhibit 11).

At trial, Petitioner testified that after the fusion surgery he returned to work in February, 2007. Petitioner stated that he was on light duty for six months and was then authorized to return to work at full duty.

In regard to the January, 2010, accident, Petitioner stated that on January 4, 2010, he was required to transport a load of seed to a fertilizer company. While Petitioner was in the process of unloading the seed, he felt a "pop" in his low back. Petitioner testified that he called his supervisor, Dennis Hull, that same day and informed him that he had sustained an injury.

Petitioner initially sought medical treatment on January 8, 2010, when he was seen by Cindy Noll, a nurse practitioner. According to her record of that date, Petitioner had a back fusion three years prior and was doing well until four days ago when he experienced pain in his low back while unloading pallets off of a semi. NP Noll diagnosed Petitioner with recurrent low back pain and prescribed some medications (Petitioner's Exhibit 2).

Petitioner was able to continue to work and did not seek any further medical treatment until June 28, 2010, when he was seen by Dr. Diane Hillard-Sembell. At that time, Petitioner stated that he had hurt his back and right leg while pulling pallets of seed. Dr. Hillard-Sembell ordered an MRI and referred Petitioner to Dr. Brian Russell (Petitioner's Exhibit 2).

On July 27, 2010, Petitioner was seen by Dr. Michael Markley, and an MRI of the lumbar spine was performed that same day. The MRI revealed a disc herniation at L3-L4 on the left side (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Russell on September 1, 2010. According to Dr. Russell's record of that date, Petitioner informed him that he had hurt his back at work pushing pallets, but said "...this is not a workmen's comp case." Dr. Russell reviewed the MRI and opined that it indicated a disc herniation at L3-L4. He recommended Petitioner have an epidural injection (Petitioner's Exhibit 3).

Petitioner had epidural steroid injections performed on October 26, and November 16, 2010, at L3-L4 (Petitioner's Exhibit 3). At trial, Petitioner testified that the injections did not help, but he was able to continue to work.

Dennis Hull testified on behalf of the Respondent at trial. Hull stated that Petitioner did not inform him that he had sustained an injury in January, 2010. Hull also identified Petitioner's mileage records and stated that they indicated Petitioner hauled bulk corn, not seed, on January 4, 2010. However, Hull agreed that the records also indicated that on the following day, January 5, 2010, Petitioner made a delivery of seed (Respondent's Exhibit 9). Hull also testified that Petitioner did inform him sometime in April, 2010, that he had injured his back hauling sand.

At trial, Petitioner testified in rebuttal and stated that the accident could have occurred on January 5, 2010. At that time, Petitioner's counsel made an oral motion to amend the Application to show the date of accident as January 5, 2010. The Arbitrator granted that motion.

Petitioner was seen by Dr. Markley on January 21, 2011, for a DOT physical. It was noted that Petitioner had a history of a back fusion, but it was stable. Petitioner passed the physical (Petitioner's Exhibit 2).

In regard to the accident of July 31, 2011, Petitioner testified he was hauling sand in a grain hopper. When Petitioner attempted to open the door to the hopper, he again felt a "pop" in his back.

In regard to the July, 2011, accident, Dennis Hull testified that Petitioner informed him that he injured his back at home while weed wacking. However, on cross examination, Hull also stated that Petitioner informed him that his back bothered him while he was hauling sand.

Subsequent to the accident of July 31, 2011, Petitioner went to the ER of Mason District Hospital on August 7, 2011. According to the ER record, Petitioner was in his usual state of health until approximately eight days ago when he was doing some "weed whacking" and experienced right low back and right leg pain. There was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 4).

An MRI was performed on August 8, 2011. It revealed an acute disc herniation at L3-L4 with a right lateral recess compression (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Markley on August 22, 2011. At that time, Petitioner complained of back pain with parasthesias. Dr. Markley reviewed the MRI and opined that Petitioner had an acute disc herniation at L3-L4 with a migrated fragment into the right lateral recess. There was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Russell on September 27, 2011. Dr. Russell's record of that date noted that Petitioner had reinjured his back in late July while pushing some heavy pallets. He opined that Petitioner might require a discectomy at L3-L4 and possible extension of the fusion to that level (Petitioner's Exhibit 3).

Dr. Russell saw Petitioner again on December 20, 2011, and he renewed his recommendation that Petitioner consider having another fusion surgery. He also stated that Petitioner had sustained a couple of injuries at work and noted "I think it is reasonable to assume that his lifting injuries at work, particularly the latest injury that required a hospitalization likely exacerbated his problems." (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Patrick O'Leary, an orthopedic surgeon, on May 9, 2013. In connection with his examination of Petitioner, Dr. O'Leary reviewed medical records provided to him by Respondent as well as the MRI of August, 2011. When Petitioner was seen by Dr. O'Leary, Petitioner informed him that he injured his back in January, 2010, while pushing pallets and reinjured his back in July, 2011, while lifting bags of sand. In regard to causality, Dr. O'Leary opined that the January, 2010, accident could have aggravated his back condition, but that the symptoms resolved to where Petitioner could return to work. He also opined that the July, 2011, accident caused the onset of acute low back and right leg pain (Respondent's Exhibit 4).

Dr. O'Leary also opined that the medical treatment provided to Petitioner to date was reasonable and necessary. However, in regard to future medical treatment, he opined that no further treatment, diagnostic testing or therapy was indicated and Petitioner was at MMI. He further stated that Petitioner should refrain from repetitive bending, twisting and stooping from the waist as well as no lifting over 40 pounds. He further opined that Petitioner could walk four to six hours per day, sit for three to five hours per day and drive one hour per day. He also stated

Petitioner would require frequent breaks to adjust position and prolonged standing would not be tolerable (Respondent's Exhibit 4).

Petitioner was seen by Dr. Markley on September 16, 2013. At that time, Petitioner continued to complain of low back pain with radiculopathy into both legs. Petitioner was able to walk and Dr. Markley declined to give him a parking placard (Respondent's Exhibit 15).

Dr. Russell was deposed on January 17, 2014, and his deposition testimony was received into evidence at trial. Dr. Russell's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to the January, 2010, accident, Dr. Russell stated that it could have caused the disc herniation at L3-L4. He also testified that the accident of July 31, 2011, could have caused the disc herniation and nerve root compression, but that the second accident was more of an aggravation. Dr. Russell also testified that when he saw Petitioner on September 27, 2011, he recommended Petitioner have a discectomy and extension of the fusion at L3-L4. As to Petitioner's ability to work, Dr. Russell opined Petitioner was limited to light duty with no lifting over 20 pounds (Petitioner's Exhibit 1; pp 7-13).

Dr. O'Leary was deposed on January 30, 2014, and his deposition testimony was received into evidence at trial. Dr. O'Leary's deposition testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He specifically reaffirmed his opinion that the two accidents aggravated Petitioner's low back condition (Respondent's Exhibit 1; pp 11-14).

Dr. O'Leary also testified that given the fact that Petitioner had not worked since July, 2011, and his symptoms had been relatively stable, the likelihood of Petitioner having surgery and improving was minimal. He stated that unless Petitioner had a progressively worsening condition it was unlikely that surgery would result in any substantial improvement (Respondent's Exhibit 1; pp 18-21).

Dr. Russell saw Petitioner on March 12, 2014. At that time, Petitioner stated that his pain had gotten progressively worse and he wanted to discuss surgery. Dr. Russell noted that, given the length of time since he last saw Petitioner, some physical therapy was appropriate. If afterward, Petitioner was still having symptoms, then Petitioner would need another MRI before any decision would be made regarding further decompression and extension of the fusion (Petitioner's Exhibit 7).

Dr. Russell did not evaluate Petitioner again until he saw him on November 24, 2015. At that time, Petitioner's leg weakness had worsened. Dr. Russell opined that Petitioner needed surgery because Petitioner had developed some neurological compromise. He ordered another MRI scan (Petitioner's Exhibit 11).

The MRI was performed on December 14, 2015, and it revealed a moderate disc bulge at L3-L4, and the radiologist noted that the disc herniation previously observed at that level was not present (Respondent's Exhibit 10).

Again, at the direction of Respondent, Dr. O'Leary examined Petitioner on May 5, 2016. In connection with his examination of Petitioner, Dr. O'Leary reviewed up-to-date medical records

provided to him by Respondent as well as the MRI of December 14, 2015. Dr. O'Leary's reading of the MRI scan was consistent with the interpretation of the radiologist and he opined that the herniated disc present on the prior scan had resolved. In regard to causality, Dr. O'Leary opined that it was now difficult to relate Petitioner's current condition of ill-being to the accidents given the fact the MRI showed an improvement of the condition at L3-L4 (Respondent's Exhibit 5).

Dr. O'Leary again opined Petitioner was at MMI and was capable of working at full duty with restrictions of walking from four to six hours per day, sitting for three to five hours per day and no lifting over 40 pounds. He again stated that no further treatment was indicated, especially given the findings of the recent MRI (Respondent's Exhibit 5).

Dr. O'Leary was deposed for the second time on September 1, 2016, and his deposition testimony was received into evidence at trial. Dr. O'Leary's deposition testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, in regard to his reading of the December, 2015, MRI scan, Dr. O'Leary opined that the disc at L3-L4 had resorbed, so Petitioner no longer had a disc herniation. His diagnosis was Petitioner had chronic low back pain with lumbar degeneration (Respondent's Exhibit 2; pp 12-13).

In regard to causality, Dr. O'Leary stated that Petitioner's current state was due to his chronic underlying condition. He testified that Petitioner was at a point where no further medical treatment would change his underlying condition. However, on cross-examination, Dr. O'Leary agreed that the January, 2010, accident could have caused the herniated disc at L3-L4 (Respondent's Exhibit 2; pp 18-21, 34-35).

At trial, Petitioner testified that he has not been able to work since July 31, 2011, because of daily pain in his back and right leg. Petitioner stated that he is unable to sit very long and wants to proceed with the surgery as recommended by Dr. Russell.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on July 31, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that on July 31, 2011, he was hauling sand in a grain hopper and, when he attempted to open the hopper door, he injured his back.

The only medical records that did not contain a history of a work-related accident were the ER record of August 7, 2011, which stated that Petitioner was "weed whacking" and the records of Dr. Markley of August 22, 2011, which contained no history at all. Dennis Hull also testified that Petitioner reported that he injured his back while weed wacking; however, he also agreed that Petitioner informed him that his back bothered him while hauling sand.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to the accident of July 31, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner had three low back surgeries including a fusion prior to the accident of July 31, 2011. Even after the earlier work-related accident of January 5, 2010, Petitioner was able to work without restrictions as a truck driver.

Petitioner's treating physician, Dr. Russell, testified that the accident of July 31, 2011, could have caused the disc herniation at L3-L4 and nerve root compression, but that it was more of an aggravation than the prior accident of January, 2010.

At the time of his first examination of Petitioner on May 9, 2013, Respondent's Section 12 examiner, Dr. O'Leary, opined that the accident of July, 2011, could have caused the onset of acute low back and right leg pain.

It was when Dr. O'Leary examined Petitioner on May 5, 2016, that he changed/modified his opinion in regard to causality. However, this was based primarily on his review of the MRI of December 14, 2015, which revealed that the herniated disc at L3-L4 was no longer present.

The Arbitrator is persuaded that, even with the resolution of the disc herniation at L3-L4, the accident of July 31, 2011, was a causative factor in regard to Petitioner's current condition of ill-being.

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

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

Respondent shall pay reasonable and necessary medical services provided from August 7, 2011, through December 14, 2015, identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes that Petitioner is not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physician, Dr. Russell, opined that Petitioner should undergo another back surgery consisting of a discectomy at L3-L4 and possible extension of the fusion to that level.

When Dr. Russell last evaluated Petitioner on November 24, 2015, he renewed his surgical recommendation; however, he also ordered another MRI scan.

The MRI scan performed on December 14, 2015, revealed that the disc herniation previously observed at L3-L4 was no longer present. This was noted by both the radiologist who performed the MRI and Dr. O'Leary when he examined Petitioner on May 5, 2016.

Based upon his earlier exam of May 9, 2013, Dr. O'Leary opined that further back surgery was not indicated and he reaffirmed this opinion when he saw Petitioner on May 5, 2016, especially when considering the MRI of December 14, 2015, which revealed that the disc herniation at L3-L4 had resolved.

There was no evidence tendered that Dr. Russell ever reviewed the MRI of December 14, 2015, and whether he would still recommend Petitioner have the back surgery that he previously recommended.

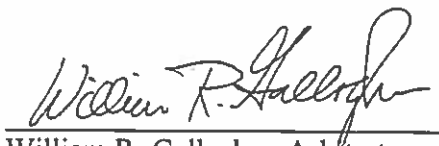
In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 248 4/7 weeks commencing July 31, 2011, through May 5, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner was unable to work subsequent to the accident of July 31, 2011.

When examined by Dr. O'Leary on May 5, 2016, Dr. O'Leary opined that Petitioner was at MMI and imposed work/activity restrictions.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Salvatore DiFranco,
Petitioner,

vs.

NO: 12 WC 08313
12 WC 08314

City of Chicago,
Respondent.

ORDER

This matter comes before the Commission on "Motion to substitute Andrea DiFranco, as Special Representative for the Estate of Salvatore DiFranco, deceased, for Salvatore DiFranco and to compel Respondent to pay benefits awarded in the October 27, 2016, award to Andrea DiFranco", having been filed by Petitioner herein and due notice having been given, this cause came for hearing before Commissioner Luskin on April 19, 2017 in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, finds:

The petitioner, Salvatore DiFranco, filed two Applications for Adjustment of Claim, receiving the above-noted case numbers. The claims ultimately proceeded to hearing over the course of two days, on September 23 and 25, 2015. The Arbitrator took the matter under advisement following closure of proofs on September 25, 2015.

The Arbitrator authored decisions on both claims, which were filed on October 12, 2016. In case 12 WC 8313, the Arbitrator found the claimant failed to prove an accident occurred on or about September 2, 2011, and that no causal connection to any such accident had been demonstrated; benefits regarding that claim were accordingly denied. In case 12 WC 8314, the Arbitrator found the claimant had proven a January 9, 2012, accident, and awarded the claimant certain medical expenses, 99 weeks of TTD benefits, and 40 weeks of PPD benefits representing 8% of the whole person pursuant to Section 8(d)2. The Arbitrator also awarded the respondent credit for any amounts paid, including $105,269.63 in disability benefits. Neither party petitioned either case for review by the Commission.

Unbeknownst to the Arbitrator at the time the decisions were filed, the claimant died of unrelated causes (coronary artery disease) on October 4, 2016. A copy of the death certificate was appended to the above-noted motion as attachment "C."

The claimant's widow filed the above-titled motion on March 16, 2017, requesting an order be entered ordering that the award of disability benefits be awarded to her in the above-captioned matters pursuant to Section 8(e)19 of the Act. At the hearing before the Commissioner, the marriage certificate was introduced as attachment "B" and the deceased claimant's widow testified she continued to be known by her married name of Andrea DiFranco. She testified that she and the claimant had three adult children, ages 34, 30 and 30 (twins). The claimant had one other child from a prior relationship, aged 45, who was not financially dependent on the claimant. Ms. DiFranco requested that the benefits due be paid to her under her married name.

The Arbitrator found the respondent liable for certain medical benefits, which were to be paid to the providers, as well as 99 weeks of TTD benefits, a total liability of $92,928.33, with credit for TTD benefits of $105,269.63 having been paid. The PPD award of 40 weeks presents a liability to the respondent of $27,831.20; after noting the overpayment of disability of $12,341.30 to be applied against the PPD award, a present outstanding liability of $15,489.90 results.

Accordingly, the respondent is hereby ordered to pay the outstanding $15,489.90 to the claimant's widow, Andrea DiFranco, pursuant to Section 8(e)19 of the Act.

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

DATED: JUL 11 2017

Joshua D. Luskin

jdl/mp
r-04/19/17

68

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

Catherine Berger,
Petitioner,
vs.

NO: 12 WC 01388

Illinois Department of
Commerce & Economic Opportunity,
Respondent,

17IWCC0463

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, causal connection, 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 15, 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.

DATED: JUL 21 2017
o062917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERGER, CATHERINE
Employee/Petitioner

Case# **12WC001388**

IL DEPT OF COMMERCE & ECONOMIC OPPORTUNITY
Employer/Respondent

17IWCC0463

On 12/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

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

DEC 15 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

C. Berger v. Illinois Dept. of Commerce, etc.

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

Catherine Berger
Employee/Petitioner

Case # 12 WC 01388

IL Dept. of Commerce & Economic Opportunity
Employer/Respondent

17IWCC0463

An *Application for Adjustment 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 **October 6, 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 _____

17IWCC0463

FINDINGS

On **1/5/2012**, 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 not* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$74,147.80**; the average weekly wage was **$1,425.92**.

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

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

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

Respondent shall be given a credit of **$0.00** 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

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent.

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

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

Signature of Arbitrator

December 14, 2016
Date

DEC 15 2016

FINDINGS OF FACT

Petitioner worked for Respondent as an Executive Assistant from 2005 to 2015. She worked on the 3rd floor of the James R.Thompson Center (JRTC) , a building owned by Respondent, State of Illinois. Petitioner was working for Respondent on January 5, 2012. That afternoon, Petitioner took a walk for her afternoon break. She was walking through the ground floor atrium of the JRTC when her right foot slipped and she fell to the ground. Petitioner testified that she was on a mandatory, paid, break and was returning to her office from going to the bank. She testified that she walks to stretch her legs during her breaks. She testified that Respondent suggests that employees leave Respondent's premises for their breaks. She was not required to leave the premises on her break. After the fall, Petitioner immediately felt pain in her right arm, left arm, and left shoulder. Upon surveying the scene Petitioner saw a yellow cone, approximately 18-24 inches high, placed on the marble floor in the area when she had slipped. Petitioner testified that she was wearing rubber-soled heels and that she believes that she slipped on something slick. In her mind, Petitioner thought that she slipped on something wet, but she did not see anything. Petitioner's fall was on the street level of the building in the area near the Randolph/Clark street entrances. She fell in front of what is now the Walgreens. The Illinois State Police immediately responded and Petitioner was transported to Northwestern Memorial Hospital, via ambulance.

Petitioner filled out a Notice of Injury, dated January 20, 2012. In this document, she reported that her right heel slipped on something on the floor. After she fell, she noticed the yellow cone about 6-8 feet from where she slipped. The weather outside was dry all day and she did not know why the cone had been placed there. She did not report that the floor was wet and did not say that her pants or purse was wet. (PX 1) After Petitioner submitted the injury report, she was advised that her claim was denied.

The JRTC building has entrances on 3 sides of the building. Respondent did not direct her as to which entrance to use. The building is open to and used by various members of the public. At least hundreds of people come through the JRTC every day.

Petitioner was treated in the emergency department at Northwestern. She complained of left shoulder pain radiating to her elbow. X-rays of Petitioner's left arm revealed a non-displaced fracture of the left greater tuberosity and a mildly displaced fracture fragment from the surgical neck. According to the triage notes, Petitioner reported that she had been walking and her right foot slipped on a marble floor and she fell, bracing herself with her left arm. The history contained in the ATTENDING INPUT was: "Pt is a 56 yo female o/w healthy who slipped on wet floor falling on outstretched hand. Had pain to her L shoulder immediately with limited ROM." The nurses' notes state that she was walking and tripped on a marble floor. The history of present illness states that the patient was walking at work on a marble floor and slipped. Petitioner was discharged with a sling, prescribed Norco and was advised to follow up with an orthopedist. (PX 2)

Petitioner sought follow up care with Dr. Robert Carbone, her PCP, at DuPage Medical Group on January 9, 2012. Dr. Carbone noted that Petitioner had slipped and fallen at work on January 5, 2012. (PX 3) Petitioner was referred for an orthopedic consultation. On January 11, 2012, she saw Dr. Samuel Park with DuPage Medical Group. Dr. Park diagnosed the Petitioner with fractures in her left arm, placed Petitioner in a sling, and took Petitioner off work until January 17, 2012. Petitioner testified that she used her personal days and received full pay from the Respondent while she was off work during the lost time from work.

Petitioner followed up with Dr. Park on January 18, 2012 and physical therapy was ordered. It was noted that the fracture alignment was maintained. Petitioner had physical therapy performed at DuPage Medical Group from January 20, 2012 through March 31, 2012. (PX 3)

Petitioner followed up with Dr. Park on February 6, 2012 and it was noted that the fractures were healing. Physical therapy was continued. On April 2, 2012, Petitioner again saw Dr. Park and it was noted that she was having difficulty reaching behind her back and had a positive impingement test in her left shoulder. Dr. Park recommended an MRI and discussed injections, which the Petitioner declined. Petitioner testified that it was discussed that she could potentially have surgery or simply live with the issues. This is not charted. (PX 3)

An MRI of the Petitioner's left shoulder, performed on May 19, 2012 at Chicago Ridge Radiology, revealed mild degenerative changes of the A/C joint, partial tear of the supraspinatus tendon, tendinosis of the distal subscapularis tendon and impingement. (PX 4)

Following the MRI, Petitioner did not seek any further medical care for her condition, opting to "live with it", as she did not wish to have any surgery. Petitioner testified that prior to January 5, 2012 she had never had any issues with her left shoulder or arm. Since the injury, she has been unable to do things such as swim, push herself up from a seated position, or lift things such as pans. She continues to complain of pain, weakness, and limited range of motion. She takes Aleve whenever she has pain, which is typically twice per month. She is right handed and performs most tasks with her right upper extremity.

Respondent submitted no witnesses or documentary evidence. Neither Party submitted any video evidence.

CONCLUSIONS OF LAW

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

B. ACCIDENT

Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on January 5, 2012.

Petitioner was on break and in Respondent's building where she worked (albiet in an area regularly traversed by members of the public who are not employees of Respondent) when she slipped and fell, injuring her left arm. The injury occurred in the course of her employment.

If the fall occurred on Respondent's premises and it was due to a hazardous condition of the premises, the injury would arise out of Petitioner's employment. In this case, Petitioner's testimony, the Notice of Injury, and the medical records do not establish that there was a hazardous condition of Respondent's premises that caused

the fall. There is a lack of evidence regarding what Petitioner slipped on. Therefore, it cannot be said that Respondent's premises was defective and contributed to the fall. Liability cannot be based upon conjecture-it must be based on facts contained in the Record. Here, it was not shown that the fall was as a result of a hazardous condition of Respondent's premises or was associated with a risk incidental to or connected with the employment. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52 (1989)

The injury did not arise out of Petitioner's employment by Respondent. Therefore, the claim for compensation is denied.

F. CAUSAL CONNECTION; J. MEDICAL EXPENSES; L. NATURE & EXTENT

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent, the Arbitrator needs not decide these issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Gilmore, Sr.,

Petitioner,

17IWCC0459

vs.

NO: 12 WC 18726

Hull Trucking of Mason City IL Inc,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 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 $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 19 2017
o7/13/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0459

GILMORE SR, JOHN
Employee/Petitioner

Case# **12WC018726**

11WC040540

HULL TRUCKING OF MASON CITY IL INC
Employer/Respondent

On 12/12/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2593 GANAN & SHAPIRO PC
SARAH ANTRIM
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

17IWCC0459

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Gilmore, Sr.
Employee/Petitioner

Case # 12 WC 18726

v.

Consolidated cases: 11 WC 40540

Hull Trucking of Mason City, Illinois, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on October 20, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, January 5, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $35,880.00; the average weekly wage was $690.00.

On the date of accident, Petitioner was 49 years of age, married with 0 dependent child(ren).

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

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

Respondent is entitled to a credit of $4,076.93 under Section 8(j) of the Act. Total amount in this case and 11 WC 40540.

ORDER

Respondent shall pay reasonable and necessary medical expenses, provided from January 8, 2010, through January 21, 2011, as identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Conclusions of Law attached hereto, Petitioner's petition for prospective medical treatment is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

December 9, 2016
Date

DEC 12 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment for Respondent. In case number 12 WC 18726, the Application alleged that on January 4, 2010, Petitioner was "injured at work" and sustained an injury to the "back and other parts of the body" (Arbitrator's Exhibit 4). As is later noted herein, at trial, Petitioner's counsel made a motion to change the date of accident to January 5, 2010, which was granted by the Arbitrator. In case number 11 WC 40540, the Application alleged that on July 31, 2011, Petitioner was "injured at work" and sustained an injury to the "back and other parts of the body" (Arbitrator's Exhibit 3). These two cases were previously consolidated for trial.

These cases were tried in a 19(b) proceeding and Petitioner sought orders for payment of temporary total disability benefits and medical as well as prospective medical treatment. In case number 12 WC 18726, Respondent disputed liability on the basis of accident, notice and causal relationship. In case number 11 WC 40540, Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner began working for Respondent sometime in 2004, as a truck driver. Prior to both of the accidents, Petitioner underwent three low back surgeries.

Petitioner had his first lumbar surgery performed in April, 1996. The medical records regarding that surgery were not tendered into evidence; however, when Petitioner was seen by Dr. Timothy VanFleet, an orthopedic surgeon, on July 9, 1999, Dr. VanFleet noted that Petitioner had undergone lumbar surgery in April, 1996, by Dr. Wacaser (Respondent's Exhibit 6).

When Dr. VanFleet saw Petitioner on July 9, 1999, he diagnosed Petitioner with cervical radiculopathy and lumbar spondylosis. Dr. VanFleet treated Petitioner for several years for low back symptoms. On December 3, 2003, Dr. VanFleet performed back surgery which consisted of a bilateral discectomy at L4-L5. Following surgery, Dr. VanFleet ordered physical therapy and subsequently released Petitioner to return to work without restrictions on February 6, 2004 (Respondent's Exhibit 6).

Petitioner subsequently had low back surgery performed on December 11, 2006. At that time, Petitioner's treating physician was Dr. Brian Russell, a neurosurgeon. The surgery consisted of fusions at the L4-L5 and L5-S1 levels (Respondent's Exhibit 11).

At trial, Petitioner testified that after the fusion surgery he returned to work in February, 2007. Petitioner stated that he was on light duty for six months and was then authorized to return to work at full duty.

In regard to the January, 2010, accident, Petitioner stated that on January 4, 2010, he was required to transport a load of seed to a fertilizer company. While Petitioner was in the process of unloading the seed, he felt a "pop" in his low back. Petitioner testified that he called his supervisor, Dennis Hull, that same day and informed him that he had sustained an injury.

Petitioner initially sought medical treatment on January 8, 2010, when he was seen by Cindy Noll, a nurse practitioner. According to her record of that date, Petitioner had a back fusion three years prior and was doing well until four days ago when he experienced pain in his low back while unloading pallets off of a semi. NP Noll diagnosed Petitioner with recurrent low back pain and prescribed some medications (Petitioner's Exhibit 2).

Petitioner was able to continue to work and did not seek any further medical treatment until June 28, 2010, when he was seen by Dr. Diane Hillard-Sembell. At that time, Petitioner stated that he had hurt his back and right leg while pulling pallets of seed. Dr. Hillard-Sembell ordered an MRI and referred Petitioner to Dr. Brian Russell (Petitioner's Exhibit 2).

On July 27, 2010, Petitioner was seen by Dr. Michael Markley, and an MRI of the lumbar spine was performed that same day. The MRI revealed a disc herniation at L3-L4 on the left side (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Russell on September 1, 2010. According to Dr. Russell's record of that date, Petitioner informed him that he had hurt his back at work pushing pallets, but said "...this is not a workmen's comp case." Dr. Russell reviewed the MRI and opined that it indicated a disc herniation at L3-L4. He recommended Petitioner have an epidural injection (Petitioner's Exhibit 3).

Petitioner had epidural steroid injections performed on October 26, and November 16, 2010, at L3-L4 (Petitioner's Exhibit 3). At trial, Petitioner testified that the injections did not help, but he was able to continue to work.

Dennis Hull testified on behalf of the Respondent at trial. Hull stated that Petitioner did not inform him that he had sustained an injury in January, 2010. Hull also identified Petitioner's mileage records and stated that they indicated Petitioner hauled bulk corn, not seed, on January 4, 2010. However, Hull agreed that the records also indicated that on the following day, January 5, 2010, Petitioner made a delivery of seed (Respondent's Exhibit 9). Hull also testified that Petitioner did inform him sometime in April, 2010, that he had injured his back hauling sand.

At trial, Petitioner testified in rebuttal and stated that the accident could have occurred on January 5, 2010. At that time, Petitioner's counsel made an oral motion to amend the Application to show the date of accident as January 5, 2010. The Arbitrator granted that motion.

Petitioner was seen by Dr. Markley on January 21, 2011, for a DOT physical. It was noted that Petitioner had a history of a back fusion, but it was stable. Petitioner passed the physical (Petitioner's Exhibit 2).

In regard to the accident of July 31, 2011, Petitioner testified he was hauling sand in a grain hopper. When Petitioner attempted to open the door to the hopper, he again felt a "pop" in his back.

In regard to the July, 2011, accident, Dennis Hull testified that Petitioner informed him that he injured his back at home while weed wacking. However, on cross examination, Hull also stated that Petitioner informed him that his back bothered him while he was hauling sand.

Subsequent to the accident of July 31, 2011, Petitioner went to the ER of Mason District Hospital on August 7, 2011. According to the ER record, Petitioner was in his usual state of health until approximately eight days ago when he was doing some "weed whacking" and experienced right low back and right leg pain. There was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 4).

An MRI was performed on August 8, 2011. It revealed an acute disc herniation at L3-L4 with a right lateral recess compression (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Markley on August 22, 2011. At that time, Petitioner complained of back pain with parasthesias. Dr. Markley reviewed the MRI and opined that Petitioner had an acute disc herniation at L3-L4 with a migrated fragment into the right lateral recess. There was no reference to Petitioner having sustained a work-related accident (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Russell on September 27, 2011. Dr. Russell's record of that date noted that Petitioner had reinjured his back in late July while pushing some heavy pallets. He opined that Petitioner might require a discectomy at L3-L4 and possible extension of the fusion to that level (Petitioner's Exhibit 3).

Dr. Russell saw Petitioner again on December 20, 2011, and he renewed his recommendation that Petitioner consider having another fusion surgery. He also stated that Petitioner had sustained a couple of injuries at work and noted "I think it is reasonable to assume that his lifting injuries at work, particularly the latest injury that required a hospitalization likely exacerbated his problems." (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Patrick O'Leary, an orthopedic surgeon, on May 9, 2013. In connection with his examination of Petitioner, Dr. O'Leary reviewed medical records provided to him by Respondent as well as the MRI of August, 2011. When Petitioner was seen by Dr. O'Leary, Petitioner informed him that he injured his back in January, 2010, while pushing pallets and reinjured his back in July, 2011, while lifting bags of sand. In regard to causality, Dr. O'Leary opined that the January, 2010, accident could have aggravated his back condition, but that the symptoms resolved to where Petitioner could return to work. He also opined that the July, 2011, accident caused the onset of acute low back and right leg pain (Respondent's Exhibit 4).

Dr. O'Leary also opined that the medical treatment provided to Petitioner to date was reasonable and necessary. However, in regard to future medical treatment, he opined that no further treatment, diagnostic testing or therapy was indicated and Petitioner was at MMI. He further stated that Petitioner should refrain from repetitive bending, twisting and stooping from the waist as well as no lifting over 40 pounds. He further opined that Petitioner could walk four to six hours per day, sit for three to five hours per day and drive one hour per day. He also stated

Petitioner would require frequent breaks to adjust position and prolonged standing would not be tolerable (Respondent's Exhibit 4).

Petitioner was seen by Dr. Markley on September 16, 2013. At that time, Petitioner continued to complain of low back pain with radiculopathy into both legs. Petitioner was able to walk and Dr. Markley declined to give him a parking placard (Respondent's Exhibit 15).

Dr. Russell was deposed on January 17, 2014, and his deposition testimony was received into evidence at trial. Dr. Russell's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to the January, 2010, accident, Dr. Russell stated that it could have caused the disc herniation at L3-L4. He also testified that the accident of July 31, 2011, could have caused the disc herniation and nerve root compression, but that the second accident was more of an aggravation. Dr. Russell also testified that when he saw Petitioner on September 27, 2011, he recommended Petitioner have a discectomy and extension of the fusion at L3-L4. As to Petitioner's ability to work, Dr. Russell opined Petitioner was limited to light duty with no lifting over 20 pounds (Petitioner's Exhibit 1; pp 7-13).

Dr. O'Leary was deposed on January 30, 2014, and his deposition testimony was received into evidence at trial. Dr. O'Leary's deposition testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He specifically reaffirmed his opinion that the two accidents aggravated Petitioner's low back condition (Respondent's Exhibit 1; pp 11-14).

Dr. O'Leary also testified that given the fact that Petitioner had not worked since July, 2011, and his symptoms had been relatively stable, the likelihood of Petitioner having surgery and improving was minimal. He stated that unless Petitioner had a progressively worsening condition it was unlikely that surgery would result in any substantial improvement (Respondent's Exhibit 1; pp 18-21).

Dr. Russell saw Petitioner on March 12, 2014. At that time, Petitioner stated that his pain had gotten progressively worse and he wanted to discuss surgery. Dr. Russell noted that, given the length of time since he last saw Petitioner, some physical therapy was appropriate. If afterward, Petitioner was still having symptoms, then Petitioner would need another MRI before any decision would be made regarding further decompression and extension of the fusion (Petitioner's Exhibit 7).

Dr. Russell did not evaluate Petitioner again until he saw him on November 24, 2015. At that time, Petitioner's leg weakness had worsened. Dr. Russell opined that Petitioner needed surgery because Petitioner had developed some neurological compromise. He ordered another MRI scan (Petitioner's Exhibit 11).

The MRI was performed on December 14, 2015, and it revealed a moderate disc bulge at L3-L4, and the radiologist noted that the disc herniation previously observed at that level was not present (Respondent's Exhibit 10).

Again, at the direction of Respondent, Dr. O'Leary examined Petitioner on May 5, 2016. In connection with his examination of Petitioner, Dr. O'Leary reviewed up-to-date medical records

provided to him by Respondent as well as the MRI of December 14, 2015. Dr. O'Leary's reading of the MRI scan was consistent with the interpretation of the radiologist and he opined that the herniated disc present on the prior scan had resolved. In regard to causality, Dr. O'Leary opined that it was now difficult to relate Petitioner's current condition of ill-being to the accidents given the fact the MRI showed an improvement of the condition at L3-L4 (Respondent's Exhibit 5).

Dr. O'Leary again opined Petitioner was at MMI and was capable of working at full duty with restrictions of walking from four to six hours per day, sitting for three to five hours per day and no lifting over 40 pounds. He again stated that no further treatment was indicated, especially given the findings of the recent MRI (Respondent's Exhibit 5).

Dr. O'Leary was deposed for the second time on September 1, 2016, and his deposition testimony was received into evidence at trial. Dr. O'Leary's deposition testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, in regard to his reading of the December, 2015, MRI scan, Dr. O'Leary opined that the disc at L3-L4 had resorbed, so Petitioner no longer had a disc herniation. His diagnosis was Petitioner had chronic low back pain with lumbar degeneration (Respondent's Exhibit 2; pp 12-13).

In regard to causality, Dr. O'Leary stated that Petitioner's current state was due to his chronic underlying condition. He testified that Petitioner was at a point where no further medical treatment would change his underlying condition. However, on cross-examination, Dr. O'Leary agreed that the January, 2010, accident could have caused the herniated disc at L3-L4 (Respondent's Exhibit 2; pp 18-21, 34-35).

At trial, Petitioner testified that he has not been able to work since July 31, 2011, because of daily pain in his back and right leg. Petitioner stated that he is unable to sit very long and wants to proceed with the surgery as recommended by Dr. Russell.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on January 5, 2010.

In support of this conclusion the Arbitrator notes the following:

In the Application, Petitioner initially alleged the date of accident to be January 4, 2010; however, at trial, the correct accident date was determined to be the following day, January 5, 2010.

Respondent disputed accident, in part, because Petitioner alleged that he sustained the accident while delivering seed on January 4, 2010. Respondent's witness, Dennis Hull, testified that Petitioner did not make a delivery of seed on January 4, 2010; however, Hull stated that Petitioner did make a delivery of seed on January 5, 2010.

The medical records following the accident of January 5, 2010, all contained a history of Petitioner having sustained a work-related accident.

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

The Arbitrator concludes that Petitioner gave timely notice to Respondent of the accident of January 5, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he informed Dennis Hull that he sustained a work-related accident on the same day it occurred.

Dennis Hull testified that Petitioner did not inform him that he had sustained a work-related accident. However, Hull testified that sometime in April, 2010, Petitioner informed him that he injured his back while hauling sand. As is noted in case number 11 WC 40540, Petitioner was hauling sand when he sustained the accident on July 31, 2011.

Based upon the preceding, the Arbitrator finds Petitioner's testimony to be more persuasive than that of Dennis Hull.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to the accident of January 5, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner had three low back surgeries, including a fusion, prior to the accident of January 5, 2010; however, Petitioner was able to work without restrictions as a truck driver prior to January 5, 2010.

Petitioner's treating physician, Dr. Russell, testified that the January, 2010, accident, could have caused the disc herniation at L3-L4.

At the time of his first examination of Petitioner on May 9, 2013, Respondent's Section 12 examiner, Dr. O'Leary, opined that the accident of January, 2010, could have aggravated Petitioner's back condition.

It was when Dr. O'Leary examined Petitioner on May 5, 2016, that he changed/modified his opinion in regard to causality. However, this was based primarily on his review of the MRI of December 14, 2015, which revealed that the herniated disc at L3-L4 was no longer present.

The Arbitrator is persuaded that, even with the resolution of the disc herniation at L3-L4, the accident of January 5, 2010, was a causative factor in regard to Petitioner's current condition of ill-being.

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

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

Respondent shall pay reasonable and necessary medical services provided from January 8, 2010, through January 21, 2011, as identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes that Petitioner is not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physician, Dr. Russell, opined that Petitioner should undergo another back surgery consisting of a discectomy at L3-L4 and possible extension of the fusion to that level.

When Dr. Russell last evaluated Petitioner on November 24, 2015, he renewed his surgical recommendation; however, he also ordered another MRI scan.

The MRI scan performed on December 14, 2015, revealed that the disc herniation previously observed at L3-L4 was no longer present. This was noted by both the radiologist who performed the MRI and Dr. O'Leary when he examined Petitioner on May 5, 2016.

Based upon his earlier examination of May 9, 2013, Dr. O'Leary opined that further back surgery was not indicated and he reaffirmed that opinion when he saw Petitioner on May 5, 2016, especially when considering the MRI of December 14, 2015, which revealed that the disc herniation at L3-L4 had resolved.

There was no evidence tendered that Dr. Russell ever reviewed the MRI of December 14, 2015, and whether he would still recommend Petitioner have the back surgery that he previously recommended.

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

The Arbitrator concludes Petitioner is not entitled to payment of temporary total disability benefits.

In support of this conclusion the Arbitrator notes the following:

Petitioner did not lose any compensable time from work as a result of the accident of January 5, 2010.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Scanlon,
Petitioner,

vs. NO: 12 WC 20817

Adrian Rivera, individually and d/b/a EGA Landscaping & Design, and the Illinois State Treasurer as Ex Officio Custodian of the Illinois Injured Workers' Benefit Fund,
Respondent.

17IWCC0430

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, casual connection, temporary total disability, permanent partial disability, employment relationship, jurisdiction, notice, penalties and attorney's fees and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In so affirming the outcome of the case, however, the Commission notes that based on the evidence presented, the Arbitrator found that the claimant was an independent contractor, not an employee, and that benefits under the Workers' Compensation Act were therefore inapposite. While the Commission concurs that benefits under the Act should not apply, the Commission concludes that rather than acting as an independent contractor, the claimant was more akin to a working partner and co-venturer.

Specifically, the Commission notes that claimant testified that "I helped him [Adrian Rivera] start his landscaping company, actually." (Tr. 34) The claimant further testified:

Q: Did you ask him to work there?
A: No. We were basically – we were trying to get some little side jobs to make some extra money in the summer, and then he happened upon somehow getting into doing the Chicago Public Schools.

17IWCC0430

See Tr.34. The evidence presented clearly suggests that the claimant was neither hired by the respondent as an employee, nor retained or commissioned by the respondent as an independent agent. Rather, the claimant assisted the respondent as a co-founder of the venture. The claimant's lack of W-2 forms, securing his benefits in cash, and flexibility regarding his schedule were entirely consistent with this partnership arrangement.

The Commission notes the holding in *Metro Construction, Inc. v. Industrial Commission*, 39 Ill. 2d 424, 235 N.E.2d 817 (1968), where the Illinois Supreme Court observed "'In the workmens' compensation field it appears that with the exception of one jurisdiction (Oklahoma) every court where this issue has arisen has held that working partners are not employees within the meaning of the statutes.' ... We think the majority view to be sound and it is adopted." *Id.* at 426-7. Furthermore, pursuant to Section 1(b)3 of the Act, partners of a business may elect to be covered by the Act, but must declare themselves to be so covered. There was no such showing, especially given the lack of insurance coverage heretofore demonstrated.

Benefits under the Act are inapposite and therefore denied in their entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2016 is hereby affirmed. Benefits are denied.

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

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

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

DATED: JUL 3 - 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

Charles J. DeVriendt

o-06/21/17
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCANLON, EDWARD Case# **12WC020817**

Employee/Petitioner

RIVERA, ADRIAN INDIVIDUALLY AND D/B/A EGA LANDSCAPING & DESIGN AND THE ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE ILLINOIS WORKERS' BENEFIT FUND

17IWCC0430

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.

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0000 ADRIAN RIVERA, INDV AND DBA
EGA LANDSCAPING & DESIGN
2718 W 59TH ST
CHICAGO, IL 60615

5462 ASSISTANT ATTORNEY GENERAL
MAGGIE TIMLIN
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

Edward Scanlon 17IWCC0430 Case # **12** WC **20817**
Employee/Petitioner
v.
Adrian Rivera, individually and d/b/a EGA Landscaping & Design, and the Illinois State Treasurer, as Ex Officio Custodian of the Illinois Injured Workers' Benefit Fund
Employer/Respondent

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

FINDINGS

On **June 8, 2012**, Respondent **Adrian Rivera, individually and d/b/a EGA Landscaping & Design** *was* operating under and subject to the provisions of the Act.

On this date, an employer-employee relationship *did not* exist between Petitioner, **Edward Scanlon**, and Respondent, **Adrian Rivera, individually and d/b/a EGA Landscaping & Design**.

ORDER

Because an employer-employee relationship did not exist, benefits are denied.

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

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

Milton Black

Signature of Arbitrator

February 2, 2016
Date

FEB 2 - 2016

FINDINGS OF FACT

Petitioner testified that on June 8, 2012, he was working as a general manager foreman for EGA Landscape & Design (EGA). Petitioner testified that Adrian Rivera was the owner. Petitioner testified that his job duties included maintenance and landscaping at fourteen Chicago Public Schools. Petitioner testified that each week, he would set the schedule and the route for the landscaping crew.

Petitioner testified that his position was seasonal from March through October. Petitioner testified that he worked approximately twelve hours per week for thirty two weeks for Adrian Rivera at a rate of $14.00 per hour. Petitioner testified that his normal work day would begin at 6 a.m. and that the end time would vary depending on that day's job. Petitioner testified that he was paid in cash and that taxes were not withheld. Petitioner testified that he did not receive any W-2's from EGA.

Petitioner testified that he was a childhood friend of Adrian Rivera and that he helped Mr. Rivera start EGA. Petitioner testified that he did not apply for his job and that he just asked Mr. Rivera to be a part of the business. Petitioner testified that Mr. Rivera owed and maintained all the landscaping equipment, which included lawnmowers, weed whackers, hedgers, and power machinery.

Petitioner testified that he and Adrian Rivera held a second job at Mobile Rail Solutions (Mobile) on the date of the accident. Petitioner stated that he worked at Mobile approximately twenty seven hours per week for twelve weeks prior to his date of accident at a rate of $9.00 per hour. Petitioner testified that he stopped working at EGA and Mobile on the date of his accident. Petitioner testified that Adrian Rivera was aware of his concurrent employment at Mobile.

Petitioner testified that on June 8, 2012, he was scheduled to work at Owen Scholastic Academy and that when he arrived, the principal asked him to remove weeds. Petitioner testified that he was walking and weed whacking in tall grass when he fell into a hole that was eight feet deep (PX3).

Petitioner testified that he felt immediate and immense shooting pain in his right leg. Petitioner testified that after his coworker, Jose Juarez, pulled him out of the hole by his wrists, he telephoned Adrian Rivera to inform him of the accident. Petitioner then arranged to be driven back to the office of EGA so that his wife could pick up his vehicle from the office and drive him to the hospital. Petitioner testified that when he returned to the office, he spoke with Adrian Rivera, in person, regarding the accident and informed Mr. Rivera that he was headed to the hospital.

Petitioner presented to Mercy Hospital on June 8, 2012, complaining of right lateral knee pain. Petitioner was diagnosed with a right knee sprain, was fitted with a knee immobilizer, was prescribed Norco and Ibuprofen for pain, and was instructed to follow up with his primary physician in two to four days (PX4).

Petitioner presented to Integrated Pain Management on June 18, 2012. A right knee MRI was taken, and he was recommended to have a consultation with an orthopedic surgeon (PX7). The MRI revealed bone contusions and a meniscus tear (PX9). Petitioner consulted at Orthopedic and Rehabilitation Centers, S.C.

Petitioner was prescribed pain medications and physical therapy (PX5). Petitioner underwent physical therapy on various dates from June 26, 2012 through September 24, 2012 (PX8). Petitioner was kept off work by his treating physicians (PX5; PX7).

On October 1, 2012, Petitioner underwent a right knee arthroscopy with partial lateral meniscectomy and chondroplasty of the lateral tibial plateau. The postoperative diagnosis was a right knee lateral meniscus tear and chondromalacia of the lateral tibial plateau (PX6). Thereafter, Petitioner underwent physical therapy and was kept off work (PX5).

Petitioner testified that he never returned to work at EGA after Adrian Rivera refused to accept this claim. Petitioner testified that he stopped working at EGA and at Mobile on the date of his accident. Petitioner testified that he eventually began working for Chicago's Mr. Handyman. Petitioner testified that his job duties for Mr. Handyman included general contracting and snow removal.

Petitioner testified that he continues to experience right knee pain. Petitioner testified that he is able to perform the demands of his current position.

CONCLUSIONS OF LAW

Was Respondent operating under and subject to the Act?

Petitioner testified that the work of EGA required him to perform various landscaping and maintenance tasks, including weed removal and mowing lawns. Petitioner testified that EGA used power machinery, hedgers, lawnmowers and weed whackers. These are sharp edged tools. The Arbitrator finds that the landscaping, the use of power machinery, and the use of sharp edged tools are sufficient for EGA Landscaping & Design to be subject to the automatic coverage provision of the Illinois Workers' Compensation Act.

Was there an employee-employer relationship?

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. A case by case analysis is required. There are multiple factors to consider when assessing the nature of the relationship

between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Robertson v. Indus. Comm'n.*, 866 NE.2d 191, 200 (Ill. 2007). Other relevant factors include the label the parties place on their relationship, and whether the parties' relationship was "long, continuous, and exclusive." *Ware*, 318 Ill.App. at 1122, 1126. No single factor is determinative and such determination of the employee-employer relationship rests on the totality of the circumstances. *Roberson*, 866 NE.2d at 200.

In the present matter, Petitioner failed to meet his burden of proving the existence of an employee-employer relationship. Petitioner testified that he was personally in charge of setting the schedule and planning the weekly route. Petitioner worked varying hours depending on the day's schedule, which he was in charge of setting. Petitioner was paid hourly in cash with no taxes were withheld. Petitioner was able to hold a second concurrent job at Mobile Rail Solutions with Adrian Rivera, and worked Petitioner there for approximately twenty seven hours per week. Petitioner was a childhood friend of Adrian Rivera, never formally applied for a job, helped Mr. Rivera start EGA, and then became part of the venture. Petitioner never testified that he was fired. It is a reasonable inference that he was free to come and go on his own without any outside control.

The totality the evidence indicates that Petitioner was an independent contractor, not an employee. Therefore, the Arbitrator finds that Petitioner failed to meet his burden of proving an employer-employee relationship existed between Petitioner and Adrian Rivera, individually and doing business as EGA Landscaping & Design.

The remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherry Livingston,

Petitioner,

17IWCC0455

vs.

NO: 12 WC 33303

The TJX Companies, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator, which is attached hereto and made a part hereof. After reviewing all of the evidence, the Commission finds that Petitioner's work-related condition resolved by December 21, 2010. Accordingly, we modify the Arbitrator's award of temporary total disability benefits and medical expenses as set forth below. Finally, we modify the Arbitrator's award of permanent partial disability benefits from 20% of the right foot to 12.5% of the right foot based on the credible evidence presented.

Petitioner, a 73-year-old part-time retail associate for Respondent, sustained an injury to her right medial ankle on September 21, 2010 when the corner of a mirror struck her ankle as she attempted to move the merchandise. The records in evidence show that Petitioner had a history of bilateral venous ulcers on her lower legs. Petitioner is diabetic and suffers from vascular disease; these pre-existing conditions are risk factors for the development of venous ulcers and also complicate their healing. Although a claimant can still recover for a work injury despite a pre-existing condition, the claimant must show that the injury was a causative factor. We agree with the Arbitrator's finding that the September 21, 2010 accident was causally related to the right medial ankle ulcer for which Petitioner initially sought treatment on October 5, 2010. The records and testimony of Petitioner's podiatrist, Dr. Olszewski, show that the ulcer was fully

17IWCC0455

healed by the end of 2010. Therefore, we find that Petitioner failed to prove her current condition of ill-being is causally related to the accident of September 21, 2010.

Petitioner was discharged from the Advocate Lutheran General Wound Care Center on December 21, 2010. In a letter to Petitioner's family physician, Dr. Brander, the Wound Care Center concluded that all treatment goals had been met and that closure of Petitioner's venous ulcer had been achieved. When Petitioner returned to Dr. Olszewski for her regular appointment on December 28, 2010, Dr. Olszewski did not mention any ulcers. Dr. Olszewski testified that if there was still an active problem on that day she believed she would have mentioned it. (PX1, p. 80-81) On January 6, 2011, Dr. Brander confirmed that the right ankle ulcer was healed. Petitioner continued to see Dr. Brander and Dr. Olszewski on a monthly based from January 2011 through the beginning of November 2011 and the records do not indicate any active right ankle ulcers; both Dr. Brander and Dr. Olszewski find that the former ulcer is healed.

Dr. Olszewski testified on direct examination that the work-related injury on December 21, 2010 made Petitioner more susceptible to future problems and therefore the original injury "greatly contributed" to the problem for which Petitioner began treating for in November of 2011. (*Id. at* 41) However, on cross-examination, Dr. Olszewski was confronted with multiple medical records regarding prior ulcers and openings in the skin in the same area before the September 21, 2010 accident. Dr. Olszewski admitted that prior to rendering her opinion on causal connection she was not aware that Petitioner had earlier episodes of ulcers on the same ankle. Dr. Olszewski did not review any of Petitioner's prior medical records before rendering her causal opinion, nor did she review any treatment records from Dr. Brander or the Wound Care Center other than the December 21, 2010 discharge note. In light of the credible medical records, Dr. Olszewski's causal opinion is not persuasive. We do not find that Petitioner's right ankle ulcer occurring in November of 2011 is related to her employment by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 7 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 $220.00 per week for a period of 20.875 weeks, as provided in §8(b)2 of the Act, for the reason that the injuries sustained caused 12.5% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay bills pursuant to §8(a) and §8.2 of the Act for medical treatment related to the accidental injury of September 21, 2010 but shall not be liable for any medical expenses incurred by the Petitioner after December 21, 2010 including but not limited to any costs for office visits, testing, treatments, medications or medical equipment or supplies. Specifically, the medical bills submitted at hearing show charges of $4,886.00 from Advocate Lutheran General for treatment from October 25, 2010 through December 21, 2010 and Respondent shall pay these bills pursuant to §8(a) and §8.2 of the Act.

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

17IWCC0455

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for the amount of $1,778.01 for payment of a Medicare lien for Petitioner.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 18 2017
KWL/plv
o-6/29/17
46

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0455

LIVINGSTONE, SHERRY
Employee/Petitioner

Case# **12WC033303**

THE TJX COMPANIES
Employer/Respondent

On 9/8/2016, 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 0.47% 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:

0000 PAPPAS & BELL LLC
JAMES PAPPAS ESQ
234 WAUKEGAN RD
GLENVIEW, IL 60025

1120 BRADY CONNOLLY & MASUDA PC
MEGHAN P MURRAY ESQ
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0455

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

SHERRY LIVINGSTON
Employee/Petitioner

v.

THE TJX COMPANIES
Employer/Respondent

Case # **12** WC **33303**

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **June 23, 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 and average weekly wage?

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

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

J. ☒ Were the 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. ☒ Is Respondent due any credit for Medicare payments made for Petitioner?

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 as explained infra.

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

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

In the year preceding the injury, Petitioner earned **$11,036.97**; the average weekly wage was **$220.74**.

On the date of accident, Petitioner was **73** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.00**.

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

ORDER

Medical Benefits
Respondent shall pay to Petitioner the sum of **$35,296.15** for medical services provided by Dr. Mary Olszewski, Orsini Medical Clinic, Advocate Lutheran General, Byram Healthcare, Inc., Dr. Samer Najjar and pay unpaid prescriptions in the amount of **$1,130.32,** as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for any payments it has made on these bills.

Temporary Total Disability
Respondent shall pay petitioner $220.00 per week for a period of 7 6/7th weeks, as provided in Section 8(b) of the Act.

Permanent Partial Disability
Respondent shall pay to Petitioner $220.00 for 33.4 weeks as the injury sustained caused 20% loss of use of the right foot as provided by Section 8(b)2 of the Act.

Respondent's Credit
Respondent shall be given a credit in the amount of $1778.01 for payment of a Medicare lien for Petitioner.

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

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

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

The disputed issues in this matter are: 1) accident; 2) casual connection; 3) earnings; 4) average weekly wage; 5) medical bills; 6) temporary total disability; 8) Respondent's credit; and 9) the nature and extent of Petitioner's injuries. *See,* AX1.

FINDINGS OF FACTS

Petitioner's testimony

Ms. Sherry Livingston, ("Petitioner"), a 79 year old woman, was employed by the TJX Companies, Inc. ("Respondent"), as an associate cashier for four (4) years prior to the date of the claimed accident. She testified that part of her job duties included moving, lifting and carrying heavy objects and doing whatever the manager told her to do. She also testified that she had no prior problem with the particular part of her right foot that she claimed was injured on the date of accident.

On September 21, 2010, she was working as a cashier and instructed to affect the sale of a large mirror. She attempted to move the 5 ½' x 5' foot mirror closer to the register by "rocking" it and in the course of that action, the mirror struck her right ankle. She stated that she felt immediate pain in her right ankle, lifted her cuff and saw redness in the area where the mirror struck her. She stated that the accident was witnessed by another associate cashier named Maryanne.

She testified that she continued to work until her break, then went to the employee lunchroom to the medicine cabinet. She obtained gauze pads and tape which she used to bandage that area of her right ankle. Petitioner further stated that after her work shift she went home, removed the bandage on her right ankle and noticed blood on the bandage.

Petitioner testified that she is and was, at the time of the accident, a type 2 diabetic. She has approximately thirty (30) years of wound care experience, having been a caregiver for her mother through doctor's instructions and having taken care of pressure wounds on her legs. She testified that over the next few days after the accident she tried to control the wound herself but the wound got out of control. It expanded and the skin changed colors, which meant a possible infection. She testified that in her experience, it is more difficult to close an open wound if you have type 2 diabetes. She reported the accident to Assistant Manager, Armi Eberhart and made an appointment for October 5, 2010, to see Dr. Mary Olszewski.

On October 5, 2010, she was seen by Dr. Olszewski regarding the wound on her right ankle and gave a history of how the accident occurred. On October 19, 2010, she was seen by Dr. Brander who referred her to the Lutheran General Wound Center. She then returned to Dr. Olszewski, who took her off work from October 29, 2010 until January 1, 2011, while her wound was cared for. Petitioner was afraid of losing her job because the respondent hired seasonal employees therefore, she asked Dr. Brander for an early release to return to work. Petitioner stated that at the time she was discharged from care, on or about January 10, 2011, the wound had improved but had not completely healed. She

testified that throughout the next months of 2011, she continued to care for the wound herself by applying saline, Santyl, Mepilex and bandages. In October of 2011, the wound had scabbed over. In late 2011 and 2012, she was sent back to the Luther General Wound Center for care.

Petitioner testified that she had great pain in her right ankle and that her doctors prescribed the pain medications that she had marked in yellow in Petitioner's Exhibit 5, in the amount of $1,130.32. She eventually underwent three (3) surgeries to apply Apligraft graphs to the wound on her right ankle, twice by Dr. Olszewski and once by Lutheran General Wound Care Center. Closure of the wound was finally achieved in February of 2013.

Petitioner testified that prior to the date of the subject accident; she had never injured her right ankle in that spot. Also, Petitioner testified that the bills for medical treatments, doctors' bills and equipment company bills that are included in Petitioner's Group Exhibit #4, in the total of $35,874.16, were incurred in treatment of her right ankle injury and were not paid. She continues to experience shooting pains in her right ankle once in a while and that she has to put cream on it constantly, to keep the graph on her ankle from drying.

During cross-examination, Petitioner testified that on three (3) separate occasions, in 2013 and 2014, she was accused by the respondent of giving checks back to customers that were meant to be payment for goods; and as a result, she was terminated from her employment. On re-direct examination she stated that she did give two checks back to customers by mistake. She realized that she had made the mistake on the second occasion; and reported it to the loss prevention department. She stated that did not believe that it happened a third time and asked to see the surveillance video, but that request was denied.

Respondent's witness

Ms. Armi Eberhart testified that she is an assistant manager employed by Respondent. She further testified that Petitioner had never reported ulcer issues before the date of the accident on September 21, 2010. Ms. Eberhart corroborated the Petitioner's testimony that she reported the accident to her a few days after the accident.

She further testified that she had known the petitioner for approximately three (3) years and knows that she is diabetic. She has observed bandages on Petitioner's foot prior to the date of accident and that the petitioner wore ace bandages around her foot for protection. Ms. Eberhart never states which foot she saw the bandages and is not specific as to when she saw the bandages. Ms. Everhart corroborated Petitioner's testimony that the mirror was large and heavy. However, she also testified that the clerks are not required to move heavy objects as the respondent has workers who move furniture.

Deposition of Dr. Olszewski dated April 8, 2016

Dr. Olszewski testified that she is the petitioner's treating physician. She is a licensed doctor of podiatric medicine, who is certified by the American Board of Podiatric Surgery and the American Board of Podiatric Orthopedics; with over 25 years of experience in the field. She testified that patients who are diabetic and have open wounds, are more prone to infection and have a slower healing time.

She personally examined the petitioner on February 6, 2010 and May 4, 2010 and at those times, Petitioner's right ankle did not have any ulcers or open areas on the skin. She also examined the petitioner on October 5, 2010 and took a history from her. On that date, she noted an ulceration on Petitioner's right ankle. Based on the history of the accident, it was her opinion that Petitioner's injury to her right ankle was caused by the mirror hitting that spot. She also said that her examination revealed some scarification from a previous ulceration which, in her opinion, was not related to this accident. It was her opinion that the petitioner had a traumatic injury that she sustained at work. The doctor prescribed medication, compression and requested that Petitioner return in a few weeks. She also clarified the clerical error where she references the ulcer being on the left ankle.

Dr. Olszewski further testified that when she examined the petitioner on October 19, 2010, the ulceration had grown in size and that Petitioner had been referred to the Lutheran General Wound Care Center for treatment. Dr. Olszewski also examined Petitioner on December 28, 2010, March 22, 2011 and May 31, 2011. She stated that on May 31, 2011, her records showed that she noted scarification on the medial aspect of the right lower extremity, although the ulceration was closed. She further testified that in wound care, a closed ulcer could be an ulceration that has a scab over it which appears to be closed, but the ulceration could be open underneath. Dr. Olszewski corroborated Petitioner's testimony that the petitioner was well versed in taking care of ulcerations.

Dr. Olszewski testified that she examined the petitioner on October 4, 2011 and noted scarification at the site of the injury. She stated that Petitioner had had a prior injury with scar tissue at that spot, and therefore the tissue is less pliable. She stated that when there is a scar, there is less blood supply to the area, which makes the area prone to re-injury. Dr. Olszewski opined that Petitioner had a previous injury which left residual scarring, contributing to this problem.

Dr. Olszewski testified that on November 3, 2011, after the scab peeled off, the ulceration on the right ankle was evident. She further testified that on November 15, 2011, she re-examined the ulceration and opined that it was located in the same area as the ulceration that was the result of the injury Petitioner sustained on September 21, 2010.

The doctor then stated as is typical with diabetics, ulcerations usually occur at the end of toes; and they {diabetics} typically do not get ulcers on the inside or outside of the ankle, unless there is some traumatic event. Dr. Olszewski testified that since the petitioner's wound continued to grow, an Apligraft surgical procedure was medically necessary to help the ulceration heal.

Dr. Olszewski testified that she continued to treat the petitioner for the ulceration on her right ankle through August of 2012. She opined that the ulcer and pain that Petitioner was experiencing at that time, was initially caused by the traumatic injury Petitioner sustained at work, in 2010. She stated that the prior injury that Petitioner sustained on that ankle, made her more susceptible to future problems and that it was her opinion that that the traumatic injury on September 21, 2010, greatly contributed to the problems Petitioner was experiencing in August 7, 2012.

Dr. Olszewski further testified that the ulcer, which occurred on Petitioner's inside right ankle, had healed at one time but had opened again. Dr. Olszewski testified that due to a change in her record keeping to electronic medical records, any recurring notes that Petitioner's condition was present for 6-8 weeks with sudden onset, were not accurate statements.

Dr. Olszewski testified that she believed the ulcer had become a chronic problem by September of 2012 and that the traumatic injury of September 21, 2010 started the whole process. She further testified that an Apligraft procedure was performed in October 2012, involving the surgical application of the Apligraft combination Xeno/Allograft. She testified that a third application of the Apligraft was prescribed and that the surgery was performed on November 2, 2012. Dr. Olszewski testified that thereafter, on January 2, 2013, her notes did not suggest that the ulcer reappeared therefore although it took the ulcer a long time, it finally did heal.

Dr. Olszewski testified that to a reasonable of medical certainty, she believed that Petitioner's treatments for her ulcerated ankle, including surgeries and debridements, were caused by the injury that Petitioner sustained when the corner of the mirror jabbed into the medial aspect of her ankle. Dr. Olszewski further testified that the treatments that she afforded to Petitioner relating to the right lower extremity and the bills she charged were reasonable in her community; and that the treatments were necessary in the healing of the wound for the right lower extremity.

On cross-examination Dr. Olszewski testified that venostasis was not significant to the cause of Petitioner's injury but that venostasis could be part of the complication as to the retardation of the healing. She testified that a prior pin-hole sized opening would not be significant to this injury. On re-direct, Dr. Olszewski also opined that Petitioner's diabetes did not cause the medial ankle ulcer however, did contribute to retardation of healing. PX1.

Deposition of Dr. Simon Lee dated June 7, 2016

Dr. Lee testified that he is an orthopedic surgeon, board certified since 2005. He was asked by the respondent, to conduct an independent medical evaluation ("IME") of the petitioner and he examined her on April 17, 2013. According to his review of her records, Petitioner did not mention an ulcer of her right ankle until October 19, 2010. Dr. Lee testified he took a history from Petitioner and then reviewed her medical records. His diagnosis of Petitioner was right bilateral lower extremity

peripheral vascular disease, neuropathy venous stasis, calcification with medial malleor bilaterally, healed and resolved; which was not caused by the September 21, 2010 incident.

He testified that the wound care center discharge note of December 21, 2010, stated that the wound should be closed in a week and Dr. Olszewski's notes from May 31, 2011 indicated that the wound was closed; and there was no mention of the open ulceration until November 2011. He testified that he needed to see his IME report and addendum to refresh his memory regarding his findings. He testified that he believed Petitioner had significant history regarding her lower extremities, including chronic and recurring ulcerations; and that her records seem to indicate to him that Petitioner experiences openings from everyday minimal or minor traumas. He testified that people with diabetes and other problems should wear special shoes and stockings. Dr. Lee testified that Petitioner had reached maximum medical improvement ("MMI") for the alleged September 21, 2010 ulcer sometime between December 21, 2010 and May 31, 2011, based on Dr. Olszewski's notes of that date, when Petitioner was discharged from the wound care center. He opined that there is no permanent disability that he could note.

On cross-examination Dr. Lee stated that all of the records that he reviewed in preparation of his opinions were provided to him by the respondent's attorney. He further admitted that he did not know that Petitioner had been examined by Dr. Olszewski on October 5, 2010 and that all of his opinions were made without the benefit of the information contained in Dr. Olszewski's initial consultation, which occurred within two (2) weeks of the accident.

Dr. Lee stated that all of his opinions were based upon his impression that there was no complaint about Petitioner having suffered an injury to her right lower extremity before October 19, 2010. He stated that he drafted his opinions on April 17, 2013, approximately thirty (30) months after the accident and that he had never examined the petitioner when she had an active problem with her right lower extremity. Dr. Lee agreed that Petitioner had an accident on September 21, 2010. Dr. Lee also stated that he agreed that Petitioner sustained an injury to her right lower extremity as a result of the accident that she had on September 21, 2010 and that Petitioner "appears to have consistency of the mechanism as she describes here".

During Dr. Lee's testimony, the record reflects that Dr. Lee passed a written note to Respondent's attorney. Dr. Lee was asked to read what the note stated. At that point Respondent's attorney stated that the note was "just for us" and that Dr. Lee was her agent. The note, when read, contained statements from Dr. Lee to the Respondent's attorney regarding the notes of Dr. Olszewski's October 5, 2010 records of the petitioner.

Dr. Lee stated that he never treated the petitioner and he acknowledged that Dr. Olszewski was Petitioner's treating physician. He testified that he did not necessarily agree with the statement that a treating physician is in a better position to make opinions as to the patient's condition rather than

someone who reviews records thirty (30) months after the accident. Dr. Lee testified that when he scribbled the note regarding Petitioner's October 5, 2010 visit and handed it to Respondent's attorney during his cross examination, that he was not trying to help Respondent's counsel. At no time during the testimony of Dr. Lee was his independent medical report ever attempted to be introduced into evidence. RX10.

CONCLUSIONS OF LAW

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

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 alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill. App.3d 43, 556 N.E.2d 261, 144 Ill.Dec.794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91, Ill.2d 288, 63 Ill. Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E.2d 307(1956). It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v Industrial Commission*, 44 Ill.2d.207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstanced support the decision. *See generally, Gallentine v Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (9180), *Caterpillar v Industrial Commission*, 73 Ill.2d 311,383 N.E. 2d 220

(9178). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The Arbitrator finds that the petitioner's current conditions of ill-being is casually related to her work injury of September 21, 2010 and in so finding, relies upon the records and testimony of Dr. Olszewski the medical records of Dr. Brander; and the information contained in the Employer's First Report of Injury.
The Arbitrator notes that the petitioner worked for the respondent for four (4) years, with no apparent health complaints being made regarding her right lower extremity or ankle. Petitioner had a previous medical condition of type 2 diabetes and venous vascular disease. The Arbitrator acknowledges that generally, an employer takes its employees as it finds them and a pre-existing condition does not bar compensation of an injury if the employment was a causative factor.

After sustaining a work accident on September 21, 2010, the petitioner was not able to continue working from November 2, 2010 through December 26, 2010. The history of the accident and mechanism of injury is confirmed by testimonies of Drs. Olszewski and Lee, the medical records from Dr. Olszewski and the information contained in Employer's First Report of Injury.

Dr. Lee's opinions are not persuasive as he did not take into account any of the information or history contained in the October 5, 2010 initial visit notes of Dr. Olszewski; and based all of his opinions on the presumption that Petitioner never complained of the injury until October 19, 2010. The Arbitrator notes that Respondent's counsel referred to Dr. Lee as an agent for Respondent.

The Respondent's evidence of how the Petitioner was discharged from employment in 2014 as a reason to suspect her credibility is unconvincing. Petitioner, an elderly woman of 79 years testified that she made a mistake when returning a check to a customer and then, self-reported another instance of mistake to Respondent.

The Arbitrator relies upon the more persuasive findings and opinions of Dr. Olszewski, whose opinions were consistent with her initial medical records and the subsequent treatment, opinions and examinations that she provided. The Arbitrator finds that the petitioner has proven, by preponderance of the evidence, that her current condition of ill-being, is causally related the work accident of September 21, 2010.

G. What were Petitioner's earnings and average weekly wage?
The Arbitrator finds that the petitioner's average weekly wage was the minimum allowed for her date of accident or $220.00.

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

The Arbitrator finds that the petitioner's medical treatment, including the three (3) Apligraft surgeries were reasonable and necessary in the treatment of the injury she sustained on September 21, 2010. The Arbitrator finds the respondent is liable for any outstanding medical bills and medicinal prescriptions for treatment rendered to petitioner after September 21, 2010. In doing so, the Arbitrator relies on Dr. Olszewski's testimony, the treating medical records from Dr. Olszewski and Lutheran General Wound Care Center and Petitioner's testimony; which demonstrate that Petitioner's current condition of ill-being is causally connected to her work injury of September 21, 2010. Further, the Arbitrator relies on the admitted exhibits #2, Group #4 and Group #5 in determining that Respondent has not paid the charges for all reasonable and necessary medical services. Respondent is entitled to a credit of $1,778.01 for money paid to Medicare. Respondent shall pay Petitioner the sum of $34,096.15 for outstanding medical bills and $1,130.32 for outstanding medical prescription bills.

K. What temporary benefits are in dispute?

The Arbitrator finds the petitioner was disabled from November 2, 2010 to December 26, 2010, after which date she returned to work. The Arbitrator relies upon the disability reports of Dr. Brander in awarding said temporary total disability. Respondent did not produce proof of payment of these benefits. Respondent shall pay Petitioner TTD for a period of 7 6/7th weeks, at the rate of $220.00 per week a total of $1,676.13. Respondent shall receive a credit for any TTD previously paid.

L. What is the nature and extent of Petitioner's injuries?

Respondent shall pay to Petitioner 33.4 weeks of permanent partial disability as the injury has caused 20% loss of use of the right foot, i.e. $7,348.00.

N. Is Respondent due any credit?

The Respondent is seeking a credit of $3,846.26 it claiming it paid in medical benefits pursuant to Section 8(j) of the Act however, the petitioner is disputed this claim and the respondent did not lay a foundation to have any supporting document admitted into evidence therefore, this credit is not allowed.

O. Is the Respondent due any credit for the Medicare payments paid for Petitioner?

Respondent's Exhibit 3 shows that a payment in the amount of $1,778.01 was issued to Commercial Repayment Center for claimant Sherry Livingston in the subject matter. The respondent shall be given a credit for this amount.

17IWCC0455

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC33303
SIGNATURE PAGE

Signature of Arbitrator

September 8, 2016
Date of Decision

SEP - 8 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elaine Theobold,
Petitioner,
vs.
Rockford Mass Transit,
Respondent.

NO: 12WC 44320

17IWCC0448

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 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: JUL 14 2017
MJB/bm
o-7/11/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THEOBALD, ELAINE
Employee/Petitioner

Case# **12WC044320**

13WC017909

ROCKFORD MASS TRANSIT
Employer/Respondent

17IWCC0448

On 9/6/2016, 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 0.48% 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:

0139 CORNFIELD & FELDMAN LLP
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CHICAGO, IL 60602

0563 WILLIAMS McCARTHY LLP
CAROL A HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elaine Theobald
Employee/Petitioner

v.

Rockford Mass Transit
Employer/Respondent

Case # 12 WC 44320

Consolidated cases: 13 WC 17909

17IWCC0448

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **July 15, 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 _____

17IWCC0448

FINDINGS

On **October 19, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,708.29**; the average weekly wage was **$955.93**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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 **$8,390.94** for other benefits, for a total credit of **$8,390.94**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $19,565.37, as provided in Sections 8(a) and 8.2 of the Act to the providers as listed in Petitioner's Exhibit 14 including the out of pocket costs incurred by Petitioner of $70.61. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $637.29/week for 47 3/7 weeks, commencing November 16, 2012 through April 23, 2013, and commencing May 14, 2013 through November 3, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$8,390.94**.

Respondent shall pay Petitioner permanent partial disability benefits of $573.56/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

September 1, 2016
Date

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Statement of Facts

Petitioner filed two separate Applications for Adjustment of Claim: 12 WC 44320 (accident date: October 19, 2012) and 13 WC 17909 (accident date: May 11, 2013) alleging accidental injuries to her right arm and shoulder. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to these claims.

Petitioner Elaine Theobald testified that she was employed by Respondent Rockford Mass Transit since December 20, 1995. In October, 2012, she was a fixed route bus driver. Her duties were to pick up and transport passengers. Petitioner testified that she is 5' 9" tall. She is right handed. The Petitioner identified Respondent's Exhibit 2 as the Recaro driver's seat she would use. Petitioner testified that she was required to change the head sign. The head sign panel is a small square panel. She pushes the buttons on it to change the sign on the outside of the bus. Petitioner identified Petitioner's Exhibit 13 as showing this panel above her head on the bus. Petitioner testified that in order to reach the head sign she needed to lift herself out of the seat and reach with her right arm to push the button to change the sign. She would change the sign every hour, 8 times a day.

Cedric Ketton testified for Respondent. He testified that he was originally employed as a bus driver for the respondent until 2005 and returned in 2009 as a bus driver. In 2011, he was promoted to supervisor. He knew Petitioner through training and supervising her occasionally. In training, he shows drivers the location of the controls and how to change the sign. Mr. Kenton viewed the videotape admitted as Respondent's Exhibit 1. The video accurately depicts the seat set up and controls. The video accurately shows the control pad for the head sign in the 700 series. To change the sign, you have to get out of the chair and reach up to change the buttons. The driver puts in the digits on the control pad to make the change. It does not take much force. Mr. Ketton is 6 feet tall, and from a seated position he can touch the panel but can't reach to change the buttons. When he worked as a driver, he would stand up to change the sign. He trains people to stand up to change the sign. When standing to change the sign the arm is at a 45 degree angle, and the shoulder is at 90 degrees. The video also demonstrates a shorter female, 5'3" to 5'4" standing to change the sign with the arm bent at the elbow without stress on the shoulder.

Petitioner testified that on October 19, 2012 she got out of her seat and stepped up on a little step to reach up with her right arm and change the head sign. Petitioner testified that she felt a pop in her shoulder, but continued to change the head sign. She continued to work that day. She had only two more runs remaining and finished her shift. Petitioner testified she was off work for a long weekend and returned on Tuesday October 23, 2012. She testified that as she continued to work her regular duty over the next few days, she noticed her pain increasing. Petitioner did not report the accident on the date it occurred. She mentioned it to Cedric on the date she went to the hospital for medical care.

Petitioner first sought medical treatment on October 25, 2012 at the Swedish American Hospital Emergency Room. The records of Swedish American were admitted as Petitioner's Exhibit 1. Petitioner provided a history of injury to the right shoulder on Friday reaching above her head. She reported she over extended reaching to change a sign. She reported she heard a pop. She complained of pain in the right shoulder and pain with raising her arm internally and above her head. She was diagnosed with a sprain and advised to follow up with Dr. Stocker (PX 1).

Petitioner saw Dr. Stocker on October 27, 2012. She was given restrictions. On November 16, 2012, Dr. Stocker ordered an MRI of the right shoulder and took Petitioner off of work. The MRI performed on November

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30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. On December 3, 2012, Dr. Stocker referred Petitioner to Lundholm Orthopedics (PX 2).

Petitioner was seen by Dr. Milos beginning January 2, 2013. Petitioner provided a consistent history of reaching up to change a sign and feeling a "pop." Petitioner complained of severe right shoulder pain with limited range of motion. Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. Dr. Milos provided an injection, prescribed physical therapy and an anti-inflammatory cream. He ordered restricted work activity of no driving city buses, lifting of 5 pounds to waist level and no overhead reaching. On February 12, 2013, Petitioner continued having significant pain despite conservative treatment. She reported she has been unable to return to work. Dr. Milos discussed continued conservative care versus surgical repair. On April 8, 2013, Dr. Milos released Petitioner to return to full unrestricted duty as of April 23, 2013 (PX 1). Petitioner had a Fitness for Duty physical with Dr. Bashku at Physicians Immediate Care on April 19, 2013. His report states that the shoulder is now feeling fine and has no pain. The exam is completely normal. He released Petitioner to return to full duty (PX 3).

Petitioner was examined by Dr. Borchardt at Respondent's request on December 12, 2012. The report of that examination was admitted as Respondent Exhibit 4. Dr. Borchardt recorded a history that on October 19, 2012, Petitioner reached up with her right arm to change her bus designation and felt a pop in her shoulder. Petitioner complained of pain with movement and loss of strength. Dr. Borchardt reviewed the treatment records and the MRI performed on November 30, 2012. He performed a physical examination. His impression was a right shoulder rotator cuff tear with acromioclavicular osteoarthritis, impingement syndrome, and possible adhesive capsulitis (RX 4).

Dr. Borchardt went on site and performed the activity of changing the sign as described by Petitioner. Dr. Borchardt stated that it would be impossible for Petitioner to change the sign in a seated position given her height. She would have to stand up, and then her shoulder would be in a bent position. Dr. Borchardt found that pushing the buttons requires very little force. Dr. Borchardt opined that raising her arm would not have caused the significant injuries she has. He further opines that he does not believe her current diagnosis is related to her job activities. He states her impingement syndrome and a grade three acromial process would contribute to her diagnosis. He agrees that Petitioner is not at MMI and that arthroscopic surgery is necessary. He recommends that Petitioner have restrictions (RX 4).

Petitioner testified that she returned to work on April 23, 2013. She noticed her arm was better, but was still quite guarded. It was stiffer than before. She worked until her alleged second accident on May 11, 2013 (the subject of consolidated claim 13 WC 17909). Petitioner testified that on that Saturday, she began her shift at 6:00 AM. She had a problem with the bus on the first run. When she returned to the main garage, Bill the dispatcher had brought out the wrong series bus for her and she was told to go into the garage to get another. While in the garage she had a conversation with her supervisor Michael Amans as to why she was taking another bus. She testified he yelled at her. She testified that she left on her 7:15 AM run a little late. When she returned to the garage, there was another bus in her berth. She testified that means someone else was going to cover her run.

Petitioner testified that she went to dispatch to find out what was going on. She was asked to go to the garage by Mr. Amans. He told her that he was going to train her on the 1300 series bus. They went over the controls and the wheelchair hook up. Petitioner testified that they had completed the training and she was sitting in the driver's seat when Mr. Amans grabbed her right wrist in both of his hands and twisted it behind her back to the

knob on the seat. Pain shot through her shoulder. She testified that she was in fear, so she clammed up and walked off the bus. Petitioner testified that she finished her shift and reported the incident to LaVonne, another dispatcher.

Petitioner testified that she had reported prior accidents without fear. She had prior "discussions" with Mr. Amans where he wanted her to do something and she told him she could not do it. She wrote him up at least a couple of times before the May, 2013 incident. She testified she was told that Mr. Amans thinks he owns the company. She testified that she felt the company should handle it. Petitioner and Mr. Amans had issues and discussions about the dress code. She testified that Mr. Amans would grab her tie and try to fix it for her. She testified that she tried to avoid him. Petitioner filed an EEOC claim with respect to the May 11, 2013 incident. She received a dismissal and notice of rights from the EEOC. Petitioner also called the Rockford Police Department and told them Mr. Amans assaulted her. The police never charged him.

Michael Amans testified for Respondent. He testified that he was a safety supervisor for approximately 15 years. He retired from Respondent in April of 2015. He would occasional do route supervision. He would supervisor Petitioner approximately every other Saturday. On May 11, 2013, he was the supervisor on duty. He testified that Petitioner would have started her shift at 6:05 AM. The first time he spoke with Petitioner that day is when he received a call from the garage that she had a problem with her bus. He assumed that the problem was that she did not want to take out the bus she was assigned. Petitioner had a medical exemption not to drive one of model buses, and an arrangement was made that if she got a bus that she didn't want to drive, she was supposed to take it out for the first run and give the garage a chance to replace it. Mr. Amans testified that he put a show up driver on the route. He and Petitioner discussed the issue. Mr. Amans testified that she was angry.

Mr. Amans testified that he decided to train Petitioner on a new 1300 series bus while they waited for the route bus to come back. The training started almost immediately after this conversation. Mr. Amans testified that Petitioner did not take any initial run before the training. He testified that training started around 6:20 AM. The training took place in the garage. When the training started, Petitioner was in the driver seat and he was standing right alongside her at the fare box pointing out the control panels. Respondent's Exhibit 2 depicts the type of seat Petitioner was seated in at the time of the training. There was no argument or disagreement with Petitioner during the training. Mr. Amans testified that Petitioner acted like she didn't know where the control knob was for the seat back tilt. He reached up and took her right hand from the 3 o'clock position on the steering wheel and said "Elaine, the control knob is back here for the seat." Mr. Amans testified that there was a little sarcasm in his voice. Mr. Amans denied that he took her arm or wrist with both hands. He did not twist her arm back. He did not yell at her. Mr. Amans testified that Petitioner did not scream out in pain. She did not indicate she was injured. The training took about 15 minutes. He then put Petitioner back out on her route. He went back upstairs.

Mr. Amans testified he was called by police the following Tuesday. He was interviewed by the police and upper management. He was not charged with any crime. Mr. Amans testified that he had a strained relationship with Petitioner. He did not feel she was a very good employee. She was not a very good driver. She had no respect for the company. Before the training on May 11, 2013, he was aware that Petitioner had been off work but he did not know that she had a shoulder injury.

Petitioner went to Physicians Immediate Care on May 11, 2013. The record states that Petitioner has an extensive history of ongoing shoulder problem. Today she reinjured her arm when supervisor pulled right arm

behind back (PX 3). Petitioner was given an off work note by Dr. Milos' physician's assistant on May 14, 2013 (PX 1). Petitioner saw Dr. Stocker on May 22, 2013 with the same history. Petitioner stated she has been under a lot of stress with her shoulder symptoms (PX 2). She continued her care with Dr. Milos. A May 21, 2013 MRI noted partial thickness tears which had worsened since the earlier study, a possible labral tear and mild bursitis (PX 1). Dr. Milos performed an arthroscopic debridement and subacromial decompression on July 2, 2013. The post operative diagnosis was partial thickness rotator cuff tear, less than 25%, impingement syndrome and labral tear. Dr. Milos released Petitioner to modified work on September 23, 2013 and to full, unrestricted duty effective November 4, 2013 (PX 1).

Dr. Milos prepared a report dated January 13, 2014 which was admitted as Petitioner Exhibit 4. He notes some confusion as to the date of accident, but states that Petitioner reported that she was reaching up to change the sign on a bus when she felt a pop in her shoulder and had aching and burning and severe limitation of motion. Dr. Milos stated he evaluated Petitioner and felt she had adhesive capsulitis which can occur from injuries and strains of the shoulder capsule. He opined that the reported accident is a reasonable mechanism that could explain the development of the condition. Dr. Milos states that he advised Petitioner surgery was an option when he saw her in February, 2013. Dr. Milos noted Petitioner's improvement with therapy and that he anticipated continuing therapy to work on overhead motion pain and shoulder mechanics (PX 4).

Dr. Milos stated his physician assistant saw Petitioner on May 16, 2013 and that she reported that her supervisor moved her arm posteriorly. A new MRI was performed on May 21, 2013 and read as showing a minimal worsening of the changes in the shoulder. On July 2, 2013, Petitioner underwent surgery to the right shoulder, with findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. After surgery Petitioner attended physical therapy and follow up visits. She was seen for a final visit with Dr. Milos on December 9, 2013. At that time she had some neck pain and trapezial symptoms, therefore the doctor provided her a prescription for a TENS unit. Petitioner was discharged from his care at that time (PX 4).

Dr. Milos opined Petitioner had an acute event when she reached up to change the sign that is consistent with her symptoms and the pain she experienced. The second injury can also be consistent with her complaints, so he believes that both of those incidents may have caused and aggravated her symptoms (PX 4).

Petitioner testified that she does not have the free range of motion she had before this accident. She cannot extend the arm because of stiffness and she guards the arm. Her reaching ability is limited. Washing and blow drying her hair is a difficult task. Petitioner testified she has not seen Dr. Milos since November, 2013. He did not provide any permanent restrictions. She is not taking any medication for her shoulder. She has been performing her regular job duties as a fixed route driver.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, the claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. An injury occurs "in the

course of employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. 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. There are three categories of risks an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics.

Petitioner testified that her injury occurred on October 19, 2012. She testified that when she got out of her seat to reach up with her right arm to change the head sign, she felt a pop in her shoulder. Petitioner provided a consistent history of this mechanism of injury at the emergency room, to Dr. Stocker, Dr. Milos and Dr. Borchardt. The Arbitrator finds Petitioner's testimony that she felt a pop while changing the head sign credible. There is no dispute that this activity occurred during the course of her employment.

The Arbitrator finds that the act of reaching upward from the driver's seat of a bus to change the head sign is a risk associated with the employment. *Young v. Ill. Workers Comp. Comm'n*, 2014 IL App (4th) 130392WC; 13 N.E.3d 1252; 2014 Ill. App. LEXIS 498; 383 Ill. Dec. 131 (4th Dist, 2014). An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. Here, Petitioner's injury arose out of an employment-related risk and is compensable. The record shows claimant was injured while performing her job duties, namely reaching up to change the head sign a required part of her assignment. This task and the mechanism of injury described are distinct to her job duties as a bus driver and connected with her assigned duties.

Based upon the record as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on October 19, 2012.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident, the Arbitrator finds Petitioner sustained an injury to her right shoulder as a result of the accidental injuries sustained on October 19, 2012. Petitioner has no history of any prior complaints or treatment to the right shoulder. She sought medical treatment within a few days of the injury and provided a consistent history of the accident and the acute onset of symptoms. The MRI performed on November 30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. On January 2, 2013, Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. Dr. Milos states that he advised Petitioner surgery was an option when he saw her in February, 2013. Dr. Milos stated he felt Petitioner had adhesive capsulitis which can occur from injuries and strains of the shoulder capsule. He opined that the reported accident is a reasonable mechanism that could explain the development of the condition.

Dr. Borchardt performed the activity of changing the sign as described by Petitioner. Dr. Borchardt opined that raising her arm would not have caused the significant injuries she has. He further opines that he does not

believe her current diagnosis is related to her job activities. He states her impingement syndrome and a Grade III acromial process would contribute to her diagnosis. He agrees that Petitioner is not at MMI and that arthroscopic surgery is necessary.

The Arbitrator notes that Dr. Borchardt acknowledged her condition of impingement syndrome and a Grade III acromial process. He agreed that Petitioner was a candidate for arthroscopic surgery on the right shoulder. The Arbitrator notes that Dr. Milos noted that the MRI showed a high grade partial rotator cuff tear, but her symptoms are more related to adhesive capsulitis. The surgery performed on July 2, 2013 confirmed findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. This is consistent with Dr. Milos' assessment.

Based upon the medical evidence submitted, the Arbitrator finds the opinions of Dr. Milos more persuasive that those of Dr. Borchardt. The Arbitrator finds that Petitioner suffer an aggravation of her right shoulder impingement and adhesive capsulitis and finds that Petitioner's condition of ill being in the right shoulder is causally connected to the accidental injuries sustained on October 19, 2012.

Petitioner suffered an additional injury on May 11, 2013 which is the subject of the consolidated case 13 WC 17909. As more fully discussed in the decision in that claim, the Arbitrator finds that that injury was not a permanent aggravation or intervening injury with respect to Petitioner's condition of ill being in the right shoulder, which condition therefore remains related to the original injury on October 19, 2012. The Arbitrator finds that Petitioner's condition of ill being after May 11, 2013, including her treatment and disability, remains causally connected to the accidental injuries sustained on October 19, 2012.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that the condition of ill being in her right shoulder including all treatment, lost time and disability is causally related to the accidental injuries sustained on October 19, 2012.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, all medical treatment provided for Petitioner's condition of ill being in the right shoulder would be causally connected to the accidental injuries sustained on October 19, 2012. Petitioner admitted outstanding medical bills as Petitioner's Exhibits 5-11 and out of pocket prescription costs as Petitioner's Exhibit 12. Petitioner's Exhibit 14 is a summary prepared showing total charges, payments and adjustments, and outstanding balances. The parties have stipulated that Respondent is self insured for group insurance and that Respondent is entitled to credit under Section 8(j) for payments made by group insurance.

PX 14 calculates total outstanding medical balances, after all payment and adjustments, of $19,494.76. There is a claim for out of pocket payments of $89.79. The Arbitrator has reviewed the medical bill exhibits and the medical records and finds that the bills submitted are supported by the records admitted and that the medical claimed is reasonable, necessary and causally connected to the accidental injuries sustained on October 19, 2012. The Arbitrator finds the balances listed on PX 14 to Swedish American Medical Group ($10,530.00), Swedish American Hospital ($7,159.36), SAMG Lundholm Orthopedics ($784.46), Rockford Anesthesiologist Associated ($231.94), EMPI ($460.00) and Rockford Associated Clinical Pathologists ($51.00 and $278.00)

are substantiated by the bills and treatment records. The Arbitrator reviewed PX 12 and noted several duplicate charges included. The Arbitrator finds the out of pocket costs for medication is $70.61. The total outstanding balances and out of pocket costs incurred total $19,565.37.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services of $19,565.37, as provided in Sections 8(a) and 8.2 of the Act to the providers as listed in Petitioner's Exhibit 14 including the out of pocket costs incurred by Petitioner of $70.61. 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 support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

The parties stipulated that Petitioner was off work following October 19, 2012 from November 16, 2013 through April 23, 2013, a period of 22 3/7 weeks and following May 11, 2013 from May 14, 2013 through November 3, 2013, a further period of 24 3/7 weeks. Based upon the Arbitrator's finding with respect to Causal Connection in this matter as well as in the consolidated claim 13 WC 17909 decided in conjunction with this matter, the Arbitrator finds that the entire condition of ill being in Petitioner's right shoulder is causally connected to the accidental injuries incurred on October 19, 2012. The Arbitrator therefore finds that both stipulated periods of temporary total disability are causally related to this matter.

The parties stipulated that Respondent paid $3,047.55 in benefits following October 19, 2012 (Arb Ex 1) and an additional $5,343.39 (Arb Ex 2) in benefits following May 11, 2013. The Arbitrator awards Respondent credit for both of these payments totaling $8,390.94 in this matter.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for 47 3/7 weeks, commencing November 16, 2012 through April 23, 2013, and commencing May 14, 2013 through November 3, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $8,390.94.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act apply to the determination of partial permanent disability.

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 fixed route bus driver at the time of the accident and that she has been able to return to work in her prior capacity as a result of said injury. The Arbitrator notes she has been performing the full duties of her employment since November, 2013. Because of this, the Arbitrator therefore gives lesser weight to this factor.

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With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. Petitioner would not be considered either a younger or older worker. Petitioner would be expected to continue with active employment for in excess of 10 years. Petitioner has been able to return to her full duty regular employment since November, 2013. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to her regular employment as a fixed route bus driver and has performed the full duties of her employment since November, 2013. The Arbitrator also notes the testimony that Petitioner is protected by a Union agreement and has 20 years seniority. The Arbitrator also notes that Respondent has made accommodation to Petitioner's need for driving only certain buses in the past. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b (b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained an injury to her right shoulder. The MRI performed on November 30, 2012 found impingement, rotator cuff partial tear, possible labral tear and possible bursitis. After the May 11, 2013 episode, a new MRI was performed on May 21, 2013 and read as showing a minimal worsening of the changes in the shoulder. On July 2, 2013, Petitioner underwent surgery to the right shoulder, with findings of less than 25% thickness tear of the rotator cuff so no procedure was performed on the rotator cuff tendon. Petitioner had a type III acromion with bursitis that was shaved down, and a labral tear was debrided. Petitioner was released to return to full, unrestricted duty in November, 2013 and has worked her regular job as a fixed route bus driver through the date of trial. Petitioner testified that she does not have the free range of motion she had before this accident. She cannot extend the arm because of stiffness and she guards the arm. Her reaching ability is limited. She has not seen Dr. Milos since November, 2013. She is not taking any medication for her shoulder. Because of this, the Arbitrator therefore gives some weight to this factor.

Pursuant to *Will County Forest Preserve Dist. v. IWCC*, 2012 Ill. App. LEXIS 109, 361 111, permanent partial disability for shoulder injuries resulting in internal structural changes should be compensated under §8(d)2 of the Act instead of §8(e). The Arbitrator finds the Commission decisions in *Brian Jones v. Southwest Airlines*, 16 IWCC 0137; *Tabatha White v. Helia Healthcare*, 15 IWCC 719; and *Kevin Acosta v. State of Illinois, Dept. of Transportation*, 15 IWCC 698, instructive as to the determination of permanent partial disability.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN HEMINGWAY,

Petitioner,

vs. NO: 13 WC 00935

SALVATION ARMY,

Respondent.

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DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner worked for Respondent as a Driver. He picked up donations from residences 8 to 9 hours daily, 5 days a week.

2. On September 26, 2012 Petitioner injured his back while lifting a couch up the stairs from a garden apartment. He was lifting at the top of the stairs while a helper was pushing the couch from the bottom. Petitioner attempted to complete a few more stops on his shift, but was physically unable to. He then reported the incident to Respondent.

3. The following day Petitioner presented at the emergency room complaining of back pain radiating down his right leg. He was diagnosed with L5-S1 Grade 1 retrolisthesis and early degenerative disc disease.

4. On October 6, 2012 at Concentra Medical Center Petitioner was diagnosed with lumbar radiculopathy and a lumbar strain. Physical therapy was recommended. Four days later Petitioner was placed on light duty.

5. A November 7, 2012 report of Dr. Simon indicated that Petitioner was scheduled for physical therapy but was non-compliant.

6. On November 15, 2012 Petitioner treated with an orthopedic surgeon, who diagnosed him with a lumbar strain causing radiculitis. A lumbar MRI was ordered and revealed moderate degenerative disc disease at L5-S1, a small central disc extrusion and moderate to severe spinal canal stenosis.

7. On December 5, 2012 Petitioner was continued on light duty, but was told by his Supervisor that no light duty work was available.

8. Petitioner received workers' compensation benefits until mid-December 2012, when Respondent informed him that his benefits would cease due to him being non-compliant with treatment.

9. On January 5, 2013 Petitioner was diagnosed with lumbar intervertebral disc syndrome.

10. On February 19, 2013 Dr. Chunduri diagnosed Petitioner with an L5-S1 disc herniation with right radiculitis. He opined that Petitioner's condition was causally related to his work accident.

11. On June 11, 2013 Petitioner was referred to a spine surgeon since his symptoms persisted.

12. On October 4, 2013 Dr. Johnson reviewed a Functional Capacity Evaluation (FCE) from September 24, 2013 and released Petitioner from care with permanent light to medium work restrictions.

13. Petitioner is no longer employed by Respondent. He last worked at a meat factory in 2015 as a Machine Operator. At the time of trial, he still suffered from low back and leg pain. He also is unable to run and be active with his children.

The Commission affirms the Arbitrator's findings relative to the issues of accident, causal connection, medical expenses, temporary total disability and permanent partial disability. However, the Commission reverses and vacates the award for §19(L) penalties. The Commission notes the November 7, 2012 medical record of Petitioner's own treating physician, Dr. Simon, wherein it was noted that Petitioner

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was noncompliant with physical therapy treatment.

Accordingly, the Commission finds that Respondent had good cause to terminate Petitioner's benefits, and thus reverses the Arbitrator's award for §19(L) penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner suffered an accident arising out of and in the course of his employment with Respondent on September 26, 2012.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is causally related to his work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $50,467.78 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits for 28-4/7 weeks at a rate of $330.00 per week, for a total of $9,428.57.

IT IS FURTHER ORDERED BY THE COMMISSION Petitioner is entitled to permanent partial disability benefits of $330.00 per week for a period of 75 weeks due to a 15% loss of use of his person as a whole under §8(d)(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent is not liable for §19(L) penalties.

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.

JUL 21 2017

DATED:
O: 5/25/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEMINGWAY, KEVIN
Employee/Petitioner

Case# **13WC000935**

SALVATION ARMY
Employer/Respondent

17IWCC0466

On 5/16/2016, 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 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JILL WAGNER
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

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

K. Hemingway v. Salvation Army, 13 WC 0935

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

Kevin Hemingway
Employee/Petitioner
v.
Salvation Army
Employer/Respondent

Case # 13 WC 0935

17IWCC0466

An *Application for Adjustment 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 February 3, 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 _____

17IWCC0466

FINDINGS

On **9/26/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,720.00**; the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **4** dependent children.

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

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

Respondent shall be given a credit of **$3,900.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$3,900.00**.

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

ORDER

Respondent shall pay **reasonable and necessary medical services**, pursuant to the Medical Fee Schedule, of **$50,467.78**, as provided in **Sections 8(a) and 8.2 of the Act** and as is set forth below.

Respondent shall pay Petitioner **temporary total disability benefits** of **$330.00/week for 28-4/7 weeks**, commencing **October 6, 2012 through April 24, 2013**, as provided in **Section 8(b) of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits** of **$330.00/week for 75 weeks** because the injuries sustained caused the **15% loss of use of a person as a whole**, as provided in **Section 8(d)2 of the Act.**

Respondent shall pay to Petitioner penalties of **$0**, as provided in Section 16 of the Act; **$0**, as provided in Section 19(k) of the Act; and **$10,000.00** , as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from September 26, 2012 through February 3, 2016, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

May 16, 2016
Date

MAY 16 2016

STATEMENT OF FACTS

The Petitioner, Kevin Hemingway (hereinafter referred to as "Petitioner"), is a 36 year old who worked for Respondent, Salvation Army (hereinafter referred to as "Respondent"), as a furniture mover. His job duties included driving a truck, picking up donations (furniture, clothes, etc.) and bringing the items back to the Respondent's facility on the near west side or to stores. He worked five days a week, eight or nine hours per day. He made $9.00 per hour. Petitioner's highest level of education was 11th Grade. He does not have a high school diploma. Petitioner has a CDL license. His primary work experience was as a truck driver, or working in a warehouse.

On September 26, 2012, Petitioner was picking up furniture at a customer's apartment, when he hurt his back. Petitioner and his co-worker had to carry a couch out of a basement apartment and up the stairs in order to get it into the truck. Petitioner testified that he was at the top of the staircase pulling the couch up the stairs and his co-worker was at the bottom of the stairs pushing the couch upwards. The couch got stuck in the stairwell. Petitioner testified that he tried to free the couch and felt an immediate pain in his back when he tried to pull and lift the couch. Petitioner could not finish his shift due to the pain, so he went back to dispatch to report his injury. Petitioner told his dispatcher and was sent home. He also reported the injury to his supervisor, Tony Cruz, the following day. Petitioner had no medical treatment on the day of injury.

On September 27, 2012, Petitioner presented to Rush Oak Park Hospital emergency room for back and right leg pain. The history was "moving furniture yesterday afternoon", developed mid back pain radiating to the tailbone and down the right thigh in the back. Petitioner gave a history of having back problems in the past, but he never saw anyone for treatment. He was diagnosed with sciatica. X-rays showed grade one retrolisthesis at L5-S1, early degenerative disk disease at L5-S1, and early spondylotic changes at L5-S1. Petitioner was given pain medications, a copy of his x-rays and was instructed to follow up with his company physician. (PX3)

Following this visit, Petitioner reported to work. He was directed to the human resources department, where he spoke to Bill. Bill referred Petitioner to Concentra Medical Center and gave him Respondent's

workers' compensation insurance information. Petitioner set up his workers' compensation claim and began treating at Concentra.

Petitioner first presented to Concentra on October 6, 2012 and was treated by Dr. Inderjote Kathuria who diagnosed him with a lumbar strain, ordered physical therapy, and placed him on light duty work restrictions. (PX4) He followed up with Concentra on October 17, 2012 and saw Dr. Stanly Simon, who ordered physical therapy and continued his work restrictions. Petitioner's pain persisted and Dr. Simon referred him to an orthopedic surgeon on November 7, 2012 and continued his work restrictions. Dr. Simon noted that Petitioner had been non-compliant with therapy at that time. Petitioner presented to Dr. Charles Mercier at Concentra for an orthopedic evaluation on November 15, 2012. Dr. Mercier noted right radicular low back pain with occasional paresthesias in right lower extremity, ordered an MRI, and continued his work restrictions. The MRI was done on November 28, 2012 and showed a central disc extrusion with inferior extension superimposed upon a moderate diffuse disc bulge at L5-S1 with moderate to severe central spinal canal stenosis. (PX5) Petitioner again followed up with Dr. Mercier on December 5, 2012. Dr. Mercier reviewed the MRI and noted an extruded disc at L5-S1 and severe spinal canal stenosis. The case was discussed with Petitioner and Mercier appears to have offered "epidural surgery" (this chart notation is not explained). Petitioner did not want injections, "therefore he has chosen to leave (sic) with it." Dr. Mercier continued his work restrictions, pain medications, and ordered work conditioning. The Petitioner completed a course of physical therapy at Concentra from October 10, 2012 through December 17, 2012 and one session of work conditioning on December 17, 2012. (PX4)

Petitioner testified that he showed his light duty work restrictions to his supervisor, Tony Cruz, who indicated that there was no light duty work available. Respondent apparently never offered Petitioner limited duty work. During the time that he was treating at Concentra, Petitioner was receiving temporary total disability benefits from Respondent.

During the course of his treatment, Petitioner missed two appointments at Concentra. Petitioner was sick for one visit. Petitioner testified that for the second missed appointment, he was en route to Concentra when his car broke down. He immediately called the facility and his adjuster, Kim Stewart, to alert them that his car broke down and that he could not make his appointment. The adjuster told Petitioner that he was being "noncompliant" and that she would not authorize more treatment and would not issue any more temporary total disability benefits. Petitioner did not receive any further temporary total disability benefits after this date. There was no further treatment at Concentra. The exact dates of payment of TTD benefits is unknown. Respondent did not present any evidence of compliance with Rule 7110.70 (b).

Petitioner testified that he was still in pain and sought a second opinion from Dr. Thomas Sperry, DC at Integrity Medical Group on January 5, 2013. The records of this provider rival those of Concentra for their lack of clarity and consistency. Petitioner's history to Dr. Sperry was of an onset of back pain in the truck after moving a couch, not the history of immediate onset of back pain that Petitioner testified to and provided to most of the providers. Dr. Sperry diagnosed Petitioner with lumbar intervertebral disc syndrome, recommended physical therapy for four weeks, and referred him to Dr. Claudia Johnson. Petitioner completed a course of physical therapy from January 10, 2013 through May 15, 2013 at Integrity Medical Group. The Petitioner was seen by Dr. Claudia Johnson at Integrity Medical Group on January 18, 2013, and she noted pain in the back radiating down the back of his leg, which she noted was consistent with the history of the work injury. Dr. Johnson ordered a new MRI (if Petitioner could not get the old film), physical therapy, and took Petiotioner off of work. The MRI was completed at Archer Open MRI on January 23, 2013 and revealed a disc bulge with a superimposed herniation at L5-S1 and mild bilateral neuroforaminal stenosis. (PX8) On February 9, 2013, Dr. Johnson reviewed the MRI, ordered an EMG/NCV, continued Petitioner off work, and referred him to Dr. Chunduri for pain management. At the February 9 and February 15, 2013 visit, Dr. Johnson charted that Petitioner's low back pain radiated down his left leg. Apparently, the EMG/NCV was never done. (PX6)

Petitioner presented to Dr. Chunduri at Integrity Medical Group on February 19, 2013. Dr. Chunduri charted the history of the onset of back pain occurring while driving the truck. Dr. Chunduri diagnosed Petitioner with an L5-S1 disc herniation with right radiculitis and lumbago which she causally related to his September 26, 2012 work injury. She noted that by the time she saw him, he had extensive conservative management without improvement and recommended a series of right L5 and S1 transforaminal epidural steroid injections and continued him off work. Petitioner underwent these injections on February 27, 2031, April 3, 2013, and May 22, 2013 at Grand Avenue Surgical Center. (PX8) Petitioner testified that he felt relief after the first injection, but not after the second or third injection. The Integrity records say that Petitioner had some relief after the last two injections. (PX6 & 7)

Petitioner presented to Dr. Gary Shapiro at Illinois Bone and Joint Institute on April 25, 2013 for an Independent Medical Examination at the request of Respondent. (RX1) Dr. Shapiro diagnosed Petitioner with a soft tissue injury to the lumbar spine as well as a central disc herniation at L5-S1 with S1 radiculopathy which he causally related to the September 26, 2012 work injury. He opined that the treatment to date had been reasonable and appropriate, but Petitioner did not need further treatment. In addition, he opined that if Petitioner was unable to perform his unrestricted work duties, he should undergo a functional capacity evaluation and his restrictions would be based off of the FCE. (RX1) There was no evidence that Respondent contacted Petitioner regarding return to work based on Dr. Shapiro's report. Petitioner did not present any evidence that he contacted Respondent regarding return to work.

Petitioner had continued pain complaints and continued to follow up with Dr. Johnson and Dr. Chunduri at Integrity Medical Group. On June 11, 2013, Dr. Chunduri referred him to a spine surgeon since he continued with moderate symptoms after the series of three injections. Petitioner testified that he never had the spine surgeon consult because it was not approved. Dr. Johnson also ordered a neurosurgeon evaluation, but, after it was not approved, she ordered a functional capacity examination. Petitioner underwent the functional capacity examination on September 24, 2013 with ATI Physical Therapy. (PX10) The examination was found to be

valid and placed Petitioner at the light to medium physical capabilities of desk-to-chair lifting of 72.8 pounds, chair-to-floor lifting of 39 pounds, and lifting 42.4 pounds above the shoulder bilaterally. Petitioner's previous employment as a furniture mover with Respondent was considered a very heavy demand position and his capabilities fell below this level. Dr. Johnson saw Petitioner on October 3, 2013, reviewed the FCE and released him from her care with permanent work restrictions of light to medium duty work per the FCE (10 pounds lifting, per Petitioner). (PX7)

Dr. Gary Shapiro provided an IME addendum on November 13, 2014. (RX2) Dr. Shapiro reviewed the functional capacity examination report, further medical records, and surveillance footage of Petitioner. Dr. Shapiro opined that based on the surveillance he viewed, Petitioner would be capable of working, but he would recommend a repeat functional capacity evaluation if Petitioner was unable to work at full duty. (RX2) A second IME addendum was completed on January 22, 2015. (RX3) Dr. Shapiro was again asked to complete a record review and provide additional opinions. In this report, Dr. Shapiro opined that there was a question of malingering and that additional care after Concentra would be called into question. (RX3)

The surveillance footage that Dr. Shapiro relied on was shown at trial. (RX4 &5) The private investigator who filmed the Petitioner, Dennis Paul Burkott, testified. Mr. Burkott testified that he performed surveillance on Petitioner on November 14, 2012, April 24, 2013, and April 25, 2013 and completed reports following his surveillance. On November 14, 2012, Burkott engaged in surveillance of Petitioner from 5:30 am until 3:00 pm. During the 9 ½ hours of surveillance, Burkott obtained 11 minutes of "active" surveillance. Resp. Ex. #6. In his report, Mr. Burkott highlighted Petitioner's activities of walking, opening a vehicle door, entering a vehicle, going up and down stairs, and slightly twisting his back, and classified them as active duties. (RX6) Burkott also performed surveillance on April 24, 2013 from 5:30 am through 12:02 pm and on April 25, 2013 from 6:30 am through 3:37 pm. (RX7) During these two days of surveillance, Burkott obtained 21 minutes of active surveillance. Petitioner was seen pulling a trash can with wheels and carrying a mattress and box spring from a house to the front of the lawn. The mattress is bulky and obviously weighs more than the 10 pounds that

Petitioner claimed that he was restricted to lifting. The box spring was not that substantial, but also had to weigh over 10 pounds. Burkott testified that any activity he observed that he did not consider high level activity would not be in the surveillance video. Petitioner is seen walking with no difficulty on the videos.

Petitioner testified that since he has been released from care, he has not been able to be employed as a furniture mover or driver. On cross-examination, Petitioner admitted to working at a meat factory as a machine operator, 10 hours per day, 5 days a week in 2015. Petitioner testified that, as of the date of trial, he continued to have pain in his back and right leg. He said, "I can no longer run, be active with my children. I have to adjust my life and learn to take it easy, basically." He has pain on a daily basis. Petitioner testified that he never had back pain or treatment for his back before September 26, 2012.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. "Decisions of an arbitrator ... shall be based exclusively on evidence in the record of the proceeding and material that has been officially noticed." 820 ILCS 305/1.1(e)

B. WITH REGARD TO ISSUE (C), WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on September 26, 2012, based upon the unrebutted testimony of Petitioner and the medical records.

F. WITH REGARD TO ISSUE (F), WHETHER THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE WORK ACCIDENT, THE ARBITRATOR FINDS:

Petitioner's current condition of ill-being regarding his low back (lumbar sprain/strain with a resulting herniated disc at L5-S1 superimposed on pre-existing degenerative disc disease at L5-S1, with resulting lumbago and radiculitis) is causally related to the injury, based upon Petitioner's testimony, the treating medical records and Dr. Shapiro's report of April 23, 2013. Petitioner's histories are a little inconsistent, his treatment efforts at Concentra are not the best and he certainly is not as disabled as he claims (10 pounds lifting?-not on April 24, 2013; ability to work 5 ten hour days a week as a machine operator), but there is no evidence of prior low back treatment or claims. Dr. Shapiro's addendum reports are not persuasive on this issue.

J. WITH REGARD TO ISSUE (J), WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY AND HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES, THE ARBITRATOR FINDS:

No Utilization Review evidence was submitted. The Arbitrator finds the opinion of Dr. Shapiro that the medical treatment rendered before April 24, 2013 was reasonable and necessary to be persuasive and awards same. The Arbitrator also awards the charges for the FCE at ATI of September 24, 2013, which is found to be reasonable and necessary.

Petitioner's Exhibit 2 was the Bills Exhibit. The following bills are awarded:

- Archer Open MRI (Dos: 1/23/2013): $1,800.00
- ATI (Dos: 9/24/2013): 2,679.30
- Windy City Anesthesia PC (Dos: 2/27/2013): 1,050.00
- Integrity Medical Group LTD (Dos: 1/5/2013-3/26/2013): 3,451.74
- Rush Oak Park Hospital (Dos: 9/27/2012): 385.74
- Grand Avenue Surgical Center (Dos: 2/27/2013; 4/3/2013): 40,746.00
- Rush Oak Park Physicians Group (Dos:9/26/2012): 355.00

TOTAL: **$50,467.78**

This award is made pursuant to §§8(a) and 8.2 of the Act.

K. WITH REGARD TO ISSUE (K), ARE TTD BENEFITS OWED TO PETITIONER, THE ARBITRATOR FINDS:

The Arbitrator finds that Petitioner is entitled to TTD benefits from October 6, 2012 through April 24, 2013, a period of 28-4/7 weeks. There was no evidence that Petitioner was taken off work by Rush Oak Park Hospital. The first work restrictions given are by Concentra on October 6, 2012. Respondent did not accommodate the work restrictions. Petitioner continued under work restrictions from Concentra apparently until Respondent stopped authorizing treatment there in December of 2012. There was no release from care or release to work given by Concentra at this time. Petitioner then begins treatment at Integrity and is taken off work completely, effective January 5, 2013. Integrity's off duty order continues through October of 2013. Dr. Shapiro releases Petitioner to full-duty work effective April 25, 2013. He opines that Petitioner is in need of no further treatment as of that date. The Arbitrator is persuaded that April 25, 2013 is the date of MMI. Accordingly, the TTD time period is from October 6, 2012 through April 24, 2013.

L. WITH REGARD TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

In determining PPD awards for injuries sustained after September 1, 2011, the Arbitrator is required to consider the criteria specified in §8.1b of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a furniture mover at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the occupation of

furniture mover is considered a very heavy physical demand level . Because of Petitioner's inability to perform at the very heavy physical demand level , the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Because of the Petitioner's young age , the Arbitrator gives more weight to this factor, given that he will have to live with the effects of the injury for a long time.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner did return to work following this injury and did not engage in a job search . Because of the failure of proof on any vocational issues , the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was released with permanent light to medium work restrictions of no lifting over 72.8 pounds desk-to-chair, no lifting over 39 pounds chair-to-floor, and no lifting over 42.4 pounds above shoulders bilaterally . Because of Petitioner's documented permanent work restrictions, complaints of lumbago and radiculopathy and objective findings of a L5-S1 herniated disc , the Arbitrator gives great weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the Person as a Whole pursuant to §8(d)2 of the Act.

M. WITH REGARD TO ISSUE (M), WHETHER PENALTIES OR FEES BE IMPOSED ON THE RESPONDENT, THE ARBITRATOR FINDS:

After considering all of the evidence, the Arbitrator finds that Petitioner is entitled to §19(l) penalties in the amount of $10,000.00 due to Respondent's failure to pay the awarded medical bills and proper TTD benefits.

Respondent failed to comply with Rule 7110.70 when it declared that Petitioner was "non-compliant" and stopped paying benefits in December of 2012. Respondent had no medical opinion upon which to rely upon

in maintaining its denial position until it received the results of Dr. Shapiro's April 25, 2013 examination of Petitioner. Thereafter, Respondent did not pay the bills associated with the treatment that Dr. Shapiro said was reasonable and necessary. Respondent's non payment of medical expenses that its §12 examiner found to be reasonable and necessary and its failure to abide by Rule 7110.70 merit the award of penalties. Attempts to legitimize Respondent's position by obtaining "addendum" reports from Dr. Shapiro in 2014 and 2015 do not persuade the Arbitrator that §19(l) penalties are not appropriate here. Respondent's actions are without good and just cause. §19(l) provides for penalties of $30.00 per day for the wrongful failure to pay benefits up to the maximum of $10,000.00. Such an award is appropriate in this case.

The Arbitrator does not find that Respondent's actions in the present case support an award of §19(k) penalties and attorney's fees under §16 and, therefore, the Arbitrator declines to award same.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Paul Lemin,

Petitioner,

vs.

NO: 13 WC 5725

17IWCC0435

Al-Amin Brothers Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and notice provided to all parties, the Commission after considering the issues of employment relationship, accident including date and notice, causal relationship, medical expenses, temporary total disability benefits, and nature and extent of the disability, and being advised in the facts and the law reverses the Decision of the Arbitrator.

PROCEDURAL HISTORY

On June 16, 2016 the Arbitrator issued his decision. On July 21, 2016 Petitioner filed his Petition for Review. On August 8, 2016 Respondent filed its Motion to Dismiss Review. On September 28, 2016 a hearing was conducted on Respondent's Motion to Dismiss Review wherein both parties were present. On December 23, 2016 the Commission entered an Order denying Respondent's Motion to Dismiss Review.

STATEMENT OF FACTS

At the May 3, 2016 arbitrator hearing, Petitioner testified he worked as an owner/operator for Respondent; in effect a truck driver. T. 9. Petitioner testified he drove LTL freight (less than a truck load) from the Lansing, Illinois area to the East Coast. *Id.*

Petitioner testified on October 4, 2012 while unloading product at John R. Morreale, he slipped and fell on the ice located in the refrigerated truck trailer. T. 11. Petitioner testified his brother and an employee of John Morreale completed the unloading of the product. T. 12. Petitioner testified he felt immediate pain in his lower back, on his right side to his buttocks all the way to his feet. T. 13. Petitioner testified he continued on to his next delivery and due to his pain, his brother unloaded the product. *Id.*

Petitioner testified he proceeded to Respondent's warehouse that afternoon and rested in his truck. T. 14-15. Petitioner testified he eventually went into the warehouse around 5 or 6 p.m. to use the facilities and check on paperwork. T. 16. Petitioner testified to experiencing severe pain, shortness of breath, and difficulty walking. *Id.* Petitioner testified he spoke with Rafi Al-Amin who was the dispatcher and one of the owners of Respondent and advised him of his back injury. T. 16-17. Petitioner testified he also informed Adrienne and Tyrek Al-Amin, both owners of Respondent, of his back injury. T. 19.

Petitioner testified he continued to work, driving a load to the East Coast with the assistance of his brother. T. 21. Petitioner testified he was unable to perform the loading/unloading of the product and relied on his brother to perform the same. *Id.*

Petitioner testified his back pain became so severe he sought treatment from an emergency room and underwent an MRI on November 5, 2012. T. 23. Petitioner testified he was evaluated by his primary care physician, Dr. Meyer who referred Petitioner to a back specialist, Dr. Maserati. T. 24-25. Petitioner testified that during his treatment he continued to inform Rafi Al-Amin as to his progress. T. 24.

Petitioner testified Dr. Meyer provided pain medication, and Petitioner underwent physical therapy with surgery being undertaken on April 15, 2013 performed by Dr. Maserati. T. 28-29. Petitioner testified prior to the surgery he spoke with Rafi Al-Amin about workers' compensation insurance, and Rafi advised Respondent carried workers' compensation insurance the premiums of which were deducted from the Petitioner's paycheck. T. 29. (PX4 evidences that such premiums were, in fact, deducted from the Petitioner's pay). Petitioner testified Rafi eventually provided the phone number for the workers' compensation insurance carrier which subsequently denied Petitioner's claim. T. 30. Petitioner testified he was terminated by Respondent as he could no longer perform his job. T. 30.

Petitioner testified following the initial surgery he continued to experience pain especially when sitting for prolonged periods of time. T. 32. Petitioner testified he attended physical therapy but eventually underwent a second surgery on August 13, 2013. T. 33-34. Petitioner testified he has not felt normal since his second surgery. T. 35. Petitioner testified he is in constant pain and when he sits for too long, he becomes numb from the waist down and experiences bouts of urinary incontinence. *Id.* Petitioner testified he has not looked for employment since his injury. T. 36. Petitioner testified since the second surgery he has not undergone any significant treatment other than physical therapy and steroid injections. *Id.*

Petitioner testified he sought treatment from Dr. Moossy on two occasions on the referral of Dr. Meyer. T. 37-38. Petitioner testified Dr. Moossy recommended either a disc fusion or a spinal cord stimulator neither of which treatment options Petitioner wishes to pursue. T. 38-39. Petitioner testified he is presently receiving social security disability benefits and has not received any temporary total disability benefits. T. 39. Petitioner testified the majority of his medical bills have been paid by his wife's group health insurance but approximately $5000.00 remains outstanding. T. 41.

On cross-examination Petitioner testified on the date of accident he advised Rafi Al-Amin of the particulars of the injury that being he fell while pulling a pallet. T. 44. Petitioner testified he paid his brother the lumper fees allowed by Respondent for unloading the freight. T. 45. Petitioner testified he signed a driver's contract and identified Respondent's Exhibit 1 as the contract he signed. T. 47. The Commission notes the contract was not offered into evidence.

Petitioner testified prior to the October 4, 2012 injury he experienced low back pain such as sore muscles but nothing requiring surgery. T. 47. Petitioner testified to obtaining an MRI 5 to 7 years prior to his employment with Respondent. T. 48. Petitioner testified he advised Dr. Meyer of his prior back problems which he described as a pulled muscle. T. 50. Petitioner testified he was able to drive a vehicle currently, but the furthest he would drive is 30 miles. T. 51. Petitioner testified to being involved in a motor vehicle accident in August or September of 2014. T. 52.

Petitioner testified he began his employment with Respondent on August 21, 2012, and prior to his accident of October 4, 2012 he took a week off of work. T. 53. Petitioner testified he became angry with the dispatcher and thusly made a decision not to work for a week. T. 54. Petitioner testified he was not directed by Respondent as to which routes to take in making his deliveries. *Id.* Petitioner testified he paid for overhead expenses including tolls and fuel as well as for licensing/tags. T. 54-55. Petitioner testified he received a set of company tags, and the expense for the same was deducted from his pay check. T. 55.

Petitioner testified after the accident he began taking pain medication which he obtained from his wife. T. 57. Petitioner testified with the use of the pain medication he was able to continue to drive. T. 58. Petitioner testified he discussed with Adrienne Al-Amin his possible inability to pass a drug test given the use of pain medication, and Adrienne Al-Amin advised he would take care of it. T. 58. Petitioner testified he did eventually take the drug test and passed. T. 59.

On re-direct examination Petitioner testified Respondent directed him as to what product to load; where to deliver it; and when to deliver it. T. 60.

Mr. Rafi Al-Amin was called to testify on behalf of Respondent. Mr. Al-Amin testified he along with his two brothers, he owned and operated Al-Amin Brothers, an over the road LTL, less than truck load refrigerated carrier. T. 77. Mr. Al-Amin testified he entered into an

agreement with Petitioner to lease Petitioner and his truck to haul product from the Chicagoland area to the East Coast. T. 78. Mr. Al-Amin testified he considered Petitioner an independent contractor. *Id.* Mr. Al-Amin testified pursuant to Department of Transportation rules, Respondent must provide permits/licensing, but the cost was charged to the driver. T. 78-79. Mr. Al-Amin identified a lease agreement purportedly signed by the parties. T. 79.

Mr. Al-Amin testified Petitioner was required to undergo a pre-employment drug test at the start of his employment on August 21, 2012. T. 80. Mr. Al-Amin testified Petitioner was called for a random drug test in September of 2012 after he began his employment. T. 83. Mr. Al-Amin testified Petitioner advised he was unable to pass the drug test as he was taking pain pills he obtained from his wife. T. 85. Mr. Al-Amin identified the driver's manifest which showed Petitioner hauling a load on September 14, 2012 and the next load hauled was September 28, 2012. T. 87-88. Therefore if Petitioner needs to take a drug test, it would be when he returned to the Lansing, IL facility. T. 89.

Mr. Al-Amin testified he spoke with Petitioner on October 4, 2012 and witnessed Petitioner walking slowly and slumped to his side causing Mr. Al-Amin to inquire about Petitioner's condition. T. 89-90. Mr. Al-Amin testified Petitioner advised him that he hurt his back, but Mr. Al-Amin denied that Petitioner advised hurting his back while pushing a pallet. T. 90. Mr. Al-Amin testified based upon the manifest, Petitioner continued to work after October 4, 2012, and during that time, Mr. Al-Amin had no knowledge of Petitioner advising him regarding hurting his back while pushing a pallet. T. 91.

Mr. Al-Amin testified as to the procedure if a driver failed a drug test stating the driver would either be terminated or allowed to complete a drug rehabilitation program. T. 93. Mr. Al-Amin testified in Petitioner's case, he would not be terminated given his good work ethic. *Id.*

Mr. Al-Amin testified Petitioner was paid 70% of freight revenue plus fuel surcharges, unloading charges, handling fees, and gate fees. T. 94. Taxes were not withheld from Petitioner's pay check, but certain expenses were such as payment for insurance or license plates. *Id.*

On cross-examination Mr. Al-Amin testified he possessed no documentation as to the requested random drug test, but such documentation existed just not in his possession. T. 95-96. Mr. Al-Amin testified on the date of accident he saw Petitioner having difficulty moving but again stated Petitioner did not advise of a fall at John Morreale. T. 96. Mr. Al-Amin testified he did receive notice of Petitioner's accident through dispatch. T. 97. Mr. Al-Amin testified his brothers were in the office Friday night, and it was very possible Petitioner discussed his accident with them. T. 98.

The medical records evidence on November 2, 2012 Petitioner sought treatment from an emergency room complaining of pain radiating down his right leg which he associated to pulling a pallet. Petitioner provided a history of experiencing back pain for some duration and

attempting to obtain an MRI for some years. There is no diagnosis or recommendation for treatment as page 2 of the record is not in evidence. PX2.

Thereafter on November 5, 2012 Petitioner sought treatment from Dr. Matthew Meyer and provided a history of severe low back pain. Petitioner stated a history of chronic back problems with a recent injury approximately one week prior while pulling a pallet, he slipped and fell backwards. Given the severity of Petitioner's symptoms, Dr. Meyer prescribed an MRI and referred Petitioner to a neurosurgeon. An MRI was undertaken on November 6, 2012 which evidenced a herniation at the L4-L5 level obscuring the right L5-S1 foramen and impinging the right L5 dorsal root. PX2.

On November 9, 2012 Dr. Matthew Maserati of Allegheny Brain and Spine Surgeons evaluated Petitioner. Petitioner provided a history of back and right leg pain which began on October 5, 2012 when he fell backwards while pulling a pallet. Dr. Maserati diagnosed a lumbar disc herniation with radiculopathy. Dr. Maserati recommended surgery as he did not feel conservative treatment would resolve the problems but recommended injections and physical therapy in the meantime. PX3.

In the interim, on December 6, 2012 Dr. Meyer re-evaluated Petitioner who continued to complain of severe back pain. Dr. Meyer authorized Petitioner off work and continued to prescribe Percocet. Dr. Meyer deferred to the neurosurgeon and his recommendations for surgery. On January 8, 2013 Dr. Meyer re-evaluated Petitioner who continued to complain of low back pain. Petitioner advised he was waiting on a decision from the workers' compensation insurance and would proceed with surgery thereafter. Petitioner also complained of symptoms consistent with a diagnosis of depression. Dr. Meyer prescribed Prozac and hydrocodone. On February 18, 2013 Dr. Meyer re-evaluated Petitioner who continued to complain of severe back pain and depression. Petitioner advised he recently initiated physical therapy without a significant improvement in his pain. Dr. Meyer continued to recommend follow-up with physical therapy and injections as well as possible surgery. Dr. Meyer diagnosed depression and recommended an increase in the amount of Prozac. PX2.

Thereafter on April 5, 2013 Dr. Maserati evaluated Petitioner who advised he underwent physical therapy as well as an epidural steroid injection neither of which provided any relief. Dr. Maserati recommended a repeat MRI given Petitioner's symptom of increased left leg numbness. Petitioner underwent the MRI on April 10, 2013 with surgery performed by Dr. Maserati on April 15, 2013 consisting of a minimally invasive right L4 hemilaminotomy, partial medial facetectomy, foraminotomy, and discectomy. On May 3, 2013 Dr. Maserati re-evaluated Petitioner at which time physical therapy was recommended, and Petitioner was continued to be authorized off work. On May 31, 2013 Dr. Maserati re-evaluated Petitioner who complained of increased pain which he associated to physical therapy. Dr. Maserati advised therapy to be placed on hold and a Medrol dose pack instituted. Petitioner was continued off work. PX3.

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Dr. Maserati evaluated Petitioner on July 2, 2013 and recommended an updated MRI to rule out a re-herniation. An MRI was performed on July 11, 2013 which evidenced a new herniation at the L4-L5 level new since April 2013. Dr. Maserati re-evaluated Petitioner on July 31, 2013 and diagnosed a recurrent herniation at L4-L5 and recommended surgery. Dr. Maserati performed surgery on August 22, 2013 consisting of a re-exploration of right L4-L5 microdisectomy. Dr. Maserati re-evaluated Petitioner on September 4, 2013 at which time physical therapy was recommended. Petitioner was authorized to drive and lift up to 25 lbs. but was not released to return to work until his re-evaluation on October 2, 2013. There is no documentation of an evaluation on October 2, 2013 other than an off work note. PX3.

Petitioner testified he was evaluated on two occasions by Dr. John Moossy although the medical records only document one visit on December 8, 2015. Dr. Moossy recommended either a spinal cord stimulator or a spinal fusion. PX5. Dr. Moossy failed to provide an opinion as to the causal relationship between the proposed treatment and the accident of October 4, 2012.

Petitioner also offered into evidence certain 1099's as well as wage records and driving manifests regarding his employment with Respondent. PX4. The driving manifest documents a delivery at John R. Morreale on October 4, 2012. PX4. A further hearing was undertaken on May 26, 2016 where no evidence was received, and the parties closed proofs. The parties stipulated to an average weekly wage of $1947.66, and the Petitioner's age at the time of injury to be 41 years.

The Commission makes the following factual findings:
*Petitioner established an employment relationship of that of employee/employer.
*Petitioner sustained an accident on October 4, 2012 while moving pallets he fell backwards injuring his back.
*Petitioner suffered a herniated disc at L4-L5 level requiring two surgeries with MMI being reached by October 2, 2013.

CONCLUSIONS OF LAW

"Whether a claimant is classified as an independent contractor or an employee is crucial, for it is the employment status of a claimant which determines whether he is entitled to benefits under the Act. *Earley v. Industrial Comm'n*, 197 Ill. App. 3d 309, 314 (1990); see also *Roberson v. Industrial Comm'n*, 225 Ill. 2d 159, 174 (2007) (noting that an employment relationship is a prerequisite for an award of benefits under the Act)." *Steel & Machinery Transportation Inc. v. The Illinois Workers' Compensation Commission*, 2015 IL App (1st) 133985WC, ¶30.

> Our supreme court has identified a number of factors to assist in determining whether a person is an employee. Among the factors cited by the supreme court are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer compensates the person on an hourly basis; (4) whether the employer withholds income and social security

taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. *Roberson*, 225 Ill. 2d at 175. Another relevant factor is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Id.*; see also *Ware*, 318 Ill. App. 3d at 1122. The label the parties place on their relationship is also a consideration, although it is a factor of "lesser weight." *Ware*, 318 Ill. App. 3d at 1122. The significance of these factors rests on the totality of the circumstances, and no single factor is determinative. *Roberson*, 225 Ill. 2d at 175. Nevertheless, whether the purported employer has a right to control the actions of the employee is "[t]he single most important factor." *Ware*, 318 Ill. App. 3d at 1122; see also *Bauer v. Industrial Comm'n*, 51 Ill. 2d 169, 172 (1972). The nature of the claimant's work in relation to the employer's business is also an important consideration. *Kirkwood*, 84 Ill. 2d at 21; *Steel & Machinery Transportation, Inc. v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 133985WC, ¶ 31. *Esquinca v. The Illinois Workers' Compensation Commission*, 2016 IL App (1st) 150706WC, ¶47.

A. Employment Relationship

The single most important factor is the right of control. Certainly Petitioner owned the truck, but the control asserted by Respondent is indicative of an employment relationship. Petitioner hauled exclusively for Respondent during his employment. The driving manifests and testimony of Petitioner and Mr. Al-Amin evidence Petitioner began his employment on August 21, 2012, and he drove without interruption through October 30, 2012. PX4; T. 30; 80. Petitioner testified he failed to work one week due to a disagreement with the dispatcher, but the issue was resolved after a discussion with Mr. Rafi Al-Amin. T. 53-54. In contrast, Mr. Al-Amin testified Petitioner was asked to undergo a random drug test which Petitioner indicated he could not pass. T. 85-86. As such Petitioner decided not to work for a time period presumably so he could avoid and/or pass the drug test at a later date. The Commission finds Petitioner's testimony more credible than that of Mr. Rafi Al-Amin.

Not only did Petitioner work exclusively for Respondent, his deliveries were pre-determined by Respondent and commenced each week on Friday. Mr. Rafi Al-Amin testified Respondent provided twice weekly service to the East Coast on either Tuesday or Friday, and Mr. Rafi Al-Amin identified Petitioner as a Friday truck. T. 84. Such facts indicate a level of control consistent with an employee/employer relationship as Petitioner's schedule was dictated solely by Respondent.

Additionally, Respondent had the authority to discharge Petitioner at will. Petitioner testified he was terminated by Respondent when he could no longer perform his job and received a letter advising him accordingly. T. 30. Mr. Rafi Al-Amin did not dispute this testimony. In fact, Mr. Rafi Al-Amin confirmed Respondent's ability to terminate Petitioner at will testifying if Petitioner failed a drug test, he would either be terminated or allowed to enter a drug treatment

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program. T. 92-93. Again such is consistent with an employment relationship as is the requirement that Petitioner pass a pre-employment drug test even if the same may be required by the rules of the Department of Transportation. T. 80.

Factors exist which weigh towards an independent contractor relationship such as Petitioner's ownership of the truck (T. 78); Petitioner's ability to hire his brother to perform loading services (T. 45); method of payment (PX4); and the purported lease agreement (T. 78), but taken as a whole, the evidence supports a finding of an employment relationship. Further the nature of the work supports a finding of an employment relationship. Respondent is an over the road LTL, less than truck load refrigerated carrier which services the food industry. T. 77. Petitioner's job was to transport the product for Respondent's customers, and Petitioner did so exclusively for Respondent from his date of hire. The Commission believes contracting parties are free to establish an employment relationship in a manner in which they see fit even if the nature of the business involves over the road trucking and this does not necessarily pre-ordain a finding of the establishment of an employee/employer relationship. The facts of the present case lead to the conclusion Petitioner established the existence of an employee/employer relationship notwithstanding the fact Petitioner was entitled to coverage under workers' compensation insurance even assuming *arguendo* an independent contractor relationship given his purchase of such coverage.

B. Accident

"We begin our analysis by recognizing that in order for an injury to be compensable under the Workers' Compensation Act, the injury must 'arise out of' and 'in the course of' the employment. (Ill. Rev. Stat. 1987, ch. 48, par. 138.2.) The phrase 'in the course of' refers to the time, place and circumstances under which the accident occurred. (*Orsini v. Industrial Comm'n (1987), 117 Ill. 2d 38, 44.*)." *Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 57 (1989). "Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co., 129 Ill. 2d at 57*; *Wise v. Industrial Comm'n, 54 Ill. 2d 138, 142, 295 N.E.2d 459 (1973).*" *Cox v. Illinois Workers' Compensation Commission*, 406 Ill. App. 3d 541, 545 (2010). The Commission finds Petitioner proved he sustained an accident on October 4, 2012 which arose of and occurred in the course of his employment.

Petitioner credibly testified on October 4, 2012 he was performing a delivery at John R. Morreale when he injured his back. T. 11. The driver's manifest confirms Petitioner was making a delivery at John R. Morreale on October 4, 2012. Petitioner's injury occurred in the course of his employment.

"Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [citations omitted]." *Caterpillar Tractor Company v. The Industrial Commission*, 129 Ill. 2d 52, 58 (1989). Petitioner credibly testified

while unloading product he slipped and fell, an act Respondent would reasonably expect Petitioner to perform incidental to his duties to haul product. T. 11. (Under a traveling employee analysis, Petitioner's injury arises out of his employment as such conduct was reasonable and foreseeable. See *Cox v. Illinois Workers' Compensation Commission*, 406 Ill. App. 3d 541 (2010)). There exists slight discrepancies in the initial histories provided by Petitioner to his medical providers as to the mechanism of injury and/or date of accident but taken as a whole, Petitioner proved an accident occurred on October 4, 2012.

As for notice, Petitioner credibly testified he advised Mr. Rafi Al-Amin on October 4, 2012 as to the particulars of his accident. T. 16-17. Mr. Rafi Al-Amin testified on October 4, 2012 he witnessed Petitioner having difficulty walking and slumped over and inquired about Petitioner's condition. Mr. Rafi Al-Amin testified Petitioner advised of an injury to his back but denied Petitioner advised it was due to a work injury. T. 90. The Commission finds Petitioner's testimony credible over that of Mr. Rafi Al-Amin. Additionally, Mr. Rafi Al-Amin testified he subsequently received notice of the accident through dispatch as well as the possibility his brothers were advised by Petitioner of the accident. T. 97-98. Such is consistent with Petitioner's testimony he advised Adrienne and Tyrek Al-Amin of his accident. T. 79.

C. Causal Relationship

The Commission finds Petitioner proved a causal relationship between his accident of October 4, 2012 and his subsequent need for treatment. After an emergency room visit on November 2, 2012, Petitioner sought treatment with Dr. Matthew Meyer who subsequently referred Petitioner to Dr. Matthew Maserati. PX2 & PX3. Following diagnostic testing and conservative treatment of physical therapy and injections, Dr. Maserati performed surgery on April 15, 2013 consisting of a minimally invasive right L4 hemilaminotomy, partial medial facetectomy, foraminotomy, and discectomy. Due to continued pain complaints voiced by Petitioner, Dr. Maserati performed surgery on August 22, 2013 consisting of a re-exploration of right L4-L5 microdisectomy. Dr. Maserati re-evaluated Petitioner on September 4, 2013 at which time physical therapy was recommended. Petitioner was authorized to drive and lift up to 25 lbs. but was not released to return to work until his re-evaluation on October 2, 2013. There is no documentation of an evaluation on October 2, 2013 other than an off work note. PX3.

The Commission finds Petitioner reached maximum medical improvement as of October 2, 2013 given the medical records do not evidence any additional medical treatment after this date other than on one occasion more than two years later. As such his condition had stabilized.

D. Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner was authorized off work by Dr. Meyer as of December 6, 2012. PX2. Both Dr. Meyer and Dr. Maserati continued to authorize Petitioner off of work throughout their treatment. PX2 & PX3. Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [Citation omitted]." *Mechanical Devices v. The*

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Industrial Commission, 344 Ill. App. 3d 752, 759. Petitioner reached MMI as of October 2, 2013. The Commission finds Petitioner is entitled to temporary total disability benefits of $1295.47 per week for the period of December 6, 2012 through October 2, 2013 or 43 weeks pursuant to §8(b) of the Act.

E. Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The Commission finds Petitioner is entitled to payment of medical bills contained in PX1 through October 2, 2013 (date of MMI) and awards the same pursuant to §§8(a) and 8.2 of the Act.

F. Permanent Partial Disability Benefits

Petitioner testified he was terminated by Respondent but has not looked for employment since the accident. T. 36. Petitioner testified he is presently receiving social security disability benefits. T. 39. Petitioner testified since the second surgery he has not undergone any significant medical treatment other than physical therapy and steroid injections. T. 36.

The medical records evidence Petitioner last sought treatment with Dr. Maserati on September 4, 2013 at which time he complained of burning pain in his left leg and trouble ambulating. PX3. Dr. Moossy evaluated Petitioner on December 8, 2015 and recommended either a spinal cord stimulator or a spinal fusion both procedures which Petitioner declined. PX5 & T. 38-39. Further there is no opinion from Dr. Moossy that the recommended treatment is a result of the October 4, 2012 accident.

The Commission weighs the following five factors accordingly:

1) AMA Impairment Rating- Neither party obtained an impairment rating, so no weight is assigned to this factor.
2) Occupation of Petitioner- Petitioner testified he has not returned to work in his occupation as a truck driver but admitted he has not looked for employment. The Commission assigns no weight to this factor.
3) Age of Petitioner- The Stipulation Sheet memorializes Petitioner was 41 years of age at the time of the accident. Petitioner has a significant work life expectancy which will require him to manage the effects of his injury for a greater period of time. As such the Commission assigns weight to this as an aggravating factor.
4) Petitioner's Future Earning Capacity- Petitioner testified he is currently receiving social security disability benefits but provided no testimony regarding any effect on his future earning capacity. As such the Commission assigns weight to this as a mitigating factor.
5) Evidence of Disability/Treating Records- Petitioner testified he is in constant pain requiring pain medication. T. 35. Petitioner testified he goes numb if he sits for prolonged periods of time and experiences bouts of urinary incontinence. *Id.* The September 4, 2013 medical record of Dr. Maserati memorializes Petitioner's

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complaints of pain and numbness as well as use of pain medication. PX3. As such the Commission assigns weight to this as an aggravating factor.

Based upon the above numerated factors as well as the record taken as a whole, the Commission awards Petitioner permanent partial disability benefits of $712.55/week for the period of 100 weeks, because the injuries sustained caused the loss of use of 20% of person as a whole, as provided by §8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 16, 2016 decision is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,295.47 per week for a period of 43 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 medical expenses contained in Petitioner's Exhibit 1 through October 2, 2013 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the lumbar spine injuries sustained caused the permanent disability of the person as a whole to the extent of 20%.

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: JUL 13 2017
LEC/maw
o05/17/17
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L. Elizabeth Coppoletti

Joshua D. Luskin

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sara Eertmoed,

Petitioner,

vs.

NO: 13WC 09370

17IWCC0477

Mental Health & Deafness Resources,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 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 $43,800. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 31 2017
o072617
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

EERTMOED, SARA
Employee/Petitioner

Case# **13WC009370**

17IWCC0477

MENTAL HEALTH & DEAFNESS RESOURCES
Employer/Respondent

On 3/9/2016, 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:

2208 CAPRON & AVGERINOS PC
MICHAEL A ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sara Eertmoed
Employee/Petitioner

v.

Mental Health & Deafness Resources
Employer/Respondent

Case # **13** WC **009370**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,379.60**; the average weekly wage was **$757.30**.

On the date of accident, Petitioner was **30** 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 **$42,713.69** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of $42,713.69.

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 $504.86 per week for 169 6/7 weeks for the periods 10/15/12 through 4/21/13 and 5/6/13 through 2/16/16 as provided in Section 8(b) of the Act.

- Respondent shall authorize and pay for up to two (2) months of additional medical care in the form of a comprehensive pain program as prescribed by Dr. Miledones Eliades.

- Respondent shall pay Petitioner $613.82 for medical treatment from NorthShore University Health Systems

- Respondent shall be given credit for all 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.

17IWCC0477

Findings of Facts

The disputed issues in this matter are: 1) causal connection; 2) temporary benefits; 3) medical bills and 4) whether the petitioner is entitled to prospective medical care. *See,* AX1.

Petitioner's testimony

On October 12, 2012, Sara Eertmoed ("Petitioner") was employed by Mental Health & Deafness Recourses (the "Respondent"), as a team leader in a psychiatric center, working with patients with deafness and autism. Her job required her to dress, bathe and restrain patients. On October 12, 2012, a teenage patient attacked an intern and Petitioner attempted to restrain him. In the process, the patient was able to grab Petitioner by her ponytail and with his full body weight, yank her from side to side. Petitioner testified that she had burning pain in her mid-back and had to lay on the floor, but finished her shift. Petitioner had the next two days off work and attempted to return to work on October 14, 2012, but her mid-back pain increased and she was not able to work.

Petitioner's treatment

On October 15, 2012, Petitioner sought medical treatment at NorthShore Medical Center, where she came under the care of numerous doctors, initially Dr. Michael McCormick. Dr. McCormick recommended a course of physical therapy, which began on November 2, 2013, at Nova Care. An MRI of the thoracic spine took place on November 8, 2012 and revealed a small central herniation at T6-7 and a right paracentral disc at T12-L1. On December 19, 2012 and January 7, 2013, Dr. Thomas Hudgins administered epidural steroid injections to the thoracic spine. PX3.

Petitioner testified that she sought a second opinion concerning the MRI results from Dr. Michael S. Roh at Rockford Spine Center. Dr. Roh found that Petitioner was not a surgical candidate and should continue with non-operative care, physical therapy and injections. PX2.

On February 13, 2013, Petitioner came under the care of Dr. Miledones Eliades. Dr. Eliades recommended physical therapy and trigger point injections. On February 16, 2013, Petitioner underwent a second MRI of the thoracic spine which revealed disk bulges in the mid-thoracic region. Petitioner started a course of physical therapy at NorthShore Omega on March 12, 2013. On March 20, 2013, Dr. Eliades administered a trigger point injection to Petitioner's thoracic spine.

On March 19, 2013, Petitioner underwent an independent medical examination (IME") at the request of the Respondent, with Dr. Sean Salehi. Dr. Salehi diagnosed a thoracic sprain which evolved into myofascial pain syndrome. He found that Petitioner could return to work without restrictions.

On April 23, 2013, Petitioner attempted to return to work at a light duty capacity. Petitioner testified that she worked for approximately two weeks and was unable to complete a full day. Dr. Eliades noted that Petitioner's physical therapy had been interrupted and that she required further physical therapy. On May 6, 2013, Dr. Eliades removed Petitioner from the workforce. On June 5, 2013, Dr.

Eliades recommended a course of physical therapy, valium and trigger point injections to the thoracic spine. On August 28, 2013, Respondent approved a course of physical therapy which was again interrupted in October of 2013.

On June 18, 2014, Petitioner had a third MRI of the thoracic spine which revealed several disc protrusions about the spinal cord and a minimal cord indentation at T6-7. The MRI report indicates that the findings are similar to the MRI of February 6, 2013.

On July 23, 2014, Petitioner was seen by Dr. Shakeel A. Chowdhry, a spine specialist who indicated that Petitioner was not a surgical candidate; and had now developed symptoms in her upper extremities and complaints of pain, while driving. He reviewed the MRI from June 20, 2014 and noted "Multilevel thoracic spine disease with desiccation, Schmorl's noted, and small disc bulges and protrusions. Several disc protrusions abut the spinal cord and there is minimal cord indentation at T6-7. However, there is no significant central canal stenosis and no significant neuroforaminal narrowing. Findings are similar to those seen on prior examination dated 2/6/2013." RX4.

On September 24, 2014, Dr. Eliades indicated that Petitioner had completed her physical therapy but referred her for a comprehensive pain management program. On July 29, 2015, Dr. Eliades reiterated the need for a comprehensive pain program.

On October 28, 2014, Petitioner was examined for a second time by Respondent's independent medical examiner, Dr. Sean Salehi. Dr. Salehi opined that Petitioner did not need a pain management program and could return to work without restrictions.

Petitioner testified that she is seeking approval for the comprehensive pain program recommended by her doctor and the associated temporary total disability benefits.

Deposition of Dr. Miledones Eliades, dated September 24, 2015

Dr. Eliades testified that Petitioner has objective findings of myofascial pain syndrome and testified as follows: "She has a certain place, roughly to the right of her area of injury, a kind of bundle of muscle that was very tight and palpably different. You know, when you feel it, it was almost like a big worm or a little rope, and that was something that was objective in the sense it is so focal that a patient cannot specifically contract and make that small an area of muscle be tight. So it is something that is done reflexively. And so in that case, I would consider it to be objective in that the patient has no contribution to the production of that abnormality." Dr. Eliades indicates that this area has remained symptomatic and objectively identifiable throughout the course of his treatment.

The record of Dr. Eliades dated June 5, 2013, indicates that Petitioner's condition is due to her work related injury. This opinion was not rendered in response to a request from any party. When asked to expand on the issue of causation Dr. Eliades testified as follows: " ...what was described , being pulled

back and forth by her hair very suddenly by someone with a lot of strength would be consistent with an area of injury in the mid thoracic spine, because that's usually a pretty stable area, but the type of injury is the kind of thing that would cause a lot of force in that area. The other thing is that her symptoms consistently in my opinion and her exam was all consistent with a problem arising in that area of injury and was—and so far as I was concerned, there was no other explanation for someone to have these symptoms other than some sort of injury in that area...." PX7, pp. 13, 32-34.

Deposition of Dr. Sean Salehi, dated December 22, 2015

Respondent's independent medical examiner, Dr. Sean Salehi is a neurological surgeon and his first examination of the petitioner was conducted in March of 2013; whereupon he found Petitioner to have a tender thoracic spine, with myofascial pain. Dr. Salehi found a largely benign physical examination and stated that Petitioner could return to full duty work. The doctor confirmed the pain was not from any of the degenerative findings on the MRI or CT scans and Petitioner could return to work full duty at maximum medical improvement with a recommendation only to taper off the narcotic medication. Dr. Salehi explained he had an understanding of Petitioner's job duties involving the dressing and treatment of patients who may be combative at times, and explained Petitioner should be capable of performing full duty work. This is based on a medical examination showing normal gait, posture and full strength and reflexes as well as the negative diagnostic testing. RX1, pp. 9-17.

Dr. Salehi testified to a second medical examination of Petitioner occurring on October 28, 2014 whereupon the doctor was provided updated treatment records including extensive therapy reports and additional MRI and CT scans in findings. The doctor was aware Petitioner had undergone a series of additional injections as well. Dr. Salehi noted Petitioner had now since undergone three full months of what was considered "specialized" physical therapy, which Petitioner described as having greatly reduced her pain. Petitioner still had burning pain in her chest and symptoms involving numbness and pain in her hands and arms, which was a new symptom from the earlier examination and treatment records. The doctor opined that this condition was not related to the original injury as it was new. Dr. Salehi explained that the trigger point injection results, which offered only temporary relief, supported his conclusion that this injury was muscular in origin and did not involve any spinal disc issue including any facet joint issue. Upon examination, Petitioner's gait, posture and strength were normal. RX1, pp. 20-27, 54.

Dr. Salehi noted non-organic symptoms and findings upon this second examination and confirmed that there was no explanation for Petitioner's new symptoms in the upper extremities but did opine that these new symptoms were not related to the original injury. Dr. Salehi testified that Petitioner's area of thoracic bulge, upon MRI findings, did not correlate to her current complaints of pain and was not the cause of her symptoms. The doctor stated that there were no significant, facet joint complications in his opinion; and there was no further need for treatment in that regard.

Dr. Salehi went on to offer a new AMA impairment rating in this case of 6%, after clarification of his calculations, where he had originally offered a 3% rating. The case was heard on a Section 19(b) Motion and the doctor's opinions on impairment rating will be reserved for consideration upon future findings as may be needed. Dr. Salehi recommended a home exercise program and that Petitioner be weaned off medication.

Conclusions of Law

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

A claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Commission,* 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R&D Thiel,* 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Commission,* 397 Ill. App. 3d 665, 674 (2009).

For an employee's workplace injury to be compensable under the Workers' compensation Act, she must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. See, *Hansel & Gretel Day Care Center v. Industrial Commission,* 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. See, *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill. 2d 207 at 214, 254 N.E.2d 522 (1969).

Proof of prior good health and change immediately following and continuing after an injury, may establish that an impaired condition was due to the injury. *Hopkins v. WSNS Telemundo,* 02 IIC 0946, 99 W.C. 42128 (2002). In determining that an employee was entitled to compensation for aggravation of a pre-existing injury in *Hopkins,* the Commission noted that petitioner was in good health prior to the fall, he had no restrictions prior to his fall; and following his fall he suffered a marked decrease in his health and ability to function at work.

Petitioner testified that she never had any problems or medical treatment to her back prior to the incident of October 12, 2012. The Arbitrator found Petitioner's testimony to be credible and unrebutted. Petitioner's treating physician, Dr. Miledones Eliades has diagnosed myofascial pain syndrome and mechanical dysfunction to her thoracic spine.

The Arbitrator finds the opinion of the treating physician, Dr. Miledones Eliades, more persuasive in the subject case. The Arbitrator adopts the opinions and findings of the treating physician, Dr. Eliades

and finds a causal connection between Petitioner's condition and her work accident of October 12, 2012. The Arbitrator further finds that the petitioner has proven, by a preponderance of the evidence, that her present condition of ill- being and need for medical treatment is causally related to the injury of October 12, 2012.

K. Is Petitioner entitled to prospective medical care?

On September 24, 2014, Petitioner completed the physical therapy recommended by Dr. Eliades. Dr. Eliades recommended pain medication but discussed with the patient that this was not treating the underlying problem. Given the complex nature of Petitioner's pain and given the fact that surgery was not an option; Dr. Eliades recommended a comprehensive pain program. Dr. Eliades testified that as of his last examination, he felt the best way for Petitioner to recover function and hopefully return to the work force was through a comprehensive pain program.

The Arbitrator finds that the petitioner is entitled to prospective medical care, specifically the comprehensive pain program recommended by Dr. Eliades. The Arbitrator further limits the approved compressive pain program in this 19(b) hearing to no more than two months per the testimony of Dr. Eliades.

L. What temporary total disability benefits are in dispute?

Petitioner testified that she stopped working on October 15, 2012, when she initially sought medical treatment with NorthShore University Medical Center. This is consistent with the medical records from that facility. The parties have stipulated that Petitioner was off work through April 21, 2013 when she made a bone fide attempt to return to work. Petitioner testified that she struggled to complete a day and constantly left work early. Petitioner worked for two weeks before again being removed from the work force. Dr. Eliades testified that he did not feel that Petitioner could perform anything he would call meaningful or productive work. PX7 p. 37.

Based on the medical records and Petitioner's testimony, the Arbitrator finds that Petitioner was temporarily totally disabled for the periods October 15, 2012 through April 21, 2013 and May 6, 2013 through February 16, 2106 for a period of 169 6/7 weeks, and therefore is entitled to have and receive from the respondent the sum of $504.86 per week as provided in Section 8(b) of the Act.

17IWCC0477

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC9370
SIGNATURE PAGE

Signature of Arbitrator

March 8, 2016
Date of Decision

MAR 9 - 2016

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Teresa Beruman,
Petitioner,

vs. NO: 13 WC 16428

Arvin Meritor,
Respondent.

17IWCC0427

DECISION AND OPINION ON REVIEW

Petitioner and Respondent cross-appeal the §19(b) decision of Arbitrator Andros filed on November 24, 2015. Notice has been given to all parties. The Commission, after considering issues including accident, causal connection, and medical expenses (incurred and prospective), and being advised of the facts and law, hereby reverses the Arbitrator's decision as described below. The Arbitrator's decision is attached hereto and made a part hereof.

The Arbitrator found that Petitioner sustained a work-related repetitive trauma injury (affecting Petitioner's left shoulder and neck). However, the Arbitrator also found that Petitioner's current ill-being was not related to repetitive work. Accordingly, he denied Petitioner's request for reimbursement of medical expenses and for prospective medical treatment.

The Commission finds that Petitioner failed to prove an occurrence of accident under the Act and reverses the Arbitrator's decision in that respect. The Commission agrees that no benefits, including medical expenses or prospective treatment, are due.

17IWCC0427

BACKGROUND

Petitioner was employed as an assembler at Arvin Meritor, a producer of automotive parts and systems. Prior to filing the instant claim, in late 2012, Petitioner filed 12 WC 38274 and 12 WC 38275; up until the morning of the hearing for the instant matter, these two other claims were pending.[1] The latter claim alleged right elbow lateral epicondylitis, for which Petitioner underwent surgery on March 1, 2013. This surgery was performed by Dr. Brian Foster of Rockford Orthopedic Associates, to whom Respondent sent Petitioner for treatment. (PX 1)[2].

Five days after the right elbow surgery, on March 6, 2013, Petitioner returned to work in a restricted capacity with only the use of her non-dominant left arm. With her right arm in a splint, she assembled hundreds of shock absorbers every day using her left arm and hand, 10 hours per day, 4 days per week. She stood slightly bent over a table while she did this work. She also pushed carts that were filled with assembled parts, several times a day; she had to use force to do this pushing as the the wheels on some carts would often get "stuck." (Tr.8-15).

Petitioner testified that, after working in this manner for a couple of weeks, she noticed pain in the left hand, left elbow and left shoulder. She also described having difficulty walking because of back pain. (Tr. 27-31). Petitioner testified that she orally reported this pain to her supervisor on March 19, 2013. As well, she stated that, during several visits and physical therapy sessions with Rockford Orthopedics Associates following the right elbow surgery, she reported her new discomfort. However, according to Petitioner, she initially was told by the "company's doctor" there that they were authorized to look at her right elbow only. (Tr. 31-33).

The first time that reference to a cervical spine issue appears in the medical records was May 15, 2013. On that day, Dr. Robin Borchardt noted Petitioner's complaints of left-sided pain. X-rays were taken of her cervical spine and left shoulder; the doctor's impressions included cervical radiculitis, and a cervical spine MRI was ordered. Dr. Borchardt discussed the findings with Petitioner on May 28, 2013. He wrote:

> "I had a long discussion regarding her MRI scan which shows significant degenerative changes. At this point in time, she has no specific injury, and as I discussed with her these findings are degenerative and I cannot attribute this to a work-related injury. She was advised that due to the amount of spinal stenosis she has and her symptoms, she will need to see a spinal surgeon. She is starting to develop some myopathy of her left arm.... I explained to her that with her type of medical diagnosis, with time this can become worse, irrespective to any of her activities."(PX 1) (emphasis added).

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[1] These two claims were settled on the morning the instant matter proceeded to hearing, September 24, 2015. Regarding the right elbow claim, the settlement contract, approved by Arbitrator Andros, provided for compensation reflecting 15% loss of use of the right arm. (RX 3).

[2] Citations to the pages of the hearing transcript, Petitioner's exhibits and Respondent's exhibits are styled "Tr. --," "PX --," and "RX --," respectively.

On May 17, 2013, Petitioner filed her instant Application for Adjustment of Claim, asserting injury to "left arm and body" with a manifestation date of March 19, 2013. The Application indicated that the injury occurred through "working with injured right arm and injured left arm."

On June 13, 2013, Petitioner returned to unrestricted work, having been deemed recovered from her right elbow surgery by her surgeon. (PX 1). Thus, Petitioner was limited to left arm use for a total period of a little over 3 months (March 6 through June 13, 2013).

On July 29, 2013, Petitioner received a recommendation for cervical spine surgery (C5 through C7 anterior discectomy and fusion) from Dr. Brian Braaksma, to whom Petitioner was referred by Dr. Borchardt. (PX 1). Petitioner has not seen any doctor for her cervical spine issue since July 2013. (Tr. 45).

This matter proceeded to §19(b) hearing on September 24, 2015. At that time, Petitioner had long since achieved recovery as to her right elbow and had been working full-time, without restrictions, since then. However, regarding her neck and left arm, Petitioner stated that she continues to have pain and every day she feels worse. (Tr. 37). Nevertheless, she has missed no work due to any left arm or cervical spine issue. (Tr. 37, 42).

Petitioner requests that the Commission award her the prospective recommended cervical spine surgery and payment of medical bills related to the cervical spine. Petitioner states she wishes to undergo the surgery because she was told she might become paralyzed if she does not have it. (Tr. 37-38).

DISCUSSION

Petitioner claims a work-related aggravation to her preexisting degenerative cervical spine disease. Her theory of injury is based on repetitive trauma. She explicitly concedes that she can identify no sudden injury. In essence, Petitioner is claiming that repetitive use of her left arm caused an ongoing need for cervical spine surgery.

In a repetitive trauma case, there must be a showing that the injury is work-related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n,* 115 Ill. 2d 524 (1987). Furthermore, as to aggravation of a preexisting condition, this question is a factual one to be decided by the Commission. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 206 (2003). Although medical testimony regarding causation is not necessarily 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 the claimant's work activities caused the condition complained of. *Interlake Steel Co. v. Industrial Comm'n*, 136 Ill. App. 3d 740 (1985). "Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions... and this is especially true in repetitive trauma cases." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (1987).

Petitioner offered the medical testimony of Dr. Jeffrey Coe, who examined her at her counsel's request in May 2014. Dr. Coe is an occupational medicine specialist, not a surgeon. Dr. Coe opined that Petitioner had left cervical radiculopathy with early symptoms of cervical myeloradiculopathy. (PX 4 at 17-18; deposition exhibit 3). Dr. Coe opined that her repetitive work aggravated her previously-asymptomatic disc disease, and that appropriate treatment would include the fusion surgery recommended by Dr. Braaksma. (PX 4 at 17-21). The basis for Dr. Coe's causation opinion was that Petitioner's complaints arose contemporaneously with her work activities beginning in March 2013. (PX 4 at 43, 47).

Respondent offered the testimony of Section 12 examiner Dr. Carl Graf, who examined Petitioner in December 2014. Dr. Graf is a board certified surgeon who has completed a combined orthopedic and neurosurgical fellowship in spine surgery. Dr. Graf opined that, in his view, the May 2013 cervical spine MRI demonstrated preexisting degenerative changes with no acute findings; his diagnosis was preexisting cervical spondylosis. Further, Dr. Graf believed that it was not reasonable or necessary to operate on a patient that exhibited the subjective and objective findings of Petitioner. He pointed out that Petitioner had normal neurological examinations. (RX 1 at 24-25, deposition exhibit 2). Dr. Graf was unable to causally relate Petitioner's cervical spinal condition and complaints of pain with her work activities. (RX 1 at 26).

Under the evidence presented, the Commission finds that Petitioner has failed to prove an occurrence of accident as alleged. Petitioner offered no testimony or other evidence to describe her work activities -- repetitive or otherwise -- after she was returned to regular, unrestricted work in June 2013. The Commission further finds (as did the Arbitrator) that Petitioner has failed to prove a causal relationship between her repetitive work activities as alleged and her current cervical spine condition. Her claim that repetitive use of her left arm aggravated her cervical disc disease (to the point of requiring surgery) is implausible enough on its face, but is even more incredible in light of the fact that this repetitive trauma was experienced in its entirety during a 3-month period in 2013. At worst, Petitioner suffered a strain to her left upper extremity while she was restricted to one-armed work. This strain was long resolved by the time of the hearing.

Regarding medical causation testimony, the Commission finds (as did the Arbitrator) Dr. Graf to be more credible than Dr. Coe. It should be kept in mind that even one of her treating orthopedists, Dr. Borchardt, believed her cervical spine disease to be not work-related. (The notes of Dr. Braaksma, who recommended the spine surgery, were silent as to causation). Dr. Graf believed that Petitioner was not a candidate for surgery. Given the Commission's findings regarding accident and causation, the Commission need not reach the question of whether the sought-after fusion surgery is reasonable or necessary.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed November 24, 2015, is hereby reversed as discussed above. Benefits 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 the alleged 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:

Joshua D. Luskin

Charles J. DeVriendt

o-05/17/17
jdl/ac
68

L. Elizabeth Coppoletti

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

BERUMAN, TERESA
Employee/Petitioner

Case# **13WC016428**

ARVIN MERITOR
Employer/Respondent

17IWCC0427

On 11/24/2015, 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 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
MITZI HENIFF
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Teresa Beruman
Employee/Petitioner

v.

Arvin Meritor
Employer/Respondent

Case # **13** WC **16428**

Consolidated cases: _____

17IWCC0427

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Rockford**, on **September 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. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, **Arvin Meritor**, Respondent *was* operating under and subject 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 **$38,863.72**; the average weekly wage was **$747.36**.

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

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

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

Respondent is entitled to a credit of **$813.40** under Section 8(j) of the Act.

ORDER

Respondent is NOT liable to pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $753 to Dr. Sliwa, $1880 and to Rockford Orthopedic Assoc., as provided in Sections 8(a) and 8.2 of the Act.

Respondent is NOT liable for authorize/ pay for cervical fusion.

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

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

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

George J. Andros #01
Signature of Arbitrator

November 20,2015
Date

ICArbDec19(b)

NOV 24 2015

Statement of Facts 13 WC 16428

Petitioner, Teresa Beruman, was employed as a laborer for Respondent, Arvin Meritor. Petitioner settled two other cases on the date that this matter proceeded to hearing, 12 WC 38274 and 12 WC 38275. In the latter claim, Petitioner underwent surgery for right lateral epicondylitis. The surgery took place on March 1, 2013.

Petitioner had a splint on her right arm. She was released by the surgeon, Dr. Foster, to return to work with one arm. Petitioner testified that she was forced to return to one armed work. Petitioner testified that she worked a ten hour shift in a factory using her non-dominant left hand. She stood before a table and put a metal cap on small parts. She testified that she used her left hand to push in the metal. It had to snap in place and this took some force. She pantomimed using the thenar eminence on the left hand to push and then taking her left thumb to push more and to secure the piece of metal onto the small part. Once she had put together 250 pieces she filled a box. The box had wheels. She then pushed the box with her non-dominant arm (her right arm being in a sling from the recent surgery) to another table. Petitioner testified that about half the boxes were very difficult to push as the wheels would not turn correctly.

Petitioner then put a larger part on a table and put the smaller ones that she had assembled on top. A machine then secured the two parts together.

Petitioner testified that putting the metal on the parts and pushing the boxes was difficult and required force with the one arm she had to use.

After performing this job for a few weeks Petitioner began to notice pain between her shoulder blades. She also complained of pain in her left shoulder, arm and hand. She described having difficulty walking because of the pain. She testified that she informed her supervisor, Morgan Troy about the difficulty that she was having. These events occurred on March 19, 2013.

Petitioner saw her elbow surgeon, Dr. Foster on April 9 and April 22. His record does not mention any complaint regarding the left shoulder, hand or neck. Petitioner testified that she informed the doctor but he would only look at her right elbow as that is all he was authorized to treat. Petitioner was finally sent by the company to see Dr. Borchardt. She had seen Dr. Borchardt before being referred to Dr. Foster for the elbow as well. Dr. Borchardt saw Petitioner on May 15, 2013 and recommended an MRI. The MRI was done on May 23, 2013 and showed a mild bulge at C5/6 with mild to moderate stenosis with ventral cord effacement and moderate left neuroforaminal stenosis impinging on the exiting C6 root. Dr. Borchardt diagnosed a left arm myelopathy and referred Petitioner to Dr. Braaksma but opined that the findings were due to spinal stenosis and not to a work related injury. When asked how Petitioner was sent to Dr. Borchardt she answered that he was a "company doctor."

Dr. Braaksma saw Petitioner on June 24 and July 29, 2013. He saw a gradual onset of symptoms. He felt Petitioner may be a candidate for surgery in June. By July, he recommended a C5 through C7 anterior discectomy and fusion. Petitioner described to the doctor that she felt like she was drunk and she was dropping objects.

Petitioner saw Dr. Sliwa for a second opinion on July 31, 2013. He recommended the same surgery. He noted that there had been neck and left arm pain progressively for about four months.

Both sides obtained expert opinions. Dr. Coe opined that the condition was work related and Dr. Graf opined that it was not work related.

Petitioner continues to work full duty having long healed from the elbow surgery. She testified that she has pain in her neck and left arm. She has difficulty when she lifts items or works long hours. She testified that she feels worse than she did when she saw the doctors in 2013 but continues to work. She is afraid she will be paralyzed if she does not have surgery. She was asked if she wants to have surgery and answered that she does not want it but has to have it.

In support of the Arbitrator's decision relating to C and D, the Arbitrator finds the following facts:

Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent due to repetitive trauma. The date of manifestation plus the date of notice under section 6 (c and case law is March 19th, 2013. There is no specific accident. However, the work Petitioner did, standing and forcing pieces of metal onto a part using her left arm, in a pushing downward manner where it was clear that force was generated up to the shoulder and neck, and then struggling to push a box of 250 units that did not roll well despite having wheels, aggravated Petitioner's underlying degenerative disc disease. Using only one arm made all movements awkward and Petitioner's symptoms arose contemporaneously with this repetitive, forceful and awkward work.

Petitioner's testimony that her doctors at first only wanted to look at her right elbow is unrebutted and credible. She testified that she attempted to work and her stoic attempt to work gives credence to her testimony that she worked in pain. She also testified that she did tell her doctors about her pain before May 15 and this credible testimony was unrebutted. Given Dr. Borchert as the gatekeeper of ROA it is accepted that the Petitioner's testimony is true that she told the worker she can only treat what the employer says she can treat.

In support of the arbitrator's decision relating to F , J and K the Arbitrator finds the following facts:

The Arbitrator has heard the testimony then evaluated and studied at length the medical evidence. The Decision is based upon the preponderance of the evidence based upon the totality thereof.

The Arbitrator adopts the opinion of Dr. Carl Graf, board certified spinal surgeon, who completed his fellowship in both the orthopedic and neurosurgical traditions of spine surgery. He was chief resident in orthopedics his final year of that service.

Inter alia, the Arbitrator adopts his testimony that the Petitioner has a degenerative spinal condition thus agreeing with the company doctor. Rx.1, Page 16:1-4.

The Arbitrator adopts Dr. Graf's opinion that Petitioner is not a surgical candidate. Page 19: 21-24 & Page 20: 1.

The Arbitrator underscores his testimony that Petitioner has a normal neurological exam with no " hard neurological findings" Page 24: 16-20.

The Arbitrator cites page 24 and the discussion about is issue of the Petitioner being mylopathic as extremely informative plus determinative of the balance of the medical evidence turning to Dr. Graf over the testimony of Dr. Coe , particularly with regard to the condition found and the diagnosis. In particular see page 24, lines 21-24 then all page 25 , 26 and 27.

Having found the condition not causally related to repetitive work the medical bills for treatment to the cervical spine are denied These are from Rockford Orthopedic Associates in the amount of $1,800.00 and Dr. Sliwa in the amount of $753.00 both of which are the responsibility of the Petitioner.

Further the request for spine surgery in the case at bar is denied as a matter of fact and law under 8(a).

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

Bernardo Cardona,

Petitioner,

vs. NO. 13 WC 16951

A.Q.L., Robert Choi, Dreambag, Inc.,
And Illinois State Treasurer as ex officio Custodian,
Of the Injured Workers' Benefit Fund
Respondents.

17IWCC0478

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and notice given to all parties, the Commission, after considering the issues of notice, and whether the matter remains pending as to A.Q.L and Dreambag, 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 20, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent, Robert Choi, 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: JUL 31 2017
SJM/sj
o-6/29/2017
44

Stephen J. Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARDONA, BERNARDO
Employee/Petitioner

Case# **13WC016951**

A Q L ROBERT CHOI DREAMBAG INC AND ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0478

On 1/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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CHICAGO, IL 60601

17IWCC0478

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

Bernardo Cardona
Employee/Petitioner

v.

A.Q.L., Robert Choi, Dreambag, Inc., and Illinois State Treasurer as *ex officio* Custodian, of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **13** WC **16951**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **December 19, 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 X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Notice of Hearing, Insurance coverage, all issues**

FINDINGS [ALSO SEE BELOW FOR THE ARBITRATOR'S FINDINGS AS TO THE ADEQUACY OF NOTICE OF THE HEARING AND WHETHER THE INJURED WORKERS' BENEFIT FUND IS IMPLICATED IN THIS CASE]

On **March 14, 2013**, Respondent Robert Choi *was* operating under and subject to the provisions of the Act.

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

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 Robert Choi.

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

In the year preceding the injury, Petitioner earned $ **23,400.00**; the average weekly wage was **$450**.

On the date of accident, Petitioner was **58** years of age and 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.

ORDER

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner failed to provide adequate notice of the hearing to Respondents AQL and Dreambag, Inc. Petitioner did establish adequate notice as to Respondents Robert Choi and the Injured Workers' Benefit Fund but offered no evidence indicating that Choi lacked workers' compensation coverage at the time of the accident. The Arbitrator thus finds that the Injured Workers' Benefit Fund is not implicated in this claim.

The Arbitrator awards Petitioner the following benefits as against Respondent Robert Choi only: 1) temporary total disability benefits in the amount of $300 per week from March 15, 2013 through May 17, 2013, a period of 9 1/7 weeks; 2) the $376.00 bill from ECP Services (PX 4), subject to the fee schedule, the $1,936.07 bill from Alex Orthopedics, LLC (PX 6), subject to the fee schedule, and the $1,685.88 in prescription expenses from EqMD (PX 7); 3) permanent partial disability equivalent to 40% loss of use of the left middle finger, representing 15.2 weeks of benefits under Section 8(e) of the Act. The Arbitrator declines to find Robert Choi liable for penalties and fees.

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

Molly C Mason

Signature of Arbitrator

1/20/17

Date

JAN 20 2017

Bernardo Cardona v. AQL, Robert Choi, Dreambag, Inc. and IWBF
13 WC 16951

Procedural History

Petitioner alleges a work-related finger injury of March 14, 2013. In his Second Amended Application, filed on February 5, 2014, he named four respondents: AQL, Robert Choi, Dreambag, Inc. and the Injured Workers' Benefit Fund [hereafter "the Fund."]. Arb Exh 2. At some point during 2016, counsel for Petitioner and the Fund selected a hearing date of October 18, 2016. On that date, counsel for Petitioner and the Fund appeared before the Arbitrator. Counsel for the Fund objected to proceeding, arguing that Petitioner had failed to provide adequate notice of the hearing to the non-Fund respondents. The Arbitrator agreed with the Fund's assessment and the hearing was continued to December 19, 2016.

Arbitrator's Summary of Notice-Related Evidence

The hearing held on December 19, 2016 began at approximately 10:20 AM, with the Arbitrator noting that no one purporting to represent any of the non-Fund respondents had checked in with her that morning. In response to a question posed by the Arbitrator, counsel for Petitioner and the Fund denied having prior contact with anyone purporting to represent the non-Fund respondents.

The Arbitrator then asked Petitioner's counsel to offer evidence concerning his attempts to notify the non-Fund respondents of the December 19, 2016 hearing. Petitioner offered into evidence a group of pleadings (notices and requests for hearing) dating back to late 2013 along with United States Postal Service documents. All of the service lists in the pleadings show "1363 Western Avenue" in Blue Island as the address for respondents Dreambag and AQL and "4534 West North Avenue" in Chicago as the address for respondent Robert Choi. As to Dreambag, certified mail documents show an inability to effect delivery in Blue Island on November 3, 2016 due to the intended recipient having moved and, ultimately, delivery on December 5, 2016 at an unspecified address in Atlanta, Georgia. As to AQL, certified mail documents reflect that the letter was returned to the sender due to an "insufficient address" and no forwarding information. As to respondent Robert Choi, the documents show that service was attempted at the West North Avenue address but was ultimately unsuccessful, with the addressee described as "unknown" and lacking forwarding information. PX Group Exh 11. The Arbitrator made inquiry of Petitioner's counsel as to the discrepancy between the address of 13636 Western Avenue listed on the Second Amended Application (Arb Exh 2) and that on the service lists and certified mail envelopes in PX Group Exh 11. Petitioner's counsel indicated the correct address was indeed 1363 Western Avenue. Based on this representation, the Arbitrator found Petitioner's attempts sufficient and allowed the hearing to proceed.

After proofs were closed, the Arbitrator compared the documents in PX Group Exh 11 with two other exhibits she had not previously seen, namely PX 2 (a paramedic run sheet and bill from the Blue Island Fire Department dated March 14, 2013) and PX 9 (an "Affidavit of Special Process Server" dated June 13, 2013). The documents in PX 2 reflect that paramedics encountered Petitioner and tended to his finger injury at a building located at 13636 Western Avenue. [During the hearing, Petitioner testified he used his own cell phone to summon paramedics to the scene of the accident.] PX 9 reflects that Joseph Cairo, a special process server, served Antonio Rentas with a 19(b) petition, along with other documents relative to this claim, at the same address, with Rentas acknowledging that Petitioner had worked as a mechanic for a business named "Dreambag, Inc." at that location. [During the hearing,

Petitioner expressed uncertainty as to the name(s) of the business he worked for but clearly identified an individual named "Antonio" as his supervisor.]

Arbitrator's Summary of Coverage-Related Evidence

Petitioner offered into evidence only one coverage-related document, namely a Certification from Jorge Acevedo of NCCI stating that the NCCI database reflects no evidence that AQL or Dreambag, Inc. was covered by a workers' compensation insurance policy on the alleged date of accident, March 14, 2013. PX 1. Acevedo indicated he used an address of "1363 Western Avenue" in Blue Island, Illinois in searching the database.

Petitioner offered no evidence concerning Robert Choi's coverage or lack thereof.

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter. He testified he is now 62 years old. He has been divorced for 20 years. He has two adult children, ages 22 and 32. He was 59 years old and had no dependent children at the time of his alleged accident.

Petitioner testified, with no objection from the Fund, that he sustained a work-related accident on March 13, 2013. He further testified the accident took place between 4:00 and 4:30 PM that day. At that time, he was operating a machine at a business that manufactured military uniforms and leather products. The business was located on South Western Avenue in Blue Island, Illinois. He started working at this business about six months before the accident. He found the job by placing an advertisement in a newspaper.

Petitioner testified that, to his knowledge, an individual named Robert Choi owned the business. His immediate supervisor was an individual named Antonio. Other machine operators, including women named Melba and Rosia, worked with him.

Petitioner testified that the business had three or four names, one of which was IAMC Manufacturing. When his counsel asked him whether another of these names was "AQL," he said "no." When asked whether another name was "Dreambags," he responded that he knew this name at one time.

Petitioner testified that, during the time he worked for the business, he earned $21 per hour and was paid in cash, with taxes deducted. He worked 30 hours per week. [On the Request for Hearing form, his counsel alleged earnings of $23,400 and an average weekly wage of $450. No wage- or tax-related documents are in evidence.]

Petitioner testified that, immediately before the accident, he was operating a "pressure machine" at the business. The owner, Robert Choi, cut off the electricity, which caused Petitioner's machine to lose power. The press mechanism of the machine came down onto Petitioner's left middle finger, severing a small section of the tip of that finger. Petitioner testified he screamed and picked up the severed tissue. Choi apologized and left. Antonio was present at the time of the accident, as were Melba and Rosia. Antonio went to an ice machine and obtained ice for Petitioner to apply to the finger.

Petitioner testified he used his own cell phone to call 911 since it was his understanding that workers were not allowed to use the business's phones. An ambulance arrived and transported him to the Emergency Room at Metro South.

As noted above, the Blue Island Fire Department run sheet (PX 2) reflects that paramedics arrived at the "Libby Building," located at 13636 Western Avenue, at 4:04 PM on March 14, 2013 and encountered Petitioner in front of the building. The run sheet also reflects that Petitioner "had a crushed left middle fingertip" and that, due to a language barrier, the paramedics were unable to obtain Petitioner's Social Security or telephone number. The run sheet contains no information as to how Petitioner's injury took place.

The Metro South Medical Center Emergency Room records dated March 14, 2013 reflect that Petitioner complained of an acute onset of left middle finger pain secondary to a "crush injury in machine at work" that day. PX 3, p. 3. Forms entitled "admission record" and "patient demographics" list AQL as Petitioner's employer. PX 3, pp. 1, 19. On left hand examination, the Emergency Room physician, Dr. Kahn, noted macerated tissue with a laceration to the distal aspect of the left third finger with avulsion of the nail and a limited range of motion. He ordered left hand X-rays, which showed a displaced fracture in the tuft of the middle finger. PX 3, p. 6. After administering Lidocaine injections, Dr. Kahn re-implanted the nail under the cuticle and sutured the nail area. He indicated he was unable to entirely close the wound due to the macerated tissue. He applied a dressing and metal splint. In his note, Dr. Kahn indicated he contacted Dr. Vender, the "on call" hand surgeon, via telephone, with Dr. Vender agreeing that Petitioner could be discharged so long as he followed up in his office the next day "for continued repair and management." Petitioner was discharged with prescriptions for Norco and Clindamycin and instructions to see Dr. Vender at his office the following day. PX 3, pp. 5, 13, 20. The "discharge – home instructions" do not set forth any restrictions relative to activity or work. PX 3, p. 13, 20.

Petitioner testified that personnel at Metro South "suspended [him] from work" and directed him to return to the hospital in fifteen days.

There is no evidence indicating Petitioner ever saw Dr. Vender.

On March 16, 2013, Petitioner went to the Emergency Room at Presence Saint Mary of Nazareth Hospital. Petitioner testified he sought Emergency Room treatment on that date because his injured finger was "bleeding a lot."

The Emergency Room records (PX 5) reflect that Petitioner saw a physician's assistant, Amber Lenstrom, PA-C, on March 16, 2013. Lenstrom recorded a consistent history of the work accident and subsequent Metro South Emergency Room care. She indicated that Petitioner told her he "did not fill prescriptions for Norco and Clindamycin because he was waiting for his workers' compensation paperwork to go through before he wanted to pay for anything." She also indicated that Petitioner was seeking more care because he could not tolerate the pain. She described Petitioner as typically using his right hand to write but his left hand to work. On left hand examination, she noted tenderness to palpation of the left distal middle finger "with partially avulsed nail being held on by 3 nylon sutures" and "several macerated lacerations adjacent to nail and distal finger that remain open." She saw no signs of infection. She cleaned the wound, applied Bacitracin and re-applied the splint. She directed Petitioner to fill the previous prescriptions and seek follow-up care at the hospital's orthopedic clinic. PX 5, pp. 12-16. The printed discharge/self care instructions, as interpreted by the Arbitrator, reflect that

Petitioner was to change his dressings on a regular basis and keep his left hand elevated as much as possible. They do not specifically address work status.

Petitioner testified that personnel at Presence Saint of Mary Nazareth Hospital told him he could work but only so long as he avoided contamination of his finger. Petitioner testified that, the day after his visit to Presence Saint of Mary Nazareth Hospital, he went back to the business where he had been injured but was told by Antonio that no work was available. About a week later, he went back to the business again, after some of his co-workers told him they had found his tools and other belongings in the street, outside the business. Antonio opened the door to him but told him he could not resume working. Petitioner asked Antonio for the earnings he was owed for his last week of work. Petitioner testified he never received these earnings. He returned to the business on several other occasions but was not permitted to enter.

On March 18, 2013, Petitioner saw Dr. Snitovsky at Alex Orthopaedics. The doctor recorded a consistent history of the work accident and subsequent treatment. He noted that Petitioner reported taking Norco and Clindamycin. He obtained repeat left hand X-rays, which showed a "comminuted distal phalanx fracture of the third digit." He prescribed a supportive device for the finger along with therapy. He dispensed Tramadol, Mobic and Protonix and directed Petitioner to return to him in one week. He did not comment on work status. PX 6.

On March 22, 2013, Petitioner underwent an initial therapy evaluation at Alex Orthopaedics. The therapist's history reflects that, on March 14, 2013, Petitioner was placing a part in a machine without sensors with the machine started on its own, causing the press to come down and "slam" Petitioner's left middle finger. The therapist noted that Petitioner complained of throbbing pain in the finger along with pain and numbness in the left wrist. She recommended a total of twelve therapy visits. PX 6.

Petitioner saw Dr. Snitovsky again on March 25, 2013, with the doctor removing the sutures and obtaining repeat X-rays, which showed interval healing. PX 6.

Petitioner attended two more therapy sessions, on March 25 and 27, 2013. The therapy consisted of ultrasound, electrical stimulation, ice applications and passive range of motion exercises. On March 27, 2013, the therapist reviewed wound care instructions with Petitioner and noted that Petitioner demonstrated "poor dexterity with pasta shell pick up as well as poor strength and ROM with putty squeeze." She recommended that Petitioner continue therapy. PX 6.

Petitioner testified he did not undergo additional therapy at Alex Orthopaedics after March 27, 2013 due to lack of insurance coverage and funds. About a month later, he went to Stroger Hospital at the recommendation of the doctor at Alex Orthopaedics.

The Stroger Hospital records (PX 8) reflect that Petitioner underwent repeat left middle finger X-rays on April 29, 2013 and saw an orthopedic surgeon, Dr. Brown, on several dates thereafter. Dr. Brown's notes do not appear in PX 8. A note dated June 19, 2013, authored by a certified nurse practitioner, reflects that Petitioner underwent surgery, consisting of a "partial tuft amputation and revision," on May 29, 2013 and that Petitioner was now "doing well." No operative report appears in PX 8. The nurse practitioner described Petitioner's fingernail as "intact." She noted a partial amputation of the tip of the finger. She indicated Petitioner was able to make a composite fist and complained of hypersensitivity at the tip of the finger. She discharged Petitioner from care. PX 8.

Petitioner testified he continues to undergo therapy for his hand at Stroger Hospital on an occasional basis. Petitioner did not offer any records concerning this ongoing care. The last Stroger Hospital treatment note in evidence is the June 19, 2013 note referenced in the preceding paragraph.

Petitioner testified he eventually resumed working, for a different employer, in March 2014.

Petitioner testified his affected finger hurts if he accidentally bumps the finger against a surface. He would rate the pain resulting from such contact at 7 on a scale of 1 to 10. If he grips an object for a long time, he experiences pain. For example, if he is at work, holding and polishing a piece for fifteen minutes, he feels pain. He uses vices at work now, in order to stabilize objects, due to his grip weakness. He is not able to use the affected finger when he types. Before the accident, he considered himself to be left-handed but he now tries to use his right hand to write.

Under cross-examination, Petitioner testified that, in approximately August 2012, he placed an advertisement in a newspaper, indicating he was looking for work. About two days after he placed the advertisement, Antonio contacted him via telephone and set up an appointment for him to go to the business in Blue Island. Petitioner testified he went to this appointment on the third Friday in August 2012. At that time, he did not know the name of the business. At the appointment, he met with Antonio and a person who referred to himself as "Robert." This person was never again referred to by that name. He was later referred to as "Choi" or "Suey." At the appointment, Robert, who was said to be the owner of the business, wanted to see what tasks Petitioner could perform, in terms of repairing machines. Petitioner demonstrated his skills. Petitioner testified that five other applicants appeared at the business at the same time but that only he was hired. He started working as a machine repairman for the business about two weeks after going to the appointment. Fifteen employees worked at the business as of Petitioner's start date. The business then hired more people. As of the accident, about twenty employees worked at the business.

Petitioner testified that Antonio completed some documents at the August 2012 appointment.

Petitioner testified that Rosia, one of his co-workers, told him the name of the business about two months after the accident. [Petitioner did not testify to the name Rosa supplied.]

Petitioner testified his work schedule varied but he always worked a total of thirty hours per week. He worked Monday through Saturday. He typically worked some hours in the morning and some hours in the afternoon. He would leave the business and take a break between the morning and afternoon shift. Sometimes no work was available in the morning. Robert set his schedule and told him when to arrive and leave. When Robert was away from the workplace, he would call in and dictate Petitioner's schedule to Antonio.

Petitioner testified he used his own tools while working at the business. Based on what Antonio told him, it is his understanding that the equipment he used was owned by Robert and Robert's "partners." He wore his own overalls while working at the business. He did not wear a uniform. He was not permitted to work elsewhere during the period he worked at the business. His general duty was to maintain the machines at the business. At the time of the accident, he was working on a machine that was used to stamp leather. The machine had "200 pounds of pressure." He was placing a piece in the machine when Choi stopped the power, causing the punch to come down on his left middle finger. The machine was in an isolated area of the business, due to the pressure it could apply.

Petitioner testified he signed a contract and other pay-related papers, as required by the business. The business did not give him copies of the documents he signed. He was paid in cash. In response to a question asking whether he had any records confirming the receipt of this cash, he stated he had an account at Chase Bank at one time but this account was closed "due to a lack of transactions."

Petitioner denied injuring his left middle finger before or after the March 14, 2013 accident.

Petitioner testified he has not recently seen any doctors for his finger but he continues to undergo therapy, from time to time, at Stroger Hospital. He denied undergoing any therapy during the six months preceding the hearing. He stopped going after he received a bill. He estimated he has gone to Stroger for his finger on six occasions since June 2013.

On redirect, Petitioner reiterated he has never heard of "AQL." He does not know whether Robert operated under the name "AQL." If his attorney's investigator identified AQL as his employer, he would have no reason to dispute this information.

Under re-cross, counsel for the Fund asked Petitioner about the initial Emergency Room records, which identify "AQL" as Petitioner's employer. Petitioner testified that Melba, one of his co-workers, rode with him in the ambulance on the day of the accident and stated that the business went by those letters. Carmen Arce, whose name appears in the Emergency Room records, is his friend and not a co-worker.

In addition to the exhibits previously described, Petitioner offered into evidence itemized bills from the City of Blue Island, ECP Services, Alex Orthopaedics and the Cook County Health and Hospital System. The Fund raised no objections to these bills.

Petitioner also offered into evidence, with no objection from the Fund, the previously described "Affidavit of Special Process Server" dated June 13, 2013. The affiant, Joseph A. Cairo, who is identified as a special process server, stated that, on the morning of June 10, 2013, he served an Application, Attorney Representation Agreement and 19(b) Petition, on AQL "by leaving a copy with Antonio Rentas, manager of Dreambag, Inc. and authorized person." Cairo indicated he encountered Rentas at a business located on the third floor at 13636 Western Avenue in Blue Island. He stated there was "no business name listed in the third floor directory" for this business. He described Rentas as a 35-year-old Hispanic male. He indicated that Rentas told him the name of the business was "Dreambag, Inc." and that Rentas acknowledged that Petitioner "had worked at this location as a mechanic." PX 9.

The Fund did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

Petitioner came across as a straightforward individual. His description of the August 2012 "appointment," his subsequent work activities and the March 14, 2013 accident was detailed and credible. The histories recorded by Emergency Room personnel, Dr. Snitovsky and the various therapists are fully consistent with Petitioner's account of the mechanism of injury.

Arbitrator's Conclusions of Law

Did Petitioner provide adequate notice of the December 19, 2016 hearing to the non-Fund respondents?

As noted at the outset, the Arbitrator allowed a continuance in October 2016 after the Fund raised an objection as to the adequacy of notice on the non-Fund respondents. At the continued hearing of December 19, 2016 the Arbitrator made a preliminary finding that notice was adequate, based in part on Petitioner's counsel's representation that the "1363 Western Avenue" address in Blue Island was correct. Having since had an opportunity to review all of the exhibits, and having considered the post-hearing arguments raised by the Fund, the Arbitrator finds that notice was inadequate as to AQL and Dreambag. The Arbitrator further finds that notice was adequate as to Robert Choi, there being no evidence contradicting the accuracy of the address on West North Avenue.

The Arbitrator views the December 19, 2016 hearing as a valid ex parte proceeding as against Robert Choi.

Is the Fund implicated in this case?

Section 4(d) of the Act clearly states that "moneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) and has failed to pay the benefits due to the injured employee."

The Arbitrator has previously found that, with respect to the non-Fund respondents, Petitioner established adequate notice of the December 19, 2016 hearing only as against Robert Choi. As noted earlier, Petitioner failed to offer any evidence bearing on the issue of whether Robert Choi had workers' compensation coverage as of the claimed accident. Based on the analysis that follows, the Arbitrator views the accident as compensable and awards Petitioner benefits but enters that award only against Robert Choi. Based on the clear language of Section 4(d), the Arbitrator finds that the Fund is not implicated insofar as this award is concerned.

Did Petitioner establish that Robert Choi was operating under the Act as of March 14, 2013 and that he and Choi had an employment relationship as of that date?

The Arbitrator finds that, pursuant to Section 3 of the Act, Robert Choi was operating under the Act as of March 14, 2013. Petitioner credibly testified that, as of that date, Choi was engaged in the business of fabricating leather goods and military uniforms. Petitioner also credibly testified that press machines were utilized in this business and that he was injured when Choi cut off power to the machine he was operating. Section 3 states that the provisions of the Act apply automatically and without election to employers engaged in businesses deemed to be "extra hazardous", with such businesses including any enterprise in which sharp-edged cutting tools or similar implements are used (subsection 8), any enterprise in which power driven equipment is used in its operation (subsection 15) and any enterprise in which goods, wares or merchandise are produced, manufactured or fabricated (subsection 16).

The Arbitrator further finds that Petitioner and Robert Choi had an employment relationship as of March 14, 2013. Petitioner testified that Choi, via Antonio, responded to his newspaper advertisement and that he essentially auditioned for a job by going to a designated workplace and demonstrating his skills as a machine repairman. Petitioner further testified that other candidates appeared on the same date but that only he was hired. While Petitioner indicated he provided his own

tools and overalls, he was clearly subject to Choi's control. Petitioner testified it was Choi who dictated his schedule. Petitioner further testified he was not permitted to work for any other entities during the time he worked for Choi. The work Petitioner performed was "in the nature of" Choi's business in that he maintained and operated machines that were used to fabricate the goods Choi sold.

The Arbitrator, having applied the "right to control" and "nature of the work" tests set forth in Roberson v. Industrial Commission, 225 Ill.2d 159 (2007), finds that Petitioner was Robert Choi's employee at the time of the accident.

Did Petitioner sustain an accidental injury arising out of and in the course of his employment by Robert Choi? If so, what was the accident date?

The Arbitrator finds that Petitioner established a compensable work accident of March 14, 2013. Petitioner credibly testified he was at his workplace, performing his assigned machine-related duties, when the accident occurred. Petitioner also credibly testified he called 911, on his own, immediately after the accident, and was transported to Metro South's Emergency Room via ambulance. The history set forth in the Emergency Room records is consistent with Petitioner's testimony concerning the mechanism of injury. The paramedics and Emergency Room physician described acute findings consistent with a recent trauma to the left middle finger. There is no evidence suggesting that Petitioner's injury occurred at some location other than the workplace.

Did Petitioner provide Robert Choi with timely notice of the March 14, 2013 accident?

The Arbitrator finds that Petitioner established timely notice as to Robert Choi. Petitioner testified that Choi was in his immediate vicinity at the time of the accident and, in fact, likely caused the accident by turning off the power.

Did Petitioner establish a causal connection between the accident of March 14, 2013 and his claimed current condition of ill-being?

The Arbitrator finds that Petitioner met his burden of proof on the issue of causation. Petitioner denied injuring his left middle finger at any time before or after the accident. There is no reason for the Arbitrator to question this denial. The treatment records in evidence contain no mention of any such injuries. Petitioner also credibly testified to a traumatic event, with a press coming down on his left middle finger and severing tissue from that finger. Petitioner underwent Emergency Room care shortly after the accident. The paramedic and hospital records fully support Petitioner's account of the accident.

What was Petitioner's age and marital status as of March 14, 2013? Did Petitioner have any dependent children as of that date?

Based on Petitioner's credible testimony, along with the date of birth [5/18/54] reflected in his medical records, the Arbitrator finds Petitioner was 59 years old as of March 14, 2013. Based on Petitioner's credible testimony, the Arbitrator further finds that Petitioner was divorced and had no dependent children as of that date.

What is Petitioner's average weekly wage?

Petitioner testified his schedule varied somewhat but he always worked 30 hours per week. Petitioner further testified he was paid $21 per hour, in cash. He did not offer any wage-related documents.

The Arbitrator finds Petitioner's wage-related testimony credible. That testimony establishes an average weekly wage of $630 ($21/hour x 30 hours) but Petitioner's counsel claimed an average weekly wage of $450 on the Request for Hearing form. Petitioner's counsel did not seek to amend the Request for Hearing form after Petitioner testified as to his earnings. Petitioner is bound by the Request for Hearing form, in accordance with Walker v. Industrial Commission, 345 Ill.App.3d 1084, 1087 (4th Dist. 2004). The Arbitrator finds Petitioner's average weekly wage to be $450.

Is Petitioner entitled to temporary total disability benefits?

On the Request for Hearing form, Petitioner claimed he was temporarily totally disabled from March 14, 2013, the date of accident, through May 17, 2013. Arb Exh 1.

The Arbitrator, having considered Petitioner's testimony and treatment records, as well as the general nature of his injury and the Request for Hearing form, finds that Petitioner was temporarily totally disabled from March 15, 2013 through May 17, 2013, a period of 9 1/7 weeks. The Arbitrator finds credible Petitioner's testimony as to the instructions he received from Emergency Room personnel on March 14 and 16, 2013. While no specific work restrictions appear in the Emergency Room records, it is clear that hospital personnel recommended additional care on both the 14th and the 16th. The Arbitrator views Petitioner's left middle finger injury as unstable as of those dates. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). It is also clear that, on March 16, 2013, personnel at Saint Mary of Nazareth Hospital expressed concern about wound care and the possibility of infection. The Arbitrator finds credible Petitioner's testimony that he was told he could work only if he could avoid contaminating his finger, which was at that point only partially sutured. The Fund raised no objection to Petitioner's testimony on this point. The Saint Mary records also reflect that Petitioner was instructed to keep his finger elevated as much as possible. This instruction is not consistent with many types of employment. Also credible was Petitioner's testimony that he presented to Antonio on several occasions after the accident, requesting re-employment, only to be rebuffed.

The Arbitrator declines to award temporary total disability on the date of the accident in accordance with the statute. The Stroger Hospital records provide a clear basis for finding Petitioner to be temporarily totally disabled after May 17, 2013, since they show that Petitioner did not undergo surgery on his finger until May 29, 2013, but Petitioner is bound by the Request for Hearing form. Walker v. Industrial Commission, 345 Ill.App.3d 1084, 1087 (4th Dist. 2004). In accordance with Walker, the Arbitrator ends her award of temporary total disability benefits on May 17, 2013.

The Arbitrator has previously found Petitioner's average weekly wage to be $450. The Arbitrator thus awards temporary total disability benefits at the rate of $300 per week. This award is as against Robert Choi only.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of medical and prescription expenses charged by the following providers: Blue Island Fire Department (PX 2), Metro South Medical Center (PX 3), ECP Services (PX 4),

Saints Mary and Elizabeth Hospital (PX 5), Alex Orthopaedics (PX 6), EqMD (PX 7) and John H. Stroger, Jr. Hospital (PX 8).

The Arbitrator, having reviewed all of the foregoing exhibits, declines to award the bills from Blue Island Fire Department, Metro South Medical Center, Saints Mary and Elizabeth Hospital and John H. Stroger, Jr. Hospital since all of these bills show various adjustments and/or charity write-offs resulting in zero balances.

As against respondent Robert Choi only, the Arbitrator awards Petitioner the $376.00 bill from ECP Services, subject to the fee schedule. This bill relates to physician services provided at Metro South Medical Center on March 14, 2013. The Arbitrator also awards Petitioner the $1,936.07 bill from Alex Orthopaedics, LLC, subject to the fee schedule. This bill relates to office visits and therapy provided between March 18 and March 27, 2013. The Arbitrator further awards Petitioner prescription expenses in the amount of $1,685.88 charged by EqMD for various drugs prescribed by Dr. Snitovsky on March 18 and March 25, 2013. This award is not subject to the fee schedule since it involves medication.

What is the nature and extent of the injury?

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act in assessing the nature and extent of Petitioner's injury. That section sets forth five factors to be considered in determining permanency, with no single factor to be given more weight than any other. The Arbitrator views the first enumerated factor, any AMA impairment rating, as inapplicable since no such rating is in evidence. As for the second and third factors, occupation and age, the Arbitrator finds that Petitioner was a machine repairman who was 59 years old as of the accident. The Arbitrator assigns weight to these factors. The Arbitrator views Petitioner as an older worker who used his hands to repair and operate machinery. The injury involved a finger on Petitioner's dominant left hand. With respect to the fourth factor, future earning capacity, there is no clear evidence that the injury affected Petitioner's income level. Petitioner testified he eventually resumed working for a different employer in March 2014. He did not claim any diminution of earnings but he did credibly testify to having difficulty performing aspects of his current job due to his injury. As for the fifth and final factor, objective evidence of disability corroborated by the treatment records, the Arbitrator initially notes the X-ray results. Dr. Snitovsky read the films as showing a comminuted distal phalanx fracture. The Arbitrator also notes that, according to a nurse practitioner, Petitioner underwent surgery, consisting of a partial distal tuft amputation, at Stroger Hospital on May 29, 2013. Postoperatively, on June 19, 2013, this nurse practitioner described the nail as intact and described "comminuted bone at tip of DIP." PX 8. While the Arbitrator was not provided with a copy of the operative report, or any post-operative X-rays, she did view the affected finger, and compared its appearance with that of the right middle finger, during the hearing. The nail was still present but the fleshy tip of the finger was obviously deformed.

In addition to the foregoing, the Arbitrator considers Petitioner's credible and detailed testimony as to the pain he experiences when he bumps the affected finger and the manner in which his injury has affected his ability to grip and stabilize objects.

Having considered all of the above, the Arbitrator awards, as against Robert Choi only, permanency equivalent to 40% loss of use of the left middle finger, equivalent to 15.2 weeks of benefits under Section 8(e) of the Act.

Is Respondent Robert Choi liable for penalties and fees?

Petitioner did not file a petition for penalties and fees but placed penalties and fees in dispute at the hearing. Arb Exh 1. The Arbitrator initially considers whether Robert Choi is liable for penalties pursuant to Section 19(l). Based on Petitioner's credible testimony, Choi was clearly aware of the injury, since he witnessed it, but there is no evidence that Petitioner ever sent him a "written demand for payment" of medical expenses or temporary total disability benefits, as required by this section. Petitioner filed multiple requests for hearing but none of those pleadings list claimed bills or periods of claimed lost time. Petitioner testified he returned to the workplace after the accident, in order to request a week of lost earnings, but he did not testify he ever presented Choi or Antonio with unpaid bills or "off work" notes.

On this very limited record, with Petitioner not having filed a petition for penalties and fees and not having offered evidence showing a "written demand for payment," the Arbitrator declines to award Section 19(l) penalties. The Arbitrator also declines to award Section 19(k) penalties and Section 16 attorney fees. As the Appellate Court noted in Oliver v. IWCC, 2015 Ill. App. LEXIS 940 (1st Dist. 2015), the standard for awarding such penalties and fees is higher than that governing Section 19(l).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA MADRIGAL,

Petitioner,

17IWCC0473

vs.

NO: 13 WC 18785

CHILDREN'S MEMORIAL HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

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

In affirming and adopting the Decision of the Arbitrator, the Commission finds Petitioner was not a credible historian. She completed an Application for Adjustment of Claim that indicated the claimed accident to her right shoulder occurred on February 8, 2013. She also testified to February 8, 2013, as being the date on which the claimed accident occurred. Petitioner's medical records indicate Petitioner claimed to have been injured on a number of dates, none of which indicate she injured her right shoulder on February 8, 2013.

The earliest medical record of Petitioner seeking treatment for her right shoulder is dated February 11, 2013, and was written in conjunction with Petitioner's visit to Streeterville Medical on that date. The history that was recorded at that time was that the numbness in her right hand and the pain in her shoulder started on February 6, 2013, while she was cleaning rooms

Petitioner came to be seen by Dr. Matthew Saltzman on February 14, 2013. Dr. Saltzman recorded that Petitioner had pain and swelling in her right shoulder that began three weeks earlier. No attribution was given to explain the pain and swelling in Petitioner's right shoulder. Upon returning to Dr. Saltzman on February 28, 2013, Petitioner was recorded as stating that her shoulder pain was due to her pulling a linen basket on February 6, 2013. Dr. Saltzman's records indicate that he made no attempt to reconcile the differing accident dates that Petitioner provided him with.

Following right rotator cuff repair surgery, Petitioner was started on a course of physical therapy at Athletico Physical Therapy on April 30, 2013. The history of Petitioner's condition as stated in her initial evaluation form indicates that her right shoulder became injury as a result of her lifting a heavy box on February 6, 2013.

Petitioner was seen by Dr. Prasant Atluri on November 5, 2013, for an examination pursuant Section 12 of the Act. Dr. Atluri took a history from her that recorded her injuring herself at work on February 9, 2013, while pulling garbage and linen.

It is axiomatic that an Application for Adjustment of Claim can be amended so that it comports with the proofs. In this case, however, no attempt to amend Petitioner's Application for Adjustment of Claim was made that would have reconciled the claimed date of accident with the date of accident most often given by Petitioner to her medical providers. Furthermore, Petitioner was asked on redirect examination as to whether she was injured on February 6, 2013, or February 8, 2013. She indicated that she was injured on February 8, 2013, and that she knew that was the date she had been injured on "because it was [her] last day of the week." She was not asked why none of her treatment records reflected this.

In the face of multiple records implying Petitioner came to be injured on February 6, 2013, the Commission finds Petitioner's claim to have experienced an accident to her right shoulder on February 8, 2013, that arose out of and in the course of her employment to be unsubstantiated and, accordingly, finds Petitioner failed to prove that she sustained a compensable accident as result of her employment on February 8, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 4, 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 $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: JUL 25 2017
KWL/mav
O: 06/06/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0473

MADRIGAL, MARIA
Employee/Petitioner

Case# 13WC018785

CHILDREN'S MEMORIAL HOSPITAL
Employer/Respondent

On 3/4/2016, 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE
CHICAGO, IL 60654

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
05 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

17IWCC0473

MARIA MADRIGAL
Employee/Petitioner

Case #13 WC 18785

V.

CHILDREN'S MEMORIAL 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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 1, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On February 8, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $25,563.20; the average weekly wage was $491.60.
- At the time of injury, the petitioner was 56 years of age, married with no children under 18.
- The petitioner agreed that the respondent paid $11,901.00 in non-occupational indemnity disability benefits.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert J. Williams

Signature of Arbitrator

March 4, 2016

Date

MAR 4 - 2016

FINDINGS OF FACTS:

On February 11, 2013, the petitioner stopped working and reported a right shoulder injury to her supervisor, Angelica. She sought medical care the same day with Dr. OMara at Streeterville Internal Medicine and reported right shoulder pain and right hand numbness that began on February 6, 2013, while cleaning rooms. The doctor noted a prior rotator cuff repair in October 2010. On February 14th, the petitioner saw Dr. Matthew Saltzman at the Northwestern Medical Faculty Foundation and reported right shoulder pain for three weeks with no specific trauma. The doctor noted an active forward elevation of her right arm to 170 degrees. A right shoulder MRI on February 20th revealed a large rotator cuff tear. Dr. Saltzman noted on February 28th that the petitioner clarified that she had more severe right shoulder pain when she was pulling a linen basket on February 6, 2013, and difficulty lifting her right arm ever since. The doctor's exam revealed an active forward elevation on her right to 150 degrees. Dr. Saltzman opined the same day that an MR arthrogram revealed a large cyst emanating from the acromioclavicular joint and a full thickness tear of the supraspinatus and infraspinatus that was retracted to the level of the glenoid. On March 18th, the petitioner had an arthroscopic partial right rotator cuff repair, distal clavicle excision and an aspiration of a superficial ganglion. On April 30th, the petitioner started physical therapy at Athletico Physical Therapy and followed up through November 2013. The petitioner followed up with Dr. Saltzman on June 6th, 2013, August 1st, October 1st and November 19th.

On November 5th, at the request of the respondent, the petitioner was evaluated by Dr. Prasant Atluri, who opined that her rotator cuff tear was chronic and degenerative in nature and was a natural progression of her prior rotator cuff tear. He recommended a

10-pound lifting limit. On January 9, 2014, Dr. Saltzman opined that the petitioner had reached maximum medical improvement. The petitioner was given permanent restrictions of no overhead activities, no lifting greater than 10 pounds and no abduction of her right arm.

Dr. Saltzman opined in a report that the petitioner sustained a right rotator cuff tear lifting a linen basket, that her condition is causally related to a February 2013 work injury, that she has current restrictions and that her rotator cuff surgery was reasonable and necessary. Dr. Saltzman testified that rotator cuff injuries can occur when the arms are both overhead or below shoulder level. On September 18, 2014, Dr. Atluri opined that the petitioner had a very large and retracted rotator cuff tear that is characteristic of a chronic degenerative condition and that an acute rotator cuff tear would not have been retracted and likely would be repairable. Dr. Atluri further opined that lifting with the arms well below shoulder level does not place a rotator cuff at risk of a tear.

The petitioner sustained a prior injury to her right shoulder in 2009 and had a rotator cuff repair. On November 23, 2009, the petitioner was released to full duty without restrictions. The petitioner complains of a painful shoulder and that daily activities are generally more difficult to perform. She takes over-the-counter pain medication for pain. The petitioner received short-term and long-term disability.

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

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on February 8, 2013, arising out of and in the course of her employment with the respondent. The petitioner did not report a lifting injury or

even a trauma at her initial medical care with Dr. OMara on February 8, 2013, only right shoulder pain and right hand numbness that began two days earlier while cleaning rooms. At her initial care with Dr. Saltzman on February 14th, the petitioner reported right shoulder pain for three weeks with no specific trauma. A right shoulder MRI and MR arthrogram revealed a large full thickness tear of the supraspinatus and infraspinatus retracted to the level of the glenoid. Dr. Atluri's opinion that a very large and retracted rotator cuff tear is characteristic of a chronic degenerative condition, that an acute rotator cuff tear would not have been retracted and likely would be repairable and that lifting with the arms well below shoulder level does not place the rotator cuff at risk for a tear is believable and credible. Dr. Saltzman's opinions are not consistent with his initial examination, the petitioner's complaints or the evidence. Dr. Saltzman's opinion is based on conjecture and is given no weight. The petitioner's request for benefits is denied and the claim is dismissed.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DONALD LEARNED,

Petitioner,

vs.

NO: 13 WC 25127

TRI-COUNTY COAL LLC,

Respondent.

17IWCC0433

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 occupational disease and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner worked in a coal mine for Respondent for 25 years, all underground. He was exposed to coal dust, roof bolting glue fumes, diesel fumes and epoxy used for ceramic tile. He last worked for Respondent June 3, 2013. He was a Ram Car Operator at the time of retirement.

2. Petitioner worked from October 1978 to December 1979, and then was laid off.

3. He eventually worked at other mines before going back to Respondent for work. He also worked as a Roof Bolter, drilling holes and putting bolts into roofs to keep it from falling. This exposed him to rock dust, which can legally contain 5 percent silica. While drilling holes in ceilings, some dust would fall down on him, but the majority of dust occurred

when the vacuum cleaner on the bolter stopped up and blew dust back out.

4. After being laid off in 1979, Petitioner was recalled January 1981 to Farmersville Road. In August 1981 he was transferred back to Orient 6. He was laid off again in January 1986. He was recalled again March 1986. Petitioner was again laid off in August 1989 and was recalled in March 1991. He was laid off again December 1991.

5. In 1991 Petitioner went to school for 2 years plus one semester. From 1993 to 2000 he drove a truck.

6. In 2000 Petitioner returned to mining. By this time they had workers called Scrubbers in addition to Shuttle Car Operators. If the mine was too ventilated the air could cause dust to blow past the Scrubbers and onto the Shuttle Operators. Laws were implemented to minimize ventilation so that the dust would remain close to the Scrubbers.

7. Since leaving the mine, Petitioner's breathing has "not been bad."

8. Petitioner last underwent a NIOSH exam in April 2013. NIOSH records from September 2000 to April 2013 revealed that all chest x-ray readings throughout Petitioner's career were negative for coal workers' pneumoconiosis.

9. Petitioner testified that he walks 4-5 times weekly on the hills near his home for 45 minutes. The hills are steep. He stated that he is proud to be in good health.

10. Dr. Paul is the medical director of St. John's Respiratory Therapy and clinical assistant professor of medicine at SIU Medical School. He examined Petitioner October 23, 2013. Dr. Paul found Petitioner's chest and pulmonary function tests to be normal, along with a negative test for methacholine challenge. Dr. Paul did find Petitioner's x-rays to be positive for coal workers' pneumoconiosis. He testified that it is very common for the physical exam and x-ray to be at odds. He opined that Petitioner's pneumoconiosis was caused by the inhalation of coal dust and the coal mine environment.

11. Dr. Paul admitted that he did not keep track of opacities and he did not give Petitioner's film a profusion rating. He is not an A-Reader or B-Reader. He did find the lower lung zone to be more involved.

12. Dr. Meyer has been board certified in radiology since 1992. He has been a B-Reader since 1999. He reviewed an August 22, 2013 chest x-ray and opined that Petitioner's lungs were clear with no findings of pneumoconiosis. He testified that pneumoconiosis is typically an upper lung zone process.

13. Dr. Castle is a Pulmonologist and has been board certified since 1976. He has been a B-Reader since 1985. He reviewed Petitioner's medical records and films on June 3, 2014. He opined that Petitioner was capable of heavy manual labor. He found no pathological evidence of pneumoconiosis.

14. In September 2010 Petitioner was negative for cough dyspnea and wheezing, and his lungs were clear to auscultation and percussion.

15. In August 2011 Petitioner indicated problems with aspiration, awakening with choking or heartburn. Review of systems respiratory was negative for chronic cough, dyspnea and wheezing. Oxygen saturation of room air was 95%. Physical exam revealed his lungs were clear to auscultation with normal respiratory effort. He was diagnosed with G.E.R.D.

16. In March 2013 and July 2016 a review of systems respiratory remained negative for chronic cough or dyspnea. Petitioner's chest exam was still clear to auscultation and his respiratory effort remained normal.

The Commission reverses the Arbitrator's finding of accident and causal connection. Dr. Castle opined that the pulmonary function tests were entirely within normal limits with a negative methacholine stimulation test. Based on these tests and medical records, Dr. Castle opined that Petitioner did not suffer from COPD, emphysema, chronic bronchitis, reactive airways disease or asthma.

While miners with significant mining history may have some coal dust in their lungs, not all of them have a tissue reaction to coal dust and develop pneumoconiosis. Pneumoconiosis is diagnosed either through x-rays or pathological exam. No pathology was admitted in the case at bar. Petitioner's most recent chest x-rays were taken in April 2013, and were found to be normal. Thus, after 25 years of mining, Petitioner had not developed x-ray evidence of pneumoconiosis.

Dr. Paul stated that Petitioner's lower lung zones were more involved. However, Dr. Meyer stated that pneumoconiosis is typically an upper lung zone process.

Petitioner testified that after leaving the coal mine, his breathing had not been bad. He also does not take any breathing medications. His chest x-ray 2 months prior to his retirement was negative. Accordingly, Petitioner has not offered any evidence of any permanent functional impairment or disability caused by his exposure to coal dust.

Based on the totality of testimony and evidence presented, the Commission finds that Petitioner failed to prove his claim of occupational disease, and hereby reverses and vacates the ruling of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner failed to prove he developed an occupational disease arising out of and in the course of his employment with Respondent on June 3, 2013.

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 occupational disease.

17IWCC0433

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,400.00. 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: JUL 7 - 2017
O:5/11/17
DLG/wde
45

Stephen Mathis

Deborah L. Simpson

Dissent

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

LEARNED, DONALD
Employee/Petitioner

Case# **13WC025127**

TRI-COUNTY COAL LLC
Employer/Respondent

17IWCC0433

On 11/14/2016, 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 0.53% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

17IWCC0433

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

DONALD LEARNED
Employee/Petitioner

v.

TRI-COUNTY COAL, LLC.
Employer/Respondent

Case # 13 WC 25127

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **September 27, 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 **Disease/Exposure, Causation and Sections 1(d)-f of the Occupational Disease Act**

FINDINGS

On **06/03/13**, 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 **$56,624.36**; the average weekly wage was **$1,088.93.**

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER:
Permanent Partial Disability: The Arbitrator awards Petitioner 25 weeks of compensation at a rate of $653.35/week because the injury sustained caused 5% loss of 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

11/4/16
Date

NOV 14 2016

STATEMENT OF FACTS

Petitioner, Donald Learned, of Benton Illinois was 69 years of age on the date of arbitration with a date of birth of June 22, 1947. He graduated High School from Christopher Community High School. He testified that he served three tours of duty in Vietnam in the United States Army from 1966 to 1969, reaching the rank of sergeant. Between layoffs in the mine he attended five semesters of college at Rend Lake College, he received a certificate in electrical school. Petitioner worked 25 years in the coal mine, all of those underground. During the course of his mining career in addition to coal dust, he was regularly exposed to silica dust, roof bolting glue fumes, diesel fumes, and trowel on.

He last worked in the coalmines on June 3, 2013. On that day, he worked for Tri-County Coal at their Crown III mine in Farmersville. He was 66 years of age at the time and had a job classification of ram car operator. Petitioner testified he was exposed to coal dust on that day. Petitioner testified that this was his last day of working in the mines because at 66 years of age he was just tired of working and was living 150 miles from home. Petitioner has had no post-mining employment.

Petitioner began working in the mines on November 9, 1978 for Freeman United Coal Company at their Orient #6 mine in Waltonville, Illlinois. He was hired in as a trainee and after 45 days he became a shuttle car operator. A shuttle car operator takes coal after it is cut out of the face of the mine and then hauls it to the belts where it is taken up to the surface. Petitioner testified he was exposed to the same amount of dust as anybody who is cutting coal at the face of the mine. Sometimes he would even be exposed to more dust than the people cutting the coal, depending on the airflow. Petitioner worked there until December of 1979. He was then laid off and went to work in central Illinois at Farmersville Crown II mine. Where he worked for approximately eight months before going back to the Orient #6 mine. In addition to being a laborer and shuttle car operator, Petitioner testified that he was also a roof bolter for quite a long time. A roof bolter drills holes into the roof and puts bolts in to make the top of the mine stable so that the ceiling does not fall. Petitioner indicated that there was silica rock dust exposure while performing roof bolting. Petitioner also ran the continuous miner machine, which cuts the coal directly from the face of the mine. In 2000, Petitioner went back to Freeman Coal at their Crown III mine in Farmersville. He stayed at this mine until he retired in 2013. Petitioner testified that the majority of the time that he worked those final thirteen years he worked as a shuttle car operator/hauler. Petitioner also did some roof bolting during his final years in the mines. Unlike the last time he roof bolted, this time they were using roof bolting glue pins. Petitioner described the odor that came from the pins when they broke as quite strong. Petitioner testified that at some points they put up 100 bolts a day.

Petitioner testified that since leaving the mine, his breathing has been pretty good. He describes walking up two hills on his property and has noticed somewhat of a decline in his breathing over the years. Petitioner takes no breathing medications and quit smoking in approximately 1975. He said it has been over 40 years since he has had a

cigarette. Other than some breathing difficulties, Petitioner has diabetes, which he treats with a pill of Metformin. Petitioner testified that his primary doctor is Brian Harrison in Benton. He also receives his medication from the VA.

Dr. Glennon Paul

At Petitioner's attorney's request, Petitioner was examined by Dr. Glennon Paul on October 23, 2013. Dr. Paul is the medical director of St. John's Respiratory Therapy and clinical assistant professor of medicine at SIU Medical School. (PX 1, p 6) He is also the senior physician at the Central Illinois Allergy and Respiratory Clinic. (PX 1, p 7) Dr. Paul testified that Petitioner gave a history of working 25 years in the coalmine, mostly underground. (PX 1, p 11) Upon physical examination he found Petitioner's chest to be normal, his pulmonary function tests were also normal, he had a negative methacholine challenge test. Dr. Paul found his x-ray to be positive for coal worker's pneumoconiosis. (PX 1, p 12) Dr. Paul stated that it is very common for a person to have pneumoconiosis by x-ray but have normal physical exam and pulmonary function testing. (PX 1, p 12) Dr. Paul testified to a reasonable degree of medical certainty that Petitioner has coal worker's pneumoconiosis and that it was caused by his inhalation of coal dust and the coalmine environment. (PX 1, p 12 & 13) In light of his diagnosis of coal worker's pneumoconiosis he could have no further exposures to the environment of the coalmine without endangering his health. (PX 1, p 13) In order to have coal worker's pneumoconiosis, in addition to coal dust deposited in the lungs, there must also be a tissue reaction. This tissue reaction is called scarring or fibrosis. That scarring of coal worker's pneumoconiosis cannot perform the function of normal healthy lung tissue. (PX 1, p 14) Dr. Paul testified that coal worker's pneumoconiosis is considered a progressive disease that any further exposure can progress to massive fibrosis or complicated pneumoconiosis, which can be life threatening. (PX 1, p 18) There is no cure for coal worker's pneumoconiosis and it can still progress even if the coal miner ends his exposure to coal mine dust. (PX 1, p 19) There is no way to stop the progression of coal worker's pneumoconiosis. (PX 1, p 19)

Dr. Henry K. Smith

At Petitioner's attorney's request, b-reader, Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated August 22, 2013. Dr. Smith found interstitial fibrosis of classification p/p, bilateral mid and lower zones involved, of a profusion 1/0. There were no chest wall plaques or calcifications, There were thickened interlobar fissures. Heart size was normal. There was mild thoracic atherosclerosis. The great vessels and bony structures are unremarkable. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary p, mid and lower zones bilaterally, profusion 1/0.

Dr. Michael Alexander

At Petitioner's attorney's request, b-reader, Dr. Michael Alexander reviewed a grade 1 chest x-ray dated August 22, 2013. Dr. Alexander found the lung volumes normal. Small round opacities present bilaterally, consistent with pneumoconiosis,

category p/p, 1/0. No areas of coalescence or large opacities present. No chest wall pleural thickening or pleural calcifications present. The costophrenic angles and diaphragms are clear. Atherosclerotic change present in the aorta, otherwise the cardiomediastinal structures and distribution of the pulmonary vasculature were normal. The bones were intact. Dr. Alexander's impression was coal worker's pneumoconiosis, category p/p, 1/0, aa.

Dr. Cristopher Meyer

At Respondent's request, Dr. Cristopher Meyer reviewed a chest x-ray dated August 22, 2013. (RX 1, p 40) Dr. Meyer testified that the film was of diagnostic quality but was a quality 2, underexposed with poor contrast. (RX 1, p 40) Dr. Meyer testified that the films revealed that the lungs were clear. There was calcification in the thoracic aorta indicating atherosclerotic disease. Essentially, it was a normal examination with no findings of coal worker's pneumoconiosis. (RX 1, p 41 & 42) Dr. Meyer was asked on cross-examination Q: " Now, once there is coal worker's pneumoconiosis that is progressing, is there any medicine or anything modern medical science can do to stop or reverse that progression?" A: "Not to my knowledge. Certainly, it improves -- removing the worker from the exposure is the best response." Dr. Meyer also testified on cross-examination that it is true that coal worker's pneumoconiosis can be considered to be a chronic progressive disease in some coal miners. It is also true that coal worker's pneumoconiosis, in some coal miners, can progress even after the miner leaves the exposure. (RX 1, p 57 & 58)

Dr. James R. Castle

At Respondent's request, Dr. James R. Castle did a medical records and films review of Petitioner. This was performed on June 3, 2014. Dr. Castle testified that based on the results of the pulmonary function testing that was performed on Petitioner, he felt to a reasonable degree of medical certainty that Petitioner is capable of heavy manual labor. (RX 2, p 27) Dr. Castle testified from the medical that he reviewed that there was no pathological evidence of pneumoconiosis. (RX 2, p 28) On cross-examination Dr. Castle testified that Petitioner had sufficient exposure to the environment of a coalmine to cause coal worker's pneumoconiosis in a susceptible host. (RX 2, p 34 & 35) Dr. Castle also testified on cross-examination, that one can have coal worker's pneumoconiosis, notwithstanding a negative chest x-ray. (RX 2, p 35) On cross-examination, Dr. Castle was asked, Q: "In light of the last two questions I've asked, it is possible that this man could have coal worker's pneumoconiosis notwithstanding the data set which was presented to you; is that correct?" A: It's possible that if he had a biopsy he could have some evidence of minimal pathologic changes; that would be true." (RX 2, p 35) Dr. Castle also testified that coal worker's pneumoconiosis is a latent and progressive disease. (RX 2, p 36) Dr. Castle was asked on cross-examination "Recent studies have shown that as many as 50 percent of long-term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by radiographic study during their life; is that fair?" His answer was, "Yes, there are studies that have shown that." (RX 2, p

41) Dr. Castle also answered, "That's correct" when asked, "Therefore, by definition, if a person has coal workers' pneumoconiosis, they would have an impairment in the function of lungs at the site of the scarring and emphysema, right?" (RX 2, p 46)

NIOSH Records

Respondent produced NIOSH records showing chest x-rays of various readings throughout Petitioner's mining career. All of these readings were negative for coal worker's pneumoconiosis.

CONCLUSIONS OF LAW

Issue (C) and (O): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

The Arbitrator resolves the issue of occupational disease and causation in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from CWP which was caused by his exposures as a coal miner. He worked 25 years as an underground coal miner, and he is a lifelong never smoker of cigarettes. The Arbitrator found Petitioner to be a candid and credible witness.

As described below, the universal testimony is that a positive chest x-ray combined with a sufficient history of coal mine exposure can result in a diagnosis of CWP; however, a negative chest x-ray can never rule out the existence of CWP, inasmuch as it could be found on pathologic review of the lung tissue. The only relevant studies in the record, cited by the witnesses for both Petitioner and Respondent, find that in long-term coal miners who were never found to have CWP by x-ray during life, 50% or greater have CWP diagnosed at autopsy. When added to the rate of positive x-ray findings by Respondent's b-reader/radiologist Dr. Meyer, the likelihood of Petitioner having CWP diagnosed by pathologic review at autopsy could be as high as 80%. As a result, the evidence regarding CWP consists of testimony or reports by Dr. Paul, b-reader radiologist Dr. Smith, and b-reader/radiologist Dr. Alexander that the radiographic evidence was sufficient to diagnose CWP in Petitioner. Both of Respondent's witnesses testified that while they did not find the radiographic evidence to show CWP, such radiographic evidence could not rule out the existence of it. A weighing of this evidence shows three experts with a definite diagnosis of CWP for Petitioner and two experts for Respondent testifying that they could not rule out the existence of that disease.

It was also the universal testimony that CWP determined by pathologic review would only be different from that found on x-ray in terms of the severity of the disease. The composition and nature of each of the abnormalities of CWP found on pathologic review would be the same as that of the abnormalities found on x-rays. CWP found by pathologic review would also be subject to progression, particularly if there were further coal mine exposure, and by definition, would still represent a loss of function at the site of the abnormality whether such could be measured by pulmonary function testing or not. The only treatment for CWP is the elimination of any further exposure to coal mine dust,

and it was uncontested that once a miner has been diagnosed with CWP, there is no safe level of exposure to coal mine dust.

The universal testimony also holds that all long-term coal miners will leave mining with a certain amount of coal mine dust, primarily coal and silica dust, trapped in their lungs. Such trapped dust would remain in the lungs for the rest of the miner's life, and would present coal mine dust exposure to the adjacent tissue. As a result, CWP can be a latent and progressive disease. It can progress to Progressive Massive Fibrosis (PMF) or to cor pulmonale, both life-threatening conditions.

The universal testimony was that CWP can first manifest itself on chest x-ray during the last months of coal mine exposure or even in the first year after active coal mining and its attendant exposure ceases.

Dr. Meyer, Respondent's b-reader/radiologist, testified that the gold standard for determining the existence of lung disease is pathologic review of the tissue itself rather than radiology. (RX 1, pp. 46-47) Regarding the value of treatment records, he testified that he would prefer not to know anything about the patient. "You just want to look at that film and answer the simple question: Is there anything on here consistent with CWP?" (RX 1, p. 47) He added that if the b-reader had a patient history, PFTs, blood gases, and other information, such might prejudice his reading. (RX 1, p. 48) He testified that he treats the chest x-ray as a piece of hard data, and that symptoms are symptoms and can vary by the reporting individual; that complaints of shortness of breath or failure to find shortness of breath would have no effect on his opinion on the x-ray. (RX 1, p. 52)

Dr. Meyer testified that all long-time coal miners will leave the mine with some dust trapped in their lungs, and that this trapped dust can account for as much as half the weight of the lungs. (RX 1, p. 53) He offered that when there is mixed dust exposure, to include silica, there is a greater toxicity to the lung tissue, (RX 1, pp. 55-56) and that most coal mines will have some level of mixed dust exposure rather than pure coal dust or silica dust. (RX 1, p. 56) He testified that CWp can be considered a progressive disease even after the miner leaves active exposure, (RX 1, p. 58) and that it can progress to PMF or cor pulmonale, both life-threatening conditions. (RX 1, pp. 58-59) He added that the only treatment for a person who has CWP is to remove them from any further exposure. (RX 1, p. 60)

Dr. Meyer testified that generally, CWP would appear first radiographically or pathologically, and then later begin to manifest itself in pulmonary function or clinical abnormalities. (RX 1, p. 60) He documented that CWP at the 1/0 level may take ten years or more to develop, and that it could be called a very slow and insidious disease in its onset. (RX 1, p. 65) He further testified that the miner with 1/0 CWP probably won't even know he has it; that he probably won't complain to his doctor about it; that he won't know he has it until he obtains a b-reading for it; and that CWP is similar to prostate cancer or colon cancer. Most people have no idea they have it until after testing results in a diagnosis. (RX 1, p. 65) It is a chronic, slowly progressive disease, not an acute

disease which could come on suddenly and then have the possibility of resolving. (RX1, p. 73) He further testified that a miner could work for decades in a coal mine and develop category 1 CWP that doesn't manifest itself by x-ray until the last few months of his work in the mine. (RX 1, pp. 69-70) It could even first manifest itself on x-ray a year after he leaves his work in the coal mine. (RX 1, p. 75)

Dr. Meyer opined that notwithstanding findings of no CWP on the x-rays he reviewed, this would not rule out the possibility that Petitioner could still have CWP. "It is possible to find coal macules with a negative chest x-ray. It's possible to read wrong or improperly." (RX 1, p. 76) He further stated that it is possible for a miner to have pneumoconiosis determined by pathology that was not appreciated on radiographic study. (RX 1, pp. 85-86) He confirmed that there have been studies showing that at autopsy, 50% or more of long-term coal miners have CWP that can be diagnosed by pathology that was not diagnosed radiographically, (RX 1, pp. 86, 87-88) and that "There is an old study that shows a much higher incidence of finding coal macules in coal workers that haven't reached the degree of severity to be seen at x-ray." (RX 1, p. 86) He compared radiographic diagnoses to pathologic diagnoses of CWP. If one has a positive x-ray and sufficient exposure to cause CWP, this would warrant a finding of CWP. But if the x-ray is found to be negative, that doesn't necessarily rule out that the miner may have pneumoconiosis pathologically. (RX 1, p. 88) He described pathologically-diagnosed CWP. The abnormalities would still have the same constitution as the macules or nodules that would show on x-ray, must perhaps smaller; however, they would still be subject to potential progression as with any other form of CWP. (RX 1, pp. 88-89) He estimated that of the b-readings he makes for CWP, he finds between 20% and 30% to be positive for the disease. (RX 1, p. 97)

Dr. Meyer admitted that the abnormalities of CWP can be found in the mid and lower lung zones while not being present in the upper lung zones. (RX 1, p. 77) He was familiar with a recent study by Laney and Petsonk, both of whom worked for NIOSH for many years, with Petsonk being in charge of the b-reader program and the x-ray surveillance program by NIOSH for many years. (RX 1, p. 77) He admitted that the study found that with rounded opacities, opacities of CWP appeared in the upper lung zones 35% of the time, in the middle, 32%, and in the lower, 32%. For irregular opacities, such were found in the upper lung zones 26.6% of the time, 33.2% of the time in the middle zones, and 40.3% of the time in the lower lung zones. (RX 1, pp. 82-84) He also agreed that the sizes and shapes of the opacities listed on the b-reader form could all be consistent with CWP. (RX 1, p. 105) In terms of whether the opacities noted on the form are large opacities or small opacities, he offered, "I think that small opacities can be just as debilitating..." (RX 1, pp. 106-107)

Dr. Castle performed no examination of Petitioner, but reviewed the b-readings of Petitioner's experts, the report of Dr. Paul, and records from Benton Community Health. He noted five entries from those medical records, one of which was for the purpose of a medicine refill, one of which was a routine medical examination, and one of which was a follow-up visit after lab work. These medical records contained no chest x-rays or pulmonary function testing. Dr. Castle quit seeing patients in the hospital in 2003 and

quit seeing patients altogether in 2007. His current practice "...pretty much consists of the kind of thing we're doing today." (RX 2, p. 36) He lives in Hilton Head, South Carolina, and admitted that there obviously aren't very many coal miners there. (RX 2, p. 36) In response to a question regarding the value of an exam versus just a review of the records, he testified, "I would always want to go by my own exam if possible." If he could have the records and an exam too, he admitted he would have a better database. (RX 2, pp. 43-44)

Dr. Castle's testimony was similar to that of Dr. Meyer in all relevant parts. He testified that Petitioner had sufficient exposure to coal mine dust to cause CWP, and that while the treatment records he reviewed did not mention any evidence of CWP, this would certainly not rule it out. (RX 2, pp. 34-35) He also confirmed that one can have CWP notwithstanding a negative x-ray. (RX 2, p. 35) He confirmed that CWP can be a latent and progressive disease, and that it could first manifest itself to the extent that it could be seen on x-ray even in the year after the miner left the mines. (RX 2, p. 36)

Dr. Castle admitted that no matter what he saw on these films, they would not rule out that this man could have CWP found pathologically or at autopsy. (RX 2, p. 40) He documented that recent studies have shown as much as 50% or more of miners has autopsies that found pathologically significant CWP that was not appreciated radiographically during their life. (RX 2, pp. 40-41, 60) CWP can show up on pathology even prior to showing up on radiographic study, and it might show up on pathology and be recognized by some radiologists but not by others. (RX 2, pp. 59-60) He testified that CWP is basically an x-ray diagnosis except for the caveat concerning pathology, (RX 2, pp. 44-45) and that the tissue affected by CWP can't perform the function of normal healthy lung tissue; therefore, by definition, if a person has CWP, he would have an impairment in the function of his lungs at the site of the scarring and emphysema of the CWP. (RX 2, p. 46)

Dr. Castle described CWP as being slow and insidious in its onset like most diseases, and testified that it is similar to colon cancer or prostate cancer in the early stages in that one would have no idea he has it. (RX 2, p. 48) He offered that a person can have CWP despite having normal spirometry, normal pulmonary function in all areas, normal blood gas testing, normal physical examination of the chest, and no complaints. (RX 2, p. 48) He described CWP as a chronic, slowly progressive disease which can progress to PMF or cor pulmonale, both life-threatening conditions. (RX 2, p. 49) He testified that mining can result in a mixed dust exposure including silica, which is toxic to the surrounding lung tissue, and more fibrogenic that coal dust. (RX 2, pp. 52-53) He added that if a person has trapped silica in his lungs, that toxic effect will be something that is emitted to the surrounding tissue for the rest of his life. Trapped coal mine dust will never be removed from the lungs, the exposure to that insult never ends, and it is always there. Whether it will progress in an individual is unknown, however the lung tissue would be exposed to the trapped dust for the rest of his life. (RX 2, p. 53) He testified that the only treatment for CWP is to remove the miner from any further exposure and that the American Thoracic Society's official position is that once a person has been diagnosed with CWP, there is no safe level of exposure to coal mine dust. (RX

2, p. 54) He testified that "...there is no cure for CWP; whatever you have, that's the way it's going to be unless it gets worse." (RX 2, p. 55)

Dr. Paul examined Petitioner at Petitioner's attorney's request. He has performed black lung examinations for 35 years, doing as many for coal companies as for miners. He has also done examinations for the Department of Labor, and in all of these examinations, he has read the x-rays and rendered opinions on them. (PX 1, p. 34) He testified that one can have CWP by x-ray despite having normal physical examinations and PFTs. (PX 1, p. 12) One can also have CWP by x-ray with no shortness of breath and normal blood gases. (PX 1, p. 18) He confirmed that it can progress even after active exposure ceases, and that if it progresses, there is no way to stop it. He testified that CWP comes on slowly and a miner may have it for some time before knowing it. He compared it to the onset of colon cancer or prostate cancer. (PX 1, pp. 19-20) He agreed that when a miner leaves the mines after 20 years or more, he will have coal mine dust that stays trapped in his lungs for the rest of his life, and that the lung tissue adjacent to the trapped dust will have exposure to coal mine dust for the remainder of the miner's life. He added that this is one of the reasons CWP can progress. (PX 1, p. 31)

Dr. Paul testified that if he reads a miner's x-ray as positive for CWP and there has been sufficient exposure as a coal miner to cause CWP, such is a sufficient basis to make a diagnosis of CWP. However, a person can have CWP and still have a normal chest x-ray. "It can be found on both pathology and autopsy and not show up on the x-ray." (PX 1, pp. 31-32) He is aware of recent studies that indicate that such a finding is not an uncommon event. "That's well known." (PX 1, p. 32) He testified that when there is CWP that is found only on pathology, the lesions are more diffuse, but smaller; however they will have the same ability to progress as larger lesions. At their location, there is an impairment in the function of the lung at the affected tissue. He said that a negative chest x-ray can never rule out the existence of CWP. (PX 1, p. 32)

Respondent offered b-readings made by NIOSH b-readers during routine screenings in 2000, 2005, 2007, and 2010. The most recent of these x-rays were taken three years prior to the end of Petitioner's coal mining career and five years prior to the running of the two-year period prescribed by Section 1(f) of the Act. As such, none are probative in answering the question as to whether CWP was in existence at the time Petitioner left mining or within two years of that time.

B-readings were made at the request of Respondent by Dr. Castle and Dr. Meyer, and both readers found them to be negative for CWP. B-readings were made at the request of Petitioner by Dr. Smith and Dr. Alexander, and both readers found the x-rays to be positive for CWP. In addition, Dr.Paul's reading of the x-ray was positive for CWP.

Petitioner has proven that he suffers from CWP as a result of his exposures in his 25 years of work as an underground coal miner.

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

As described above, CWP, by definition, causes an impairment in the function of the lungs at the site of the tissue reaction. It also carries a medical preclusion from further exposure due to the increased risk for progression of the disease. Because Petitioner has CWP, he has work-related disablement.

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

The Arbitrator finds that based on the existence of CWP and its related disablement, Petitioner is disabled to the extent of 5% MAW.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stefania Watroba,
Petitioner,

vs. No. 13 WC 26400

Thomas Engineering,
Respondent.

17IWCC0428

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 underlying facts of this claim were laid out in the Arbitrator's Decisions, which are incorporated by reference herein. Petitioner testified that on September 11, 2012, she was employed as a factory worker/polisher for Respondent. That day, while kneeling in front of and opening the drawer of a metal supply cabinet, it tipped over onto her. She caught the cabinet with her outstretched hands and held it for three minutes until a co-worker came by to lift it off her. She received treatment at Alexian Brothers Medical Clinic where she was diagnosed with a right knee contusion, a right hip strain and sprains/strains to her spine. Although Petitioner's treatment continued, she returned to her job and was able to perform her usual duties until September 19, 2014 when she was laid off due to Respondent's downsizing.

Alexian Brothers referred Petitioner to Dr. Mark Levin, MD for further treatment of back pain; numbness and tingling in her right foot and leg, and numbness and tingling in her forearms and hands. Dr. Levin prescribed wrist splints and ordered a lumbar spine MRI which on October 26, 2012 showed mild stenosis and a tiny L4-L5 disc protrusion. Electrodiagnostic testing of Petitioner's right leg revealed a superficial peroneal sensory neuropathy. Throughout Dr. Levin's treatment, he allowed Petitioner to continue working full duty. On March 12, 2013, Dr. Levin noted that Petitioner's carpal tunnel symptoms were stable. He believed her foot numbness could either remain chronic or improve over time; in any event, no treatment for it was required. Dr. Levin referred Petitioner to Dr. Brooke Belcher, MD, for further care.

Dr. Belcher first examined Petitioner on April 10, 2013, and prescribed physical therapy. She allowed Petitioner to continue working full duty at that time. In June 2013 Petitioner reported improvement of her symptoms; her right foot numbness was not as constant or severe. While at times Dr. Belcher gave Petitioner work restrictions, she allowed Petitioner to work full duty between October 2013 and October 2014. On October 17, 2014, Dr. Belcher administered a lumbar epidural steroid injection for what she described as Petitioner's chronic radicular pain and numbness.

Due to ongoing hand pain, Petitioner saw Dr. Mark Yaffe, MD, on February 16, 2015. He was troubled and confused by her sensory exam result which he found to be inconsistent with carpal tunnel syndrome. He recommended a diagnostic and therapeutic right carpal tunnel corticosteroid injection. He provided no causation opinion regarding Petitioner's hands or wrists.

On May 13, 2015, Petitioner sought care for her right hand and wrist with Dr. William Vitello, MD. He diagnosed Petitioner with right wrist arthralgia and tenosynovitis of her flexor carpi radialis ("FCR") following a work-related injury. When conservative treatment failed, Dr. Vitello performed right wrist FCR decompression surgery on July 14, 2015. Follow-up visits thereafter confirmed improvement in Petitioner's right hand and wrist pain and numbness.

At Respondent's request, Dr. Michael Lewis, MD, conducted two Section 12 exams of Petitioner, on February 13, 2014 and July 28, 2015. He provided a deposition on June 30, 2014, at which he testified, inaccurately, that Petitioner was struck in the back by a falling cabinet. He opined Petitioner had mild carpal tunnel syndrome and pre-existing degenerative disc disease, but that neither condition was related to her September 11, 2012 accident. He also provided opinions that Petitioner was at maximum medical improvement, was able to perform her regular daily tasks and needed no further treatment or diagnostic tests.

Following Dr. Lewis' second exam, he more accurately reported the history which Petitioner provided him: that the cabinet fell onto her outstretched hands. Dr. Lewis also reviewed Dr. Vitello's records, the operative report and Petitioner's right hand MRI dated May 19, 2015. Dr. Lewis reported that Petitioner's lumbar spine sprain and bilateral wrist conditions were not related to her work accident. He opined her lumbar injury was a sprain superimposed upon pre-existing degenerative joint disease. Dr. Lewis found that injury, along with Petitioner's left wrist problems, had resolved. Although Dr. Lewis agreed that Petitioner not at MMI and still needed restrictions because of her recent surgery, he believed those restrictions were unrelated to her work accident.

Causal Connection

The Arbitrator, in finding Petitioner proved causal connection, believed Petitioner was a highly credible witness. The Arbitrator also found credible Dr. Yaffe's causation opinions, but not those of Respondent's Section 12 doctor, Michael Lewis. With regard to the credibility of these witnesses, the Commission reviews and weighs the facts and evidence somewhat differently than did the Arbitrator.

The Commission finds Petitioner's testimony and medical records contain numerous inconsistencies which call her credibility into question. She vehemently denied receiving treatment for right leg pain prior to her September 11, 2012 accident; records from Austin Family Medicine reveal she did in fact receive treatment for right leg pain of two weeks duration, in March and April 2012. Nine days after Petitioner's September 11, 2012 accident, Dr. Shah reported Petitioner exhibited 4 out of 5 positive Wadell's signs; she also had positive Wadell's signs at a subsequent visit. Petitioner testified Dr. Belcher gave her work restrictions at every office visit except one; that testimony is contradicted by Dr. Belcher's records of April 10, 2013, January 6, 2014 and September 22, 2014, all of which expressly document that Dr. Belcher authorized Petitioner to work full duty.

Dr. Vitello's May 13, 2015 office note reported Petitioner's history of being a "former smoker." Petitioner admitted that was not true; she had not quit smoking. At her pre-operative physical in July 2015, she admitted smoking a half-a-pack per day. Petitioner gave conflicting testimony why, after her wrist surgery, she stopped seeing physical therapists from Dr. Vitello's office: she first testified his office refused to provide her with therapy, then testified Dr. Vitello wanted her continue therapy at his office and it was her decision to switch therapists. On November 3, 2014, though not under any work restrictions, Petitioner asked Dr. Belcher for a letter so she could be excused from jury duty. Dr. Belcher obliged, writing a note ordering her activities be restricted.

The Commission finds Dr. Mark Yaffe provided no causation-related opinions, contrary to the Arbitrator's finding. Dr. Yaffe, who Petitioner saw only once, was never deposed and authored no narrative causation reports. His treating records document only Petitioner's condition and diagnosis; those records provide no causal connection opinions.

The Commission disagrees that Dr. Lewis never expressed an accurate understanding of Petitioner's mechanism of injury. At his deposition, he did testify inaccurately that the cabinet fell onto Petitioner's back, and the Commission gives his deposition opinions limited consideration. However, both of his Section 12 reports show that at the time he wrote them, he possessed accurate knowledge of Petitioner's mechanism of injury. In his February 13, 2014 report, he acknowledged reviewing Dr. Shah's and Dr. Levin's treating records which described the cabinet as falling on Petitioner's hands. In his July 28, 2015 report, Dr. Lewis reported Petitioner's history of the cabinet falling onto her outstretched hands. The Commission finds Dr. Lewis understood Petitioner's mechanism of injury when he authored those reports, and finds his opinions contained therein, credible.

Low Back

The Arbitrator found Petitioner's current low back condition was causally related to her work accident. The Commission disagrees, and modifies the decision of the Arbitrator. The Commission finds the only low back injuries Petitioner received as a result of her work accident were lumbar sprains and strains. Following her accident, Petitioner denied radiating symptoms. Dr. Shah diagnosed her lumbar injury as sprains and strains, and he released her to regular duties that day. Two days later, Petitioner complained of "soreness," but again denied radiating symptoms. At her next two office visits, she exhibited positive Wadell's signs. Dr. Levin's November 13, 2012, records document Petitioner's improvement and lack of back pain.

Medical testimony as to causation is not always required to prove a case. However, it is necessary (1) where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, and (2) in cases involving aggravation of a preexisting condition. *Nunn v. Industrial Comm'n, 157 Ill.App.3d 470 (4th Dist., 1987).*

Petitioner suffered from pre-existing stenosis and degenerative disc disease. She presented no medical opinion that her *current* low back condition was causally related to her work injury as opposed to her pre-existing condition. The Commission finds Petitioner attained maximum medical improvement for her work-related low back injuries on November 13, 2012. On that date, Petitioner told Dr. Levin she had no back pain, buttock pain or leg pain. Dr. Levin documented no complaints of back pain at Petitioner's follow-up visits on December 11, 2012 and January 15, 2013. The Commission reverses the Arbitrator's finding that Petitioner's low back condition of ill-being after November 13, 2012 is causally related to her work accident, and reverses the Arbitrator's award of medical bills and prospective treatment, relating to her low back, after that date.

Bilateral Hands and Wrists

The Arbitrator found Petitioner's current bilateral hand conditions were causally related to her work accident. The Commission disagrees, and modifies that finding of the Arbitrator. The Commission finds Petitioner's only causally related hand and wrist conditions to be: hand contusions (now resolved), right wrist arthralgia and tenosynovitis of the right hand/wrist flexor carpi radialis.

While it is undisputed that Petitioner experienced bilateral carpal tunnel symptoms after her accident, this did not prove her carpal tunnel was causally related to or aggravated by her accident. At her initial post-accident physician visits, Petitioner had no complaints of hand/wrist numbness, tingling or weakness. She first voiced such complaints one month after her accident, on 10/10/12. Dr. Yaffe provided no causation opinion regarding carpal tunnel syndrome. Dr. Vitello, Petitioner's hand surgeon, likewise presented no opinion that Petitioner had carpal tunnel syndrome caused or aggravated by her work accident.

Dr. Levin noted, vaguely, that Petitioner "has findings that appear she may have aggravated a *potential* carpal tunnel syndrome," but he provided no basis for that opinion. He did not state whether Petitioner's "aggravation" was temporary or permanent, or explain why, if Petitioner's traumatic work accident caused hand/wrist numbness, tingling and weakness, those

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symptoms did not manifest until one month later. The Commission finds unpersuasive Dr. Levin's opinion regarding carpal tunnel syndrome causation.

On May 13, 2015, Petitioner saw Dr. Vitello for complaints of right wrist pain. He provided no treatment to Petitioner's left hand. He diagnosed right wrist arthralgia and tenosynovitis of the right hand/wrist flexor carpi radialis. Dr. Vitello noted Petitioner's persistent pain followed a right wrist work-related injury. After conservative treatment failed, Dr. Vitello performed right wrist flexor carpi radialis decompression surgery. Following that surgery, Petitioner's symptoms improved.

No doctors prior to Dr. Vitello diagnosed her right wrist arthralgia or flexor carpi radialis tenosynovitis. Although Dr. Lewis opined those conditions were not causally related, the Commission finds Dr. Vitello's causation opinion more persuasive. The Commission finds that at the time of Petitioner's September 15, 2015 arbitration hearing, she had not reached maximum medical improvement for her right wrist flexor carpi radialis tenosynovitis.

Right Foot

The Arbitrator found Petitioner proved her right foot condition was causally related to her accident. The Commission disagrees, and reverses that finding of the Arbitrator.

At trial, Petitioner gave no explanation of how she may have injured her right foot in her accident. She did not testify she twisted it or that it was struck by the cabinet. Petitioner had been recently treated for right leg pain a few months before her accident; a fact which she denied.

At Petitioner's first post-accident physician visit, she expressly denied radiation into her legs. At that visit, Dr. Shah documented no right foot complaints or diagnoses of any kind. At a September 13, 2012 follow-up visit, Petitioner again denied radiating leg pain. Her first complaint of tingling in her right foot was not until September 20, 2012, the same date Dr. Shah first documented positive Wadell's signs.

On November 13, 2012, Dr. Levin noted that Petitioner's foot numbness could be attributed to her chronic spondylolytic changes and right L5-S1 stenosis; he did not state it was related to or aggravated by her work accident. On March 12, 2013 he reported that no treatment was required for Petitioner's right foot condition. Dr. Lewis testified that low back pain radiating into a leg could be a natural progression of a pre-existing condition. The Commission finds this opinion of Dr. Lewis, though given at his deposition, corroborative of Dr. Levin's opinion and thus credible. Finally, the Commission notes Petitioner offered no medical opinion that any right foot numbness or other problems could have been caused by her work accident.

Medical Expenses, Prospective Medical Treatment

The Commission modifies the awards of medical expenses and prospective medical care which the Arbitrator provided in her 19(b) Arbitration Decision dated November 12, 2015, and her Revised 19(b) Arbitration Decision dated June 29, 2016.

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Relating to Petitioner's right foot, the Commission reverses the Arbitrator's award of medical expenses.

Relating to Petitioner's low back, the Commission affirms and adopts the Arbitrator's award of medical expenses only through November 13, 2012, the date it finds Petitioner attained maximum medical improvement for her low back injuries. The Commission reverses the Arbitrator's award of medical expenses relating to Petitioner's low back after that date.

Relating to Petitioner's hands, the Commission affirms and adopts the award of medical expenses relating only to the care and treatment of Petitioner's hand contusions, right wrist arthralgia and tenosynovitis of the right hand/wrist flexor carpi radialis but denies other treatment as unrelated. The Commission reverses the Arbitrator's award of the prospective diagnostic/therapeutic right hand injection prescribed by Dr. Yaffe on February 16, 2015, given Petitioner's subsequent surgery. The Commission hereby affirms and adopts the Arbitrator's award of prospective right hand/wrist treatment recommended by Dr. Vitello, but only for the care and treatment of Petitioner's right wrist arthralgia and tenosynovitis of the right hand/wrist flexor carpi radialis.

Temporary Total Disability

The Arbitrator awarded Petitioner temporary total disability benefits of $306.67 per week for a period of 30 weeks for the period between February 19, 2015 and September 15, 2015, based upon Dr. Yaffe's and Dr. Vitello's work restrictions.

The Commission finds significant the fact that Petitioner continued working her usual duties and missed no time from work for over two years until she was laid off for unrelated reasons. The Commission finds Dr. Yaffe's work restrictions of February 16, 2015 are not related to Petitioner's work accident injuries, but Dr. Vitello's restrictions relating to Petitioner's right wrist injuries, commencing May 13, 2015, are. The Commission modifies the Arbitrator's award of temporary total disability benefits to 18 weeks, for the period of May 13, 2015 through September 15, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the §19(b) Decision of the Arbitrator filed on November 12, 2015 and the Revised §19(b) Decision of the Arbitrator filed on June 29, 2016, are hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $306.67 per week, commencing May 13, 2015 through September 15, 2015, totaling 18 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. With regard to Petitioner's low back injuries, the Commission affirms and adopts the Arbitrator's award of reasonable and necessary medical expenses only through the November 13, 2012, date on which Petitioner attained maximum medical improvement, pursuant to §8(a) and §8.2 of the Act. With regard to Petitioner's wrists and hands, the Commission affirms and adopts the Arbitrator's award of reasonable and necessary medical expenses only for

treatment of hand contusions, right wrist arthralgia and right flexor carpi radialis tenosynovitis, pursuant to §8(a) and §8.2 of the Act. With regard to Petitioner's right foot, the Commission vacates the Arbitrator's award of medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical treatment is modified. The Commission affirms and adopts the Arbitrator's award of prospective right hand/wrist treatment recommended by Dr. Vitello but only for the care and treatment of Petitioner's right wrist arthralgia and tenosynovitis of the right hand/wrist flexor carpi radialis. The Commission vacates the Arbitrator's award of Dr. Yaffe's recommended diagnostic/therapeutic right hand injection.

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 $22,400.00. 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: JUN 30 2017

o-5/17/17
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

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

WATROBA, STEFANIA
Employee/Petitioner

Case# **13WC026400**

THOMAS ENGINEERING INC
Employer/Respondent

17IWCC0428

On 6/29/2016, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
REVISED 19(B) ARBITRATION DECISION
(ISSUED AFTER PROOFS WERE RE-OPENED ON JUNE 21, 2016, IN COMPLIANCE WITH THE COMMISSION'S REMAND ORDER OF NOVEMBER 24, 2015)

Stefania Watroba
Employee/Petitioner

Case # 13 WC 26400

v.

17IWCC0428

Thomas Engineering, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was originally heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 18, 2015**. At the Commission's direction, the Arbitrator re-opened proofs and held another hearing on June 21, 2016, so as to allow Respondent to offer payment-related evidence it secured after the February 18, 2015 hearing. The Arbitrator issues this revised decision in compliance with the Commission's order of November 24, 2015.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, September 11, 2012, **Thomas Engineering, Inc.**, Respondent *was* operating under and subject 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 bilateral hand, lower back and right foot conditions of ill-being ***are*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$23,920**; the average weekly wage was **$460.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

REVISED POST-REMAND ORDERS

Respondent shall pay Petitioner the following medical expenses, subject to the fee schedule: Barrington Orthopedic Specialists, $475.00. Petitioner claimed a bill from Advantage MRI ($2,050.00) but the itemized bill from this provider shows a $0 balance.

Petitioner is awarded and Respondent shall authorize prospective care in the form of the diagnostic/therapeutic right hand injection prescribed by Dr. Yaffe on February 16, 2015.

For the reasons stated in the attached decision, the Arbitrator finds that Petitioner became temporarily totally disabled on February 16, 2015 (two days before the hearing) but awards no temporary total disability benefits in this 19(b) proceeding.

The Arbitrator awards no penalties or fees.

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

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

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

Molly C Mason

Signature of Arbitrator

6/22/16
Date

JUN 29 2016

Stefania Watroba v. Thomas Engineering, Inc.
13 WC 26400

Procedural History

The Arbitrator conducted a Section 19(b) hearing in this case on February 18, 2015 and issued a decision on March 20, 2015. In that decision, the Arbitrator awarded Petitioner a bill from Open Advanced MRI in the amount of $1,210.00 along with penalties and fees on this bill. The Arbitrator specifically noted that Respondent raised no objection to the bill and presented no evidence of payment. After proofs were closed, and after Respondent filed a petition for review, Respondent presented a motion to re-open proofs to the Arbitrator, seeking to introduce newly secured evidence that the aforementioned bill had in fact been paid. The Arbitrator conducted hearings on this motion on May 28 and 29, 2015. A record was made on each date. The Arbitrator denied the motion on the basis of lack of jurisdiction, noting the pending Commission review. On June 1, 2015, Respondent filed a motion before Joshua Luskin, the Commissioner assigned to the review, seeking entry of an order directing the Arbitrator to re-open proofs. Commissioner Luskin conducted a hearing on this motion on October 26, 2015. On November 24, 2015, the Commission issued an order dismissing Respondent's pending review and remanding the case to the Arbitrator with directions to re-open proofs. The Commission relied on Honda of Lisle v. Industrial Commission, 269 Ill.App.3d 412 (1995) in taking this action. The Commission found that "a mutual mistake of fact existed between the parties as to the payment of the bill in question and, as such, the arbitrator was unable to adequately evaluate the facts based upon this incomplete record." The Commission further found that both parties would have the right to file reviews "following the issuance of the arbitrator's ensuing demand on remand."

For reasons that remain unclear, the parties did not receive the Commission's order until April 21, 2016.

In accordance with the Commission's directive, the Arbitrator re-opened proofs and conducted a hearing on June 21, 2016. A record was made on that date. At that hearing, Respondent offered RX 1, a certified billing statement it received from Advanced Open MRI pursuant to a subpoena issued on May 5, 2015. The billing statement, which is dated May 18, 2015, shows charges of $1,210.00 for a lumbar spine MRI performed on October 26, 2012, and a $0 balance. Petitioner voiced a general objection to the re-opening of proofs but did not specifically object to RX 1. The Arbitrator admitted RX 1 into evidence.

At the June 21, 2016 hearing, Petitioner also withdrew her claim for penalties and fees on the subject MRI bill.

The Arbitrator, very respectfully, disagrees with the Commission's interpretation and application of Honda of Lisle. It has long been held that piecemeal litigation is to be avoided. In the Arbitrator's view, the Commission's order encourages such litigation. It has also long been held that workers' compensation hearings are intended to be summary as well as simple.

Regardless, the Arbitrator issues this revised decision to comply with the Commission's directive and move this claim forward.

Arbitrator's Findings of Fact

Petitioner's first witness was Lisa Schulz, Respondent's human resources manager.

Schulz did not recall Petitioner's exact dates of employment but believed Petitioner worked for Respondent for ten or fifteen years before she was let go in a general layoff that also involved other workers.

Schulz testified that Respondent produces punches and dies used by the pharmaceutical industry. T. 13. Petitioner's job involved using a brush-equipped wand to polish small metal parts. The brushes had to be changed frequently. They were stored in a large metal cabinet. Schulz testified she understands Petitioner was injured when this cabinet fell forward toward her, prompting her to "catch" and support the cabinet with her hands. T. 19-20. Schulz testified she does not know the weight of the cabinet. T. 20. It is her understanding that a co-worker came to Petitioner's aid after the accident and helped Petitioner right the cabinet. T. 21. Petitioner reported an injury after the accident. It is Respondent's policy to transport an injured worker to a certain medical provider, namely Alexian Brothers Medical Group. T. 21, 26. Petitioner was transported to Alexian Brothers following the accident. T. 21. Schulz testified she reviewed the records concerning the treatment Petitioner underwent at Alexian Brothers. T. 21-22. To Schulz's recollection, the initial records from this provider did not mention hand complaints. T. 23. After looking at an Alexian Brothers note dated October 16, 2012, which was carbon copied to her, she acknowledged the note reflects Petitioner complained of bilateral hand pain. T. 28-29.

Schulz testified that Alexian Brothers refers injured workers to specialists, such as orthopedists, if deemed appropriate. Respondent has no control over which specialists Alexian Brothers chooses. T. 26. After Petitioner treated at Alexian Brothers, she began treating at Barrington Orthopedics. Schulz testified she is aware that Petitioner underwent an MRI and an EMG. T. 32. To her, it is not relevant whether an injured worker's test results are positive or negative. She is not a medical professional. She focuses on work restrictions. T. 33. When she receives carbon copies of medical records, she reads the records and then forwards them on to a workers' compensation claims administrator. It is only when the records set forth work restrictions that she gets involved to make sure the injured worker "operates within the restrictions." T. 34.

Schulz testified that, after the accident, she observed Petitioner wearing wrist braces at work. T. 40. Petitioner wore these braces for "quite some time." T. 40. Schulz testified she cannot say whether Petitioner wore wrist braces before the accident. T. 41. Schulz also recalled Petitioner coming to her office and complaining of back pain and numbness going down her leg. T. 35, 42. She could not recall Petitioner complaining of bilateral hand pain. T. 42.

Schulz testified she does not know when Petitioner last underwent care at Barrington Orthopedics. It is likely she last reviewed treatment records pertaining to Petitioner before Respondent laid Petitioner off. T. 39.

Schulz testified she does not know whether Petitioner sustained other work accidents before the September 2012 accident. She has records in her system that would have spoken to this issue but she did not check them in advance of the hearing. T. 41.

Schulz testified she helped Petitioner process some medical claims before the September 2012 work accident but those claims had nothing to do with the work injuries. The claims did not involve Petitioner losing time from work. Petitioner worked full-time both before and after the work accident. T. 42.

Schulz testified she does not know whether Petitioner was still undergoing treatment at Barrington Orthopedics when she was laid off. She knows that an independent medical examiner found Petitioner to be at maximum medical improvement. She does not know whether a treating physician also made this finding. T. 43. She does not know who, if anyone, is treating Petitioner at the present time. T. 44.

In response to questions posed by Respondent's attorney, Schulz testified she was not subpoenaed by Petitioner's counsel. T. 44. Petitioner's counsel did not ask her to bring any records with her. T. 45. She does not recall receiving any light duty notes pertaining to Petitioner between the work accident and the layoff. T. 46. She does not recall Petitioner losing any time from work due to her injuries between the work accident and the layoff. T. 46.

In response to additional questions posed by Petitioner's attorney, Schulz testified her understanding is that, if Petitioner had lost more than three days of work due to the work accident, she would have received some temporary total disability benefits. T. 49. She has "no idea" why it would matter if Petitioner is still undergoing treatment for her injuries at the present time. T. 50. She is not privy to information concerning Petitioner's current medical status. She does not know whether any current treatment relates back to the work accident. T. 51-53. In 2014, she became aware that a doctor had imposed restrictions on Petitioner but, from her perspective, that is irrelevant since Petitioner is no longer employed by Respondent. T. 53-54. Since the layoff, Respondent has not offered to accommodate any of Petitioner's restrictions. T. 54-55. That is because Petitioner no longer works for Respondent. T. 55. She would require the advice of an attorney to determine whether an injured worker who is subject to restrictions but no longer works for Respondent could be entitled to temporary total disability benefits. T. 55-56.

Petitioner opted not to testify through an interpreter but an interpreter was present. T. 62-63.

Petitioner testified she is not currently employed. T. 64. Her last job was with Respondent. T. 64-65. She began working for Respondent on March 31, 1996. She last worked for Respondent on September 19, 2014. T. 65. She worked as a polisher, using a hand-operated, brush-equipped electric machine to polish cups. She would change the brushes as needed. Sometimes she used several brushes on a single job. The brushes were delivered to Respondent. They came in bags, with each bag containing 1,000 brushes. The bags, along with other supplies, were stored in cabinets. T. 68-69.

The parties agree Petitioner sustained an accident at work on September 11, 2012. Arb Exh 1. Petitioner testified she had no problems performing her job before this accident. T. 74. She denied having any hand or wrist pain before the accident. She also denied experiencing any back pain in August or September 2012, before the accident. T. 74-75. A few years earlier, she injured her back when she slipped on ice in Respondent's parking lot. She reported this injury and was sent to a clinic. She underwent a few sessions of therapy at the clinic and was then fine. She did not file any claim in connection with the parking lot fall. T. 75-77.

Petitioner testified the accident of September 11, 2012 occurred while she was putting newly delivered bags of brushes into a multi-drawer cabinet. [Two of the photographs in PX 8 show these cabinets.] In order to put the bags away, she positioned herself between a wall and the cabinet, went down on one knee and opened one of the cabinet drawers. When she did this, the cabinet started falling toward her. T. 71. She put both hands up to catch and support the cabinet, so as to prevent it from striking her face. She began screaming "help, help!" She started getting tired because the cabinet was heavy. T. 72. After about three minutes, during which time she was supporting the weight of the cabinet, a male co-worker came to her aid and lifted the cabinet off of her. T. 72. The co-worker called a supervisor, who came over. Petitioner testified she started crying because her whole body was shaking. She told the supervisor she wanted to go to a doctor. T. 73. A maintenance man named "Glen" drove her to a clinic. It was Respondent who directed her to this clinic. Before she left, her manager filled out forms and gave her those forms so that she would know where to go. T. 74.

A document in PX 1 reflects that Respondent's production manager, Lance Tortorici, authorized Petitioner's treatment at Alexian Brothers.

The initial Alexian Brothers note of September 11, 2012 sets forth a detailed and consistent account of the work accident. The history reflects that Petitioner "was able to hold cabinet up with her arms until help came." The examining physician, Dr. Shah, noted that Petitioner complained of pain in her lower back, right knee, right hip and both hands/wrists. On examination, Dr. Shah noted some spasm in the neck and lower lumbar area, negative straight leg raising, a full range of back motion, some tenderness of the radial aspect of both wrists and tenderness at the right patella and trochanter of the right hip.

Dr. Shah obtained X-rays of the right hip, pelvis, right knee and both wrists. The hip and pelvis X-rays showed degenerative joint changes. The knee and wrist X-rays were negative.

Dr. Shah diagnosed lumbar and thoracic sprains/strains, a knee contusion and a hip strain. He prescribed Ibuprofen, Flexeril and ice applications. He released Petitioner to full duty, noting that Petitioner "feels she can do her regular job." He instructed Petitioner to return on September 13, 2012. PX 1.

Petitioner testified she elected to resume full duty because she did not want to jeopardize her job. She was her sole financial support at that time. T. 81.

Petitioner returned to Alexian Brothers on September 13, 2012. On this occasion, she saw Dr. Sandoval. The doctor noted that Petitioner was still complaining of pain in her upper back, lower back and left hand. He also noted a complaint of tingling in the right foot. He prescribed physical therapy and instructed Petitioner to continue taking Ibuprofen. He allowed Petitioner to continue full duty and instructed her to return on September 20, 2012. PX 1.

Petitioner returned to Alexian Brothers on September 20, 2012 and saw Dr. Shah. The doctor reiterated the therapy prescription. He allowed Petitioner to continue full duty and instructed her to return after several therapy sessions. PX 1.

Petitioner underwent an initial physical therapy evaluation on September 26, 2012.

Petitioner testified she attended three or four sessions of physical therapy. She did not find the therapy helpful. T. 77.

Petitioner testified she did not choose to go to Barrington Orthopedics. The doctor from Alexian Brothers referred her there. She had never previously undergone care at Barrington Orthopedics. T. 80.

Petitioner first saw Dr. Levin on October 16, 2012, at which time the doctor recorded the following history:

> "She describes an injury that occurred at work on September 11, 2012, where she was kneeling down on her right knee on the ground with her left knee bent and the metal file cabinets that they store the brushes in fell towards her. Those are lateral file cabinets, which she states are four and five drawers high. As they were falling on her, she had to push her arms up to prevent the cabinet from totally falling on her. Another employee saw the cabinet fall on her and helped remove it. At that time, she had low back pain with bilateral hand pain."

Dr. Levin noted that Petitioner had undergone several therapy sessions but was complaining of increasing low back pain going to her right buttock and down her right leg, with associated right foot numbness, as well as increasing bilateral wrist and hand pain with associated numbness and tingling.

Dr. Levin noted a past history of a work-related lumbar strain which resolved.

On initial lumbar spine examination, Dr. Levin noted tenderness over the lower lumbar paraspinal muscles with tenderness into the right buttock, pain with straight leg raising on the right and decreased sensation to pinprick in the right lateral thigh and dorsum of the right foot.

On initial upper extremity examination, Dr. Levin noted a positive Tinel's sign over both wrists and decreased sensation in both hands compared with the upper extremities.

Dr. Levin found Petitioner's back symptoms to be consistent with a lumbar myofascial strain but indicated he needed to rule out disc pathology. He further opined that Petitioner "may have aggravated a potential carpal tunnel syndrome."

Dr. Levin provided Petitioner with bilateral wrist splints, to be worn at night. He directed Petitioner to stop taking Ibuprofen and start a Medrol Dose-pak. He also prescribed a lumbar spine MRI and an EMG of the upper extremities. He instructed Petitioner to return to him in one week. PX 2.

The lumbar spine MRI, performed on October 26, 2012, showed mild to moderate spondylotic changes at L3-L4 through L5-S1, most pronounced at L5-S1, a right foraminal/extraforaminal disc protrusion resulting in mild right foraminal stenosis at L3-L4, in addition to mild central stenosis, changes at L4-L5, including a tiny disc protrusion, causing minimal to mild foraminal stenosis, and mild right foraminal stenosis with mild effacement of the lateral recesses, greater towards the right, at L5-S1. PX 3.

The EMG, performed by Dr. Goldvekht on November 6, 2012, demonstrated mild bilateral median neuropathy, compatible with bilateral carpal tunnel syndrome. Dr. Goldvekht found no evidence of cervical radiculopathy. PX 5.

Petitioner returned to Dr. Levin on November 13, 2012. The doctor noted that Petitioner was still performing full duty but was wearing her wrist splints during the day and at night. He indicated that Petitioner denied back and leg pain but complained of numbness over the right foot.

Dr. Levin reviewed the recent lumbar spine MRI. He indicated that the stenosis at the right L5-S1 level could be causing Petitioner's right foot numbness.

Dr. Levin recommended that Petitioner return to him in one month. He indicated she might require an epidural injection at that point if her right foot numbness persisted. He discussed the possibility of carpal tunnel injections but indicated that, for the time being, Petitioner would continue using the braces. He allowed Petitioner to continue full duty. PX 2.

At the next visit, on December 11, 2012, Dr. Levin noted that Petitioner was still experiencing right foot numbness and wrist pain.

On bilateral wrist examination, Dr. Levin noted positive Tinel's and Phalen's signs, "consistent with carpal tunnel." He again discussed the possibility of injections but indicated Petitioner was not interesting in pursuing this. He provided Petitioner with Celebrex samples and indicated Petitioner could "continue to work full duty using her wrist immobilizers at night."

Petitioner returned to Dr. Levin on January 15, 2013, with the doctor noting some improvement in the carpal tunnel symptoms with the use of night splints. The doctor also noted that Petitioner was still experiencing right foot numbness.

On bilateral wrist examination, Dr. Levin again noted positive Tinel's and Phalen's signs. He indicated Petitioner did not want to proceed with injections and was going to continue full duty while using braces.

On right foot examination, Dr. Levin noted decreased sensation over the dorsum of the foot. He recommended an EMG of the right lower extremity "to see if there is any impingement of the nerve or tarsal tunnel syndrome." He instructed Petitioner to return in one month. PX 2.

The right lower extremity EMG, performed by Dr. Paly on March 4, 2013, showed right superficial peroneal sensory neuropathy. PX 4.

On March 12, 2013, Dr. Levin reviewed the recent EMG results and noted complaints of recurrent low back pain as well as right foot numbness. He did not believe that Petitioner required treatment for the numbness. He started Petitioner on Celebrex and referred her to his associate, Dr. Brooke Belcher, for treatment of the low back pain. He indicated that Petitioner would continue to perform full duty. PX 2.

Petitioner first saw Dr. Belcher on April 10, 2013. The doctor recorded a consistent history of the work accident and noted Petitioner was "concerned about constant numbness in her right toes and ball of her foot." She also noted Petitioner was "wearing braces for her wrists."

Dr. Belcher described Petitioner's gait as normal. On examination, she noted normal straight leg raising bilaterally and intact sensation to the lower extremities bilaterally "except for right lateral calf and dorsal foot (L5 vs. superficial peroneal nerve pattern)." She recommended that Petitioner start therapy and continue her medications. She released Petitioner to full duty. PX 2.

On May 7, 2013, Petitioner underwent an initial physical therapy evaluation at Barrington Orthopedic Specialists. PX 2.

Petitioner returned to Dr. Belcher on June 10, 2013, with the doctor noting persistent, albeit somewhat improved, right foot numbness and intermittent low back pain, worse with sitting. The doctor recommended that Petitioner return in one month for re-evaluation, at which point an epidural steroid injection would be considered if Petitioner had not improved. PX 2.

The subsequent therapy notes document consistent complaints of low back pain and right foot numbness. On July 2, 2013, the therapist indicated that Petitioner was having difficulty pressing on the accelerator while driving due to decreased feeling in her right foot. PX 2.

Petitioner returned to Dr. Belcher on July 15, 2013. The doctor noted that Petitioner was finding therapy helpful but was still experiencing low back discomfort and right foot numbness. Her examination findings were unchanged. She recommended additional therapy and imposed restrictions of no lifting over 20 pounds and no repetitive bending, lifting or twisting. PX 2.

On October 7, 2013, Petitioner's physical therapist noted that Petitioner was having difficulty functioning at home and at work due to pain and that sitting continued to be Petitioner's most difficult activity. PX 2.

On October 7, 2013, Dr. Belcher noted some improvement of Petitioner's low back pain but indicated Petitioner's hand symptoms were worse. She recommended that Petitioner continue using the braces and return in three months. She released Petitioner to full duty. PX 2.

On October 11, 2013, Petitioner's physical therapist noted that Petitioner was still having difficulty with extended sitting and reported "getting up every hour at work to stretch."

On January 6, 2014, Dr. Belcher noted worsening of Petitioner's low back and right leg pain, aggravated by driving, and persistent right foot numbness. She recommended a lumbar epidural steroid injection. Dr. Belcher also indicated that Petitioner was still wearing the wrist splints "as much as she can." She recommended that Petitioner continue her medication and "follow up for lumbar epidural steroid injections." PX 2.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Lewis on February 11, 2014. The doctor's deposition testimony is summarized below.

Petitioner returned to Dr. Belcher on April 4, 2014 and complained of persistent low back pain radiating down her right leg, right foot numbness and numbness and tingling in both hands. Petitioner reported taking Aleve and wearing splints at night.

On lumbar spine examination, Dr. Belcher noted mildly restricted flexion, moderately restricted extension and reduced sensation in the right L5-S1 distribution. On hand and wrist examination, Dr. Belcher noted reduced sensation in the median nerve distribution bilaterally and positive Tinel's testing bilaterally.

Dr. Belcher instructed Petitioner to continue her medication and home exercises and to wear her splints. She also recommended that Petitioner wear compression socks at work due to ankle edema. She scheduled a follow-up visit based on the previous recommendation of lumbar epidural steroid injections and upper extremity EMG/NCS testing. RX 4.

Petitioner testified she and other Respondent employees were laid off on September 19, 2014. She received twelve weeks of severance pay at that time. T. 88.

Petitioner testified she worked in pain prior to the layoff. She did not take time off or request any accommodations because she needed to keep her job and pay her bills. T. 88.

On September 22, 2014, Petitioner returned to Dr. Belcher and complained of low back pain radiating down her right leg, right foot numbness and numbness in both hands. Petitioner indicated that the previously recommended injections and EMG had not been approved. She also indicated she was continuing to use the bilateral wrist splints.

On lumbar spine examination, Dr. Belcher noted mildly restricted flexion, moderately restricted extension and reduced sensation in the right L5-S1 distribution.

On hand/wrist examination, Dr. Belcher noted positive Tinel's bilaterally.

Dr. Belcher described Petitioner's examination as "unchanged" since the last examination in April. She provided Petitioner with Celebrex samples and recommended home exercises. She again recommended an epidural steroid injection. She also recommended EMG/NCV testing of the upper extremities, a right carpal tunnel brace and compression socks for bilateral leg swelling. She released Petitioner to full duty. RX 3.

Dr. Kandilakis performed the upper extremity EMG on October 10, 2014. He described the results as "highly suggestive of a bilateral cervical radiculopathy, C6, C7 and localized neuropathy at the wrist/forearm bilaterally." He recommended clinical correlation and cervical imaging. PX 6.

Petitioner returned to Dr. Belcher on October 17, 2014. The doctor noted persistent complaints of low back pain, radicular right leg pain and right foot numbness. Her lumbar spine examination findings were unchanged. She administered a right lumbar 5 transforaminal epidural injection. She instructed Petitioner to continue taking NSAIDs as needed and performing home exercises. With respect to Petitioner's hands, she recommended continued bracing. She did not comment on work status. PX 2.

Petitioner saw Dr. Belcher again on October 31, 2014. The doctor indicated that Petitioner reported "much improvement" from the epidural injection but was still experiencing "some discomfort across low back here and there." The doctor also indicated that Petitioner's right leg pain had subsided but that she was still experiencing right foot numbness.

Dr. Belcher indicated that Petitioner's right foot numbness "may improve or could be permanent nerve deficit."

Dr. Belcher noted that Petitioner was wearing a CTS brace on her right hand. She commented that the recent EMG/NCS "did not correlate with prior EMG or clinical evaluation." She described Petitioner's symptoms as "most consistent with CTS." She saw no need for a work-up of the cervical spine. She instructed Petitioner to return to her in three months. She did not comment on work status. RX 4.

On November 3, 2014, Dr. Belcher issued a note addressed "to whom it may concern," indicating Petitioner remained under her care and imposing the following work restrictions: "avoid repetitive bending, lifting, twisting activities with back and repetitive gripping activities with right hand." PX 2.

Petitioner saw Dr. Belcher again on January 23, 2015. Petitioner complained of persistent low back and hand pain as well as right foot numbness. She indicated she obtained only slight and transient relief from the injection. She described her hand pain as "stabbing" and "getting worse."

On lumbar spine examination, Dr. Belcher noted mild restriction with flexion and moderate restriction with extension. On hand examination, she noted reduced sensation to light touch in the first three fingers of the right hand, mild reduction of sensation in median nerve distribution in the left hand and positive Tinel's and Phalen's, only on the right.

Dr. Belcher referred Petitioner to Dr. Yaffe, a hand specialist. Dr. Belcher indicated that Petitioner described her back condition as "relatively tolerable at this point." She did not comment on work status. PX 2.

Petitioner saw Dr. Yaffe on February 16, 2015, two days before the hearing. The doctor indicated that Petitioner complained of right hand pain, numbness, tingling and weakness secondary to a work accident. He also indicated that Petitioner reported using a brace. He described Petitioner as right-handed.

On right hand/wrist examination, Dr. Yaffe noted 15mm two-point discrimination in all fingers and positive median nerve compression, Tinel's and Phalen's signs.

After examining Petitioner and reviewing the October 15, 2014 EMG results, Dr. Yaffe addressed diagnosis and causation as follows:

> "Pt presents with signs and symptoms consistent with R hand carpal tunnel syndrome, which she attributes to an accident in September 2012, when she was protecting herself from a metal cabinet falling."

Although Dr. Yaffe indicated that Petitioner's sensory examination (i.e., 15 mm two-point discrimination in all five fingers of the right hand) could not be explained by carpal tunnel, he nevertheless recommended a "diagnostic and therapeutic right carpal tunnel corticosteroid injection." He indicated Petitioner might be a candidate for a right carpal tunnel release if her symptoms improved following the injection.

Dr. Yaffe released Petitioner to restricted duty with lifting less than ten pounds and no repetitive grasping, gripping, pushing or pulling.

Petitioner identified PX 7 as a collection of records concerning her job search. The records are in her daughter's handwriting, not her own. She did not complete the forms herself because she has difficulty writing. She has been looking for a job in the newspaper, in person and on the Internet. She has applied at various businesses, including a cleaning service, a bakery, a hotel and a dry cleaning establishment. T. 97-98. No one has asked her to come in for an interview. T. 99. She has not earned any wages since Respondent laid her off. T. 99.

Petitioner testified she is still experiencing back pain, numbness in her right foot and hand problems. Her left hand is "much better" than her right. T. 85. She wakes at night due to hand numbness and has to shake her hands before being able to get back to sleep. T. 85. Sometimes her back pain radiates down the outside of her right thigh. Her right foot numbness is constant. She is scared to drive a car. T. 100. She initially felt much better after the epidural injection but her pain came back after a few days. T. 101. She would be interested in undergoing another injection if a doctor recommended this. T. 101.

Petitioner testified she was very active and happy before her work accident. Since the accident, her social life has disappeared because she has difficulty going places and rising from a seated position. T. 102-103.

Under cross-examination, Petitioner testified she used to see Dr. Indyk at the Austin Family Medicine Clinic. She could not recall the years she treated with this doctor. T. 103-104. If a treatment note of March 30, 2012 reflects she complained of right leg pain of two weeks' duration, she would disagree with this note. She did see a doctor at that time but it was due to leg swelling. Her legs would swell when she sat for too long. She was also experiencing "just a little bit" of right leg pain at that time. She was "worried." T. 105. She underwent an ultrasound. Actually, she had swelling but no pain. T. 105. The swelling scared her. T. 105.

Petitioner testified she supported the weight of the cabinet for more than three minutes before a co-worker, "Sinisa," came to her aid. She prevented the cabinet from falling on top of her by supporting its weight with her hands. T. 106-107. She yelled for help while she

was holding the cabinet. T. 107. Two female polishers and two male machine operators, Sinisa and Julio, worked in the vicinity of the cabinet. The cabinet was about seven feet away from her own work station. T. 109. The two female polishers, Maria and Judy, worked about twelve feet away from the cabinet. T. 109. Sinisa and Julio worked about six feet away. T. 110. Maria and Judy did not go to get help after the accident. Only Sinisa helped her. T. 111.

Petitioner testified she would disagree with the Alexian Brothers records if they reflect she complained only of her left hand. She complained of both hands. T. 113.

Petitioner acknowledged she smokes cigarettes. She does not even finish ten cigarettes per day. T. 114. She still smokes. T. 115. She did not stop smoking at any time between the work accident and the hearing. T. 115. She began smoking years before the work accident. T. 116. Between the work accident and the layoff, there were months during which she did not undergo any treatment. T. 116. Dr. Levin referred her to Dr. Belcher in March 2013. Afterward, she never saw Dr. Levin again. T. 117. Dr. Levin allowed her to continue full duty while he was treating her. T. 117. Dr. Levin told her that her right foot numbness would persist if it failed to improve within eight months. T. 117. The therapy she underwent at Barrington Orthopedics was mostly for her back. T. 118. In 2013, Dr. Belcher treated her back while she underwent therapy. She would always complain about her hands but "they" told her "they" were going to address her back first, before her hands. T. 118. Her back pain improved with therapy. T. 119. Dr. Belcher allowed her to continue performing full duty. T. 119. She saw Dr. Belcher on September 22, 2014, three days after being laid off. T. 119. She never saw Dr. Yaffe before February 16, 2015. T. 121-122.

After looking at Dr. Belcher's note of November 3, 2014, which outlines certain work restrictions, Petitioner testified she asked the doctor to prepare this note for her because she had received a summons for jury duty. She no longer has the summons. She asked Dr. Belcher to write the note so that she could be excused from jury duty. She did not report for jury duty because she was excused. T. 125-126. She went to the doctor's office on November 3, 2014 but did not receive a bill for that date. T. 128. She saw Dr. Belcher on January 23, 2015. She does not know whether Dr. Belcher imposed any restrictions on that date. T. 129-130. She is currently receiving unemployment benefits. She wants to return to work. She is required to look for work in order to qualify for unemployment benefits. T. 131. At her request, her daughter created job search forms on the computer. She told her daughter where she looked for work and her daughter wrote everything down. Her daughter did not note the dates of her job contacts. T. 131. She does not recall the dates of the contacts. T. 132. She may have to turn in the forms to unemployment at some point. T. 132. She made the contacts recently, within the last couple of weeks before the hearing. T. 132. Some of the forms reflect she was not eligible for a job due to her restrictions. Dr. Belcher wrote down restrictions in two different letters, one of which is the letter dated November 3, 2014. She does not have the other letter with her. T. 134.

Petitioner acknowledged undergoing a Section 12 examination by Dr. Lewis on February 13, 2014.

Petitioner testified other Respondent employees were laid off when she was laid off. T. 135. She was performing full duty as of the layoff. She never received temporary total disability benefits before the layoff because she never stopped performing full duty. T. 135-136.

Respondent offered into evidence records from Austin Family Medicine. These records include a handwritten note dated March 30, 2012. This note sets forth the following history:

> "Pt c/o pain rt leg for last 2 weeks. Denies hurting herself, however her job requires her to remain seated for most of the day (lab technician). No particular pattern to the pain."

The provider, whose signature is not legible, noted no tenderness to palpation of the back and no neurological abnormalities. He prescribed Mobic and recommended that Petitioner "make adjustments at work as able." He instructed Petitioner to return if she failed to improve. RX 4.

Respondent also offered into evidence Dr. Lewis's deposition of June 30, 2014. RX 2.

Dr. Lewis testified he has practiced medicine in Illinois since 1975. He holds board certifications in orthopedic surgery and independent medical examination. RX 2 at 5-6. Lewis Dep Exh 1.

Dr. Lewis testified that about 20% of his patients have lumbar complaints and another 20% have wrist complaints. RX 2 at 8. He devotes about 80% of his time to treatment and the remaining 20% to independent medical examinations. RX 2 at 8. Of the examinations he performs, the majority are for defendants. RX 2 at 9.

Dr. Lewis testified he examined Petitioner on February 11, 2014, at the request of CCMSI Insurance Company. RX 2 at 9. He issued a five-page report in connection with this examination. RX 2 at 10.

Dr. Lewis testified that Petitioner presented with an interpreter. RX 2 at 10.

Dr. Lewis was able to independently recall Petitioner. He described Petitioner as a "pleasant lady." With respect to Petitioner's history, he independently recalled that "a cabinet tipped over and struck [Petitioner] on the back and injured her." RX 2 at 11. Petitioner told him that co-workers helped her lift the cabinet. Petitioner also related that, following the accident, she experienced low back pain radiating into her right hip and down her right leg, numbness in her right foot and numbness in both thumbs. Petitioner indicated she was told she has bilateral carpal tunnel syndrome. RX 2 at 12.

Dr. Lewis testified that Petitioner complained of bilateral thumb numbness at the time of the examination. Carpal tunnel syndrome is one diagnosis that would "leap forward" from

such a complaint. RX 2 at 13. Petitioner indicated she wore a splint at night and did not believe her symptoms were severe enough to warrant an injection or surgery. RX 2 at 15. Petitioner related she had smoked one pack of cigarettes per day for ten years. Cigarette smoking has been associated with an increased incidence of carpal tunnel syndrome. RX 2 at 16. There is also an increased incidence of carpal tunnel syndrome with advancing age and being female. RX 2 at 17. Petitioner also complained of low back pain and numbness in the dorsum of her right foot. Numbness in that area could stem from a local injury or it could be referred pain from another area such as the lower back. RX 2 at 14.

Dr. Lewis testified that Petitioner told him her job involved polishing small objects "performing repetitive fine motor activities." He did not recall Petitioner mentioning having to use vibratory tools. RX 2 at 14. Petitioner indicated she did not perform any heavy lifting or forceful activity. RX 2 at 14-15.

Dr. Lewis testified that his examination of Petitioner was essentially normal. He found no evidence of significant pathology. RX 2 at 19. He conducted Phalen's, Tinel's, two-point discrimination and muscle strength testing. All of these tests are specifically for carpal tunnel syndrome. The tests were within normal limits. RX 2 at 19. With respect to the lumbar spine, Petitioner's range of motion, sensation, strength and reflexes were normal, as was straight leg testing. RX 2 at 20.

Dr. Lewis interpreted Petitioner's lumbar spine MRI as showing diffuse degenerative changes throughout much of the spine as well as disc bulging and protrusion and foraminal and central canal stenosis. RX 2 at 20. He reviewed both the MRI report and the film. RX 2 at 21. He saw no evidence of traumatic injury. RX 2 at 21. He testified that foraminal stenosis "may or may not relate to some numbness on the dorsum of the foot." RX 2 at 21. In his opinion, the foraminal stenosis seen on Petitioner's MRI is a degenerative finding. RX 2 at 22. The right leg EMG of March 4, 2013 was normal. RX 2 at 22.

Dr. Lewis testified that the November 6, 2012 EMG was consistent with mild bilateral carpal tunnel syndrome. When he examined Petitioner, he found no support for that diagnosis. RX 2 at 23.

Dr. Lewis testified he also reviewed the records of Drs. Shah, Levin and Belcher, along with various physical therapy notes. RX 2 at 23-24.

Dr. Lewis diagnosed Petitioner with mild bilateral carpal tunnel syndrome and pre-existing degenerative disc disease. He found no causal relationship between these conditions and the September 2012 work accident. As of his examination, Petitioner was performing all of her regular tasks and, by her own admission, did not believe her hand symptoms were severe enough to warrant an injection or surgery. The lumbar spine MRI revealed extensive pre-existing degenerative disc disease. RX 2 at 25.

Dr. Lewis opined that Petitioner did not require any further diagnostic studies or treatment. RX 2 at 25. He concluded that Petitioner could continue performing her regular daily tasks. RX 2 at 26.

Under cross-examination, Dr. Lewis testified he treats thousands of patients and performs about one hundred IMEs during an average year. RX 2 at 28. A typical IME, including a records review, takes about three hours. RX 2 at 28.

Dr. Lewis testified that some forms of trauma can cause low back pain. He referenced a study by an orthopedic surgeon at Stanford which concluded that anything less than major trauma does not cause low back pain. RX 2 at 29. He agrees with this study. RX 2 at 41. In his view, anything less than major trauma, such as a major motor vehicle accident, would not permanently increase pre-existing degenerative disc disease. RX 2 at 30, 41-42. Statistics show that 80% of people experience low back pain at some point in their lives, with or without trauma. RX 2 at 31. Degenerative disc disease can be asymptomatic.

Dr. Lewis testified it is possible for trauma to cause hand and wrist pain. It is also possible for trauma to cause previously asymptomatic carpal tunnel syndrome to become symptomatic. RX 2 at 32.

Dr. Lewis testified he does not know the weight of the cabinet that fell onto Petitioner. Nor does he know precisely how the cabinet fell onto Petitioner. He recalls Petitioner stating the cabinet fell onto her back. He found it difficult to understand how a cabinet falling onto someone's back could result in bilateral wrist pain in addition to back pain. RX 2 at 33. He does not know how long the cabinet remained on top of Petitioner. RX 2 at 33. The complaints Petitioner voiced to Dr. Shah after the accident were similar to the complaints she voiced at the time of his own examination. RX 2 at 34.

Dr. Lewis testified he has not seen Petitioner since February 2014 and has no knowledge of Petitioner's current condition. RX 2 at 34. The thumb numbness and back/leg complaints Petitioner voiced at the examination were subjective and indicative of abnormalities. RX 2 at 37. He has no recollection of Petitioner voicing back or hand/wrist complaints before the work accident. RX 2 at 38. He has not seen any records suggesting any intervening traumas between the work accident and his examination. RX 2 at 39.

Dr. Lewis testified that he understands a cabinet leaned onto Petitioner. The cabinet was "not a flying missile that struck [Petitioner] at a high rate of speed." Even though the cabinet may have been heavy, the accident would not qualify as a major traumatic event. RX 2 at 42-43. He does not know the force at which the cabinet came down. If Petitioner had been struck with force, it is unlikely that Dr. Shah would have released her to full duty on the very day she was struck. RX 2 at 45.

Dr. Lewis testified that foraminal stenosis creates "less than normal clearance" for the nerve root and could increase the possibility of nerve root irritation. RX 2 at 49. It is possible

that the L4-L5 disc protrusion with associated foraminal stenosis noted on Petitioner's MRI could result in compressive pathology. Anything is possible. RX 2 at 52-53. Disc protrusions shown on MRI are "notoriously unreliable and not typically indicative of pathology." RX 2 at 53.

Dr. Lewis testified that an EMG is an objective test but, like any test, it can produce false negatives and false positives. It is not 100% accurate but, if there is a positive finding, it is objective rather than subjective. RX 2 at 55-56. There was a positive finding in Petitioner's upper extremity EMG. Rx 2 at 57.

After looking at the right leg EMG report, Dr. Lewis testified this EMG was consistent with right superficial peroneal sensory neuropathy, meaning there could be an injury to the right superficial peroneal sensory nerve. This nerve goes around the ankle to the dorsum of the foot. It is in the same location where Petitioner was complaining of numbness. RX 2 at 57. Neuropathy can be idiopathic or caused by diabetes. It can also stem from irritation of a nerve root located in the lower back. RX 2 at 59. Dr. Lewis could not recall whether the peroneal nerve is a "pure one level nerve" or not. He believed it is probably mainly at L4 and L5. RX 2 at 59. He has no reason to doubt Petitioner's complaint of numbness in the dorsum of her right foot. Petitioner "seemed like a very credible, reasonable person" to him. RX 2 at 60. He does not know how long Petitioner worked each day, how she positioned herself while working or exactly what kind of tool she used. RX 2 at 61.

Dr. Lewis testified he primarily operates on hips and shoulders but does perform carpal tunnel surgery. RX 2 at 64. He has not performed back surgery for many years but regularly sees patients who have back problems. RX 2 at 65-66.

Dr. Lewis testified that, if Petitioner changed her mind concerning additional hand/wrist treatment, it would be "very reasonable" for Petitioner to undergo an injection. If the injection did not provide relief, he would more strongly consider the possibility of a carpal tunnel release. RX 2 at 65.

Dr. Lewis testified he is a salaried employee of Illinois Bone & Joint. He does not know how much his practice charges for an IME. RX 2 at 66-67. He does not recall how long his physical examination of Petitioner lasted. RX 2 at 67.

On redirect, Dr. Lewis testified that, when Dr. Paly used the term "superficial," in his EMG report, he meant that the peroneal nerve was near the skin surface rather than deep. Dr. Paly described the EMG as essentially unremarkable. RX 2 at 68. Dr. Lewis testified he found no evidence of nerve root damage involving the low back or right leg when he examined Petitioner. RX 2 at 69. Petitioner expressed no interest in hand injections or surgery and there was no evidence indicating any physician had recommended such care. RX 2 at 69. A physician was recommending a lumbar epidural steroid injection but there was no evidence indicating this injection was ever performed. RX 2 at 70. In his view, Petitioner is at maximum medical improvement. RX 2 at 70.

Under re-cross, Dr. Lewis acknowledged that a finding of right superficial peroneal sensory neuropathy is not a normal finding. RX 2 at 71. It would be reasonable for a person with radicular symptoms to consider undergoing an epidural steroid injection. RX 2 at 71. It is theoretically possible that such an injection would quiet symptoms relating to superficial peroneal sensory neuropathy. RX 2 at 72.

Arbitrator's Credibility Assessment

Petitioner came across as a motivated individual who wants to be able to work. The fact she worked for Respondent for eighteen years weighs in her favor, credibility-wise.

Petitioner's testimony concerning the mechanics of her undisputed work accident was detailed, credible and supported by the histories recorded in the treatment records.

No treating physician noted any malingering or symptom magnification. Respondent's examiner, Dr. Lewis, described Petitioner as a "very credible, reasonable person." RX 2 at 60.

The only part of Petitioner's testimony that was at odds with her medical records was her questioning of the accuracy of an isolated March 2012 treatment note documenting right leg pain of two weeks' duration.

Overall, the Arbitrator found Petitioner to be a highly credible witness.

Arbitrator's Conclusions of Law

<u>Did Petitioner establish a causal connection between the undisputed work accident of September 11, 2012 and her claimed current conditions of ill-being?</u>

The Arbitrator finds that Petitioner established a causal connection between her undisputed work accident and her current lumbar spine, right foot and bilateral hand conditions of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible and uncontradicted testimony concerning the mechanism of injury; 2) the absence of evidence indicating that Petitioner had any significant lumbar spine, right foot or hand/wrist conditions before the accident; 3) the consistent histories in the records of Drs. Shah, Levin and Belcher; 4) the absence of evidence of any post-accident re-injury or aggravation; 5) the causation-related opinions set forth in the treatment records; and 6) the MRI and EMG findings.

In finding in Petitioner's favor on the issue of causation, the Arbitrator has given consideration to the pre-accident treatment note of March 2012. That note reflects that Petitioner complained of right leg pain of two weeks' duration but the provider who documented that complaint indicated that Petitioner denied trauma and described the location of her pain as non-specific. There is no indication that the right leg pain was radicular in nature. The provider suggested that Petitioner adjust her positioning at work as needed, start Mobic

and return if she did not experience improvement. There is no indication that Petitioner returned at any time before the work accident.

The Arbitrator has also given consideration to the very recent causation-related opinions voiced by Dr. Yaffe, the hand surgeon who examined Petitioner shortly before the hearing. Dr. Yaffe indicated the two-point discrimination was not typical for carpal tunnel syndrome but he acknowledged the October 2014 EMG was positive for that syndrome. The Arbitrator views his recommendation of a dual purpose (i.e., diagnostic and therapeutic) right hand injection as a very reasonable method of resolving this conflict. See further below. This case proceeded to hearing in part because Respondent declined to authorize this injection.

The Arbitrator is not persuaded by the causation opinions voiced by Respondent's examiner, Dr. Lewis. Dr. Lewis agreed that Petitioner's upper extremity EMG showed mild carpal tunnel syndrome but he could not link this condition to the accident. He could not see how the accident could have affected Petitioner's hands, since it was his impression that the cabinet fell onto Petitioner's back. Petitioner did not testify to this and this history does not appear in any of the treatment records that Dr. Lewis indicated he reviewed. The very first treatment note, created the same day the accident occurred, reflects that Petitioner had to use her arms to support the weight of the cabinet. Dr. Lewis's negative examination of Petitioner's hands and wrists is at odds with the positive Tinel's testing Dr. Belcher documented a few weeks after Dr. Lewis's Section 12 examination.

Is Petitioner entitled to temporary total disability benefits?

Petitioner acknowledges she continuously performed full duty during the two-year interval between her work accident and her layoff. She credibly testified she performed full duty, in spite of her symptoms, because she needed the income her job provided and did not want to put her job in jeopardy. Petitioner's testimony that she "worked in pain" is substantiated by multiple physical therapy notes. It also correlates with Schulz's testimony to the extent that Schulz recalled Petitioner complaining of hip pain radiating down her leg and wearing wrist splints at work "for a long time."

At the hearing, Petitioner claimed she was temporarily totally disabled from September 22, 2014 through the hearing of February 18, 2015. Arb Exh 1. In her proposed decision, she claims benefits running from November 3, 2014 through February 18, 2015.

The Arbitrator has carefully reviewed the treatment records, Dr. Lewis's report and testimony and Petitioner's testimony concerning the circumstances under which Dr. Belcher's isolated November 3, 2014 note (setting forth various restrictions) came into existence. Petitioner testified she procured this note so as be excused from jury duty. Aside from Dr. Yaffe's note, there is no other post-layoff treatment record in evidence taking Petitioner off work or imposing work restrictions. On this record, and pursuant to Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator finds that Petitioner first became temporarily totally disabled on February 16, 2015, the date on which Dr. Yaffe prescribed a right hand injection

and imposed work restrictions. Petitioner's causally related medical conditions were unstable prior to that date, based on Dr. Belcher's treatment recommendations, but, following the September 19, 2014, layoff, Dr. Belcher did not note any restrictions on any date other than November 3, 2014. Petitioner's English comprehension was imperfect but she was adamant that Dr. Belcher issued the November 3, 2014 restrictions at her request, so as to allow her to be excused from jury duty. She recalled a prior set of restrictions (perhaps alluding to those Dr. Belcher imposed in July 2013, well before the layoff) but did not have them available.

The Arbitrator awards no temporary total disability benefits in this case, based on the facts set forth above and the statutory three-day waiting period.

Is Petitioner entitled to reasonable and necessary medical expenses?

At the original 19(b) hearing, held on February 18, 2015, Petitioner claimed the following medical expenses: 1) Open Advanced MRI, $1,210.00 (lumbar spine MRI, 10/26/12 – PX 3); 2) Advantage MRI, $2,050.00 (upper extremity EMG, 11/6/12, PX 4); and 3) Barrington Orthopedic Specialists, $475.00 (Dr. Belcher's office visit of September 22, 2014, PX 2).

The Arbitrator has previously found that Petitioner established causation as to various conditions of ill-being.

In her March 20, 2015 decision, the Arbitrator found that Petitioner established causation as to the need for the lumbar spine MRI of October 26, 2012. The Arbitrator also found that the charge for this service was reasonable and necessary. The Arbitrator further noted that Respondent raised no objection to the $1,210.00 lumbar spine MRI bill (PX 2). The Arbitrator reiterates those findings. When the Arbitrator re-opened proofs on June 21, 2016, Respondent offered into evidence certified billing records dated May 18, 2015 from Open Advanced MRI (RX 1) showing charges of $1,210.00 and a $0 balance. Petitioner did not object to RX 1. The Arbitrator revises her previous decision and declines to award the Open Advanced MRI bill of $1,210.00. The Arbitrator clarifies that she bases this revised ruling not on RX 1, which, on its face, gives no hint as to when payment was made, but rather on the Commission's finding of a "mutual mistake of fact" and resulting directive.

The Arbitrator turns to the bill from Advantage MRI. This bill relates to an upper extremity EMG prescribed by Dr. Levin, an orthopedic surgeon to whom Petitioner was referred by Respondent's selected provider, Alexian Brothers. The Arbitrator finds that Petitioner established causation as to the need for the EMG and that this service was reasonable and necessary. Respondent raised no objection to the EMG bill. T. 144, 146. The Arbitrator finds Respondent liable for the EMG but notes that the itemized bill from Advantage MRI shows multiple "bad debt adjustments" and a zero balance.

The Arbitrator finds Respondent liable for the $475.00 bill relating to Dr. Belcher's office visit of September 22, 2014. The fact that Petitioner was performing full duty when she was laid off, shortly before this office visit, does not relieve Respondent of liability for this bill. Dr.

Belcher did not discharge Petitioner from care prior to the layoff. In April 2014, she recommended a return visit so that the epidural injections could be scheduled. The epidural injections were not authorized at that time, based on Dr. Lewis's February 2014 findings as to causation and maximum medical improvement. As noted previously, the Arbitrator finds Dr. Lewis's opinions on these topics unpersuasive.

Is Petitioner entitled to prospective care in the form of a diagnostic/therapeutic right hand injection, as recommended by Dr. Yaffe? Is Petitioner entitled to other prospective care?

The Arbitrator, having previously found in Petitioner's favor on the issue of causation, awards Petitioner prospective care in the form of the diagnostic/therapeutic right hand injection recommended by Dr. Yaffe on February 16, 2015. The Arbitrator notes that, while Respondent's examiner, Dr. Lewis, disputed causation and described his hand/wrist examination as negative, he admitted that the EMG was positive for mild bilateral carpal tunnel syndrome and that it would be "very reasonable" for Petitioner to undergo a hand injection.

Petitioner seeks an award of back-related prospective care in her proposed decision but there is no evidence indicating that any treating physician is currently recommending such care. When Dr. Belcher last saw Petitioner, on January 23, 2015, she noted ongoing back complaints but indicated that Petitioner described her back condition as "relatively tolerable." Dr. Belcher recommended that Petitioner continue a home exercise program but she did not prescribe any formal treatment relative to the back. PX 2.

Is Respondent liable for penalties and fees?

In her original decision, the Arbitrator found Respondent liable for penalties and fees on the lumbar spine MRI bill of $1,210.00 from Open Advanced MRI. The Arbitrator noted that the bill related to services provided on October 26, 2012, long before Respondent obtained an IME. The Arbitrator also noted that it was Dr. Levin, an orthopedic surgeon to whom Petitioner was referred by Alexian Brothers, Respondent's selected provider, who prescribed the MRI. Respondent raised no objection to the bill (T. 144) and offered no evidence to show why it did not pay the bill.

In her original decision, the Arbitrator also noted that Petitioner filed a Section 19(b-1) petition in this case on December 2, 2014. Respondent acknowledged receiving this petition on December 4, 2014. On January 7, 2015, Petitioner filed a "second addendum" to the petition, with that addendum including a June 20, 2014 statement reflecting that the $1,210.00 lumbar spine MRI bill was still unpaid. In its response to the 19(b-1) petition, Respondent clarified it was only disputing treatment rendered after Dr. Lewis's February 2014 finding of maximum medical improvement, yet it never paid the Advanced Open MRI bill.

When the Arbitrator re-opened proofs, at the Commission's direction, so as to allow Respondent to introduce payment-related evidence (RX 1) it secured after the original hearing, Petitioner's counsel indicated he was withdrawing his claim for penalties and fees on the

subject MRI bill. Accordingly, the Arbitrator awards no penalties or fees on the bill in this revised decision.

The Arbitrator declines to award other penalties and fees, as requested by Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerardo Rangel,

Petitioner,

vs. NO. 13WC 31760

Quaker Oats Company,

17IWCC0425

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 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 August 4, 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: JUN 30 2017
SJM/sj
6/8/2017
44

Stephen J. Mathis

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RANGEL, GERARDO
Employee/Petitioner

Case# **13WC031760**

QUAKER OAKS COMPANY
Employer/Respondent

17IWCC0425

On 8/4/2016, 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 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0522 THOMAS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GERARDO RANGEL
Employee/Petitioner

v.

QUAKER OATS COMPANY
Employer/Respondent

Case # 13-WC-031760
17IWCC0425

An *Application for Adjustment 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 **Urbana**, on **June 8, 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

17IWCC0425

On **8/15/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,920.00**; the average weekly wage was $**960.00**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **3** dependent children.

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

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

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 to prove that his current condition of ill-being in his right knee is causally related to his August 15, 2013 accident. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

Aug. 2, 2016
Date

AUG 4 - 2016

17IWCC0425

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

On August 15, 2013 Petitioner completed an "Injured Employee Statement" in which he reported an injury on August 15, 2013 at 4:45 a.m. Petitioner wrote that he was cleaning build up on the orange belt rollers under the wrapper and using a metal rod cleaning tool. In response to the question, "What caused the accident/injury?" Petitioner wrote, "I took a knee to clean the rollers under the wrapper." He further stated that he put his knee on the floor to clean the orange belt rollers under the wrapper and he felt a snap in his right knee outer area. At the time he completed the report he indicated he was experiencing a stabbing pain in his knee when he would kneel down. He denied the presence of any witnesses. (RX 1)

Approximately one hour later, an "Incident & Near Miss Report" was completed regarding the event. Petitioner was reportedly in the process of getting ready to bend down to clean the roller and as he placed his right knee on the ground he felt a pull. Petitioner was given a foam cushion pad to use when doing that job. He felt okay to finish working but noted ongoing soreness. He was to see the nurse the next day when reporting to work. (RX 2)

Petitioner presented to Carle Occupational Medicine on August 19, 2013 regarding his knee. He was accompanied by his nurse case manager. Petitioner reported working on August 15th when he planted his knee and turned suddenly to the right and felt some kind of pop. Since then he was experiencing pain, worse with squatting, on the lateral aspect of the knee. He denied any swelling or prior right knee injuries. X-rays were taken and showed a small exostosis in the posterior lateral femoral condyle "possibly" due to a previous injury. He also noted tenderness over the lateral joint line. The assessment was right knee internal derangement and Dr. Scott stated he was unsure if Petitioner's condition was a "re-injury of an old injury." He was prescribed physical therapy and ice and Ibuprofen and told to avoid climbing, kneeling or squatting. Petitioner was to return in two weeks. (PX 2)

Petitioner returned to Occupational Medicine on September 3, 2013, where he was seen by P.A. Mathews. Petitioner was accompanied by the nurse case manager and the doctor noted that the work-relatedness of Petitioner's injury was being questioned by the workers' compensation carrier. Petitioner had been performing his regular job and was wearing an elastic knee sleeve. Dr. Mathews noted that x-ray examination showed a small bone island on the posterior lateral femoral condyle which might "indeed represent a previous injury." This was explained to the patient in the presence of the nurse case manager. Petitioner was offered a follow-up appointment to see Dr. Plattner but communicated that, for the time being, this would have to be pursued under his own personal medical insurance. (PX 2) Petitioner was released to return to work with no restrictions. An appointment with Dr. Plattner was requested. (PX 2)

Petitioner presented to Dr. George Gindi, his primary care physician, on September 4, 2013 complaining of right knee pain. Petitioner reported having knee pain "for awhile" but had not been taking any over-the-counter medications. He reported trouble walking, bending, lifting, and standing. He described his pain as a "6" and denied that it radiated anywhere. Petitioner also reported feeling some stress over various issues including sleep and finances (a foreclosure and loss of money on properties). Petitioner complained of pain in the proximal tibia medially. He reported living at home with his wife and children. Petitioner was not weighed due to a left foot injury. His right knee range of motion was within normal limits. There was some tenderness on palpation to the lateral side. He was diagnosed with a sprain of unspecified site in the knee and leg. Knee care was discussed. (PX 2)

Dr. Plattner examined Petitioner on September 9, 2013 noting that Petitioner had bent down to clean one of the roller machines and something popped in his right knee. The doctor further noted that Petitioner had to squat and "kind of" reach in order to do what he needed to do and felt pain. He was placed on restricted duty but informed none was available. X-rays showed no obvious fracture. "His incident was not considered a work comp type of situation." In spite of being on restricted duty Petitioner had been "pretty much" doing regular work and reporting his pain level as an "8—9/10" with certain squatting and kneeling maneuvers. He denied any prior knee problems or injuries. On examination Petitioner had lateral joint line tenderness. On examination Petitioner had no effusion, stable ligaments, lateral joint line tenderness and pain with McMurray testing. The doctor suspected a "probable" lateral meniscus tear. An MRI was ordered and Petitioner was advised to avoid squatting, kneeling, climbing stairs, etc. (PX 2)

A right knee MRI, without contrast, was performed on September 12, 2013 and revealed no convincing findings for internal derangement. A partial thickness cartilage defect of the medial patellar facet was noted along with minimal joint effusion. (PX 2)

Petitioner followed up with Dr. Plattner on September 16, 2013 at which time he was advised that the MRI showed no convincing intra-articular derangement that could be made better with surgery. Petitioner seemed to be getting along well. He was to continue with activities as tolerated. If it continued to be bothersome, "therapy, injections, etc." could be attempted. Petitioner was to follow up as needed. (PX 2)

Petitioner's Application for Adjustment of Claim herein was filed with the Commission on September 26, 2013. Petitioner alleged kneeling down to clean a buffer when he twisted his right knee. (PX 1)

Petitioner was examined by Dr. Gindi on February 13, 2014. No specific right knee complaints were noted. Good range of motion of the knee was found on physical examination. General lab work was ordered. (PX 2)

Petitioner followed up with Dr. Plattner on June 1, 2015. Dr. Plattner noted that he had seen Petitioner a "number of months ago" for some right knee pain. The doctor noted Petitioner had a work-related injury while working for Respondent. When last seen his right knee had been injected. The injection helped quite a bit for a month or so and then he noted ongoing discomfort. Petitioner stated

that it had been "about a year out" and he wanted to get his work comp claim resolved. Dr. Platter noted Petitioner was there at the behest of his attorney or the work comp carrier. Petitioner described his pain as "4/10." On examination he had no visible atrophy, no effusion, stable ligaments, and full range of motion. He did have some crepitus with flexion and extension of the knee and the doctor felt Petitioner was suffering from chronic right knee pain, possible chondromalacia patella. Dr. Plattner felt Petitioner was at maximum medical improvement. He noted the MRI findings showed some articular cartilage irregularity on the medial side of the patella which could certainly cause some patellar pain symptoms and achiness with flexion and extension. It required no treatment as it will cause some chronic achiness he would need to live with. The doctor didn't think it would haunt him or give him trouble leading to paralysis or the inability to walk. Petitioner was told he could take analgesics, anti-inflammatories, or an injection to assist with management of his symptoms. The doctor also discussed with Petitioner other treatment options including therapy, a knee sleeve, etc. but, again, they would help with symptoms. He did not feel Petitioner needed surgery. The doctor also discussed having Petitioner undergo an FCE to see if there is anything more to his residual complaints of sharp stabling pain on an objective basis but he would defer to the workers' compensation carrier for that decision. No restrictions were needed. (PX 2)

Petitioner's case proceeded to arbitration on June 8, 2016. Petitioner and one of his children, Patricia Rangel, testified. The disputed issues were accident, causal connection, and nature and extent.

Petitioner testified that he began working for Respondent in 2000 as a general laborer. He further testified that on August 15, 2013 he was working as a "wrapper operator." Petitioner testified that on that date he was cleaning inspecting lube and under the machine there was a drag roller about 12 inches in length that had build-up on it and needed to be cleaned. Petitioner got under the machine to clean the roller and "took a knee." Petitioner explained that he was crouched down and reaching up underneath when he twisted his right foot out a little bit and heard a pop in his right knee. He further testified that his right knee was on the floor when he twisted it and heard the pop. At the time he had a steel rod in his hand to help clean the roller. Petitioner testified that he told his supervisor and completed an accident report. Petitioner testified that he hurried to complete the report because he needed to get back to work and keep the line running. He estimated it took about two minutes to fill out the report. Petitioner finished his shift that day.

Petitioner testified that he went to the company doctor at Carle Occupational Medicine on August 19, 2013. He was given a splint and told to take some Ibuprofen. If he continued to hurt he was to return and an MRI would be ordered.

Petitioner denied having a bad knee prior to August 19, 2013. He denied any "old injury" as referenced in the Occ Med records.

Petitioner further testified that the Occ Med doctor told him that if his knee was torn the doctor could go in there and trim it but he would still have pain no matter what. Petitioner testified that he was going through a divorce at the time and couldn't afford to take short-term disability because it wouldn't pay very much.

Petitioner acknowledged that after the MRI in September of 2013 he didn't go back to see the doctor until June 1, 2015. When asked why he waited so long to go back to the doctor, Petitioner testified that he had been taken off for short-term disability and had to pay child support and a mortgage and he was still going through a divorce and he couldn't afford it. Petitioner testified that he continued to work for Respondent from 2013 through 2015 and continued to have problems with his knee during that time. He described it as an aching pain in his knee, especially when bending it and going up stairs. He tried to play softball but couldn't. Petitioner testified that he went back to the doctor to see if there was anything he could do to fix it. June 1, 2015 was the last time he saw the doctor. Petitioner testified that the doctor shot cortisone in his knee that lasted for 2 or 3 weeks and he went in to get another injection but the do tor couldn't give him one.

Petitioner testified that he has continued to have problems with his right knee since June 1, 2015. According to Petitioner the side of his leg hurts around the knee and he feels a pinch on the inside of it. Petitioner explained that his knee grinds and hurts when he walks or sits down. He denied the ability to run at all. He can't cut the grass or go up stairs if they are too high. Petitioner testified that he cannot play baseball with his grandchildren and he must take Aleve every day to help with the pain. Petitioner testified that he hasn't gone back to the doctor because the doctor told him there was nothing he could do and that even if he did surgery, Petitioner would experience pain. Petitioner continues to work full duty for Respondent and at the end of a twelve hour shift he will be limping. He then goes home and takes some Aleve.

Petitioner testified that he didn't mention twisting his knee in the accident report (RX 1) because he was in a hurry. Petitioner further testified that when cleaning the machine he usually had to twist his knee but this time he bent down a little further.

On cross-examination Petitioner denied undergoing any physical therapy. He denied having any lost time from work. He acknowledged that he is still performing the same job for Respondent.

On further cross-examination Petitioner denied being told by his attorney to go back to the doctor in June of 2015. When asked if there were any witnesses to the accident, Petitioner testified that there was an employee across from him who saw him. He testified that he couldn't get up. He believed it was Tanya Peterson but she is since retired.

On redirect examination Petitioner testified that his medical bills were paid by workers' compensation.

Patricia Rangel testified on her father's behalf. Ms. Rangel lives with her father and is 18 years old. When asked if she noticed her father having any problems with her right knee since August 15, 2013, Ms. Rangel testified that it bothers him a lot. Ms. Rangel explained that her father complains how much it hurts if he is walking long distances or going up the stairs. She further testified that her father has tried to play softball with the family but he would barely play and would complain about how it hurt. According to Ms. Rangel, her father "constantly" takes pain medication. She estimated that he will walk about five or ten minutes and then complain about it. She described his walk as "kind of like a little pimp walk or whatever."

The Arbitrator concludes:

1. Issue (C) Accident.

Petitioner sustained an accident on August 15, 2013 that arose out of and in the course of his employment with Respondent. It does not appear that Respondent disputed whether Petitioner was in the course of his employment as he was engaged in work duties required of him during his regularly scheduled shift. The issue appears to be that of "arising out of." While there are some inconsistencies regarding the details of the mechanism of injury as found in the histories presented to physicians, Petitioner's testimony regarding same was largely corroborated by the medical records and no substantive evidence to the contrary was presented. His Application for Adjustment of Claim referenced both "kneeling" and "twisting" at the time of the accident. Due to the nature of Petitioner's employment duties and the frequent need to clean the rollers, Petitioner was required to kneel and/or twist and position himself in an unusual way to clean the rollers. While kneeling and/or twisting may be considered an activity of everyday living, Petitioner's job duties required him to do so more frequently than that of the general public. As such, his accident arose out of his employment with Respondent.

2. Issue (F) Causal Connection.

Petitioner failed to prove that his current condition of ill-being in his right knee was causally related to his August 15, 2013 accident. Petitioner failed to meet his burden of proof on this issue. Given credibility issues with Petitioner, the Arbitrator is unable to rely upon a chain of events to establish causation. Additionally, Petitioner provided no expert medical opinion on the issue of causation.

The Arbitrator cannot rely upon Petitioner's testimony alone regarding his ongoing complaints and symptoms from 2013 through 2015 as she did not find him to be an altogether credible witness. To begin with, his explanation regarding his marital status was very unclear. Furthermore, he told Dr. Plattner on September 9, 2013 that he was on restrictions. However, in reality, he had previously been released without any restrictions. Petitioner denied any prior knee problems; however, in his initial history to Dr. Gindi on September 4, 2013 he said nothing about a specific work accident; rather, he told the doctor he had been having knee pain "for awhile." Given the question of a prior knee injury/ problem as noted by the Occ Med providers, and Petitioner's vague history when presenting to Dr. Gindi in September, his denial of prior knee symptoms or problems is suspicious. Furthermore, Petitioner's primary care physician is Dr. Gindi. From her review of PX 2, it appears to this Arbitrator that not all of Dr. Gindi's records post-accident may have been introduced into evidence. Petitioner testified he was symptomatic during the time he underwent no treatment (2013 – 2015) but nothing in Dr. Gindi's February 23, 2014 office note corroborates that. The doctor noted no right knee complaints and his exam of Petitioner's knee appears normal as no joint issues were noted and he had good range of motion of his knee.

More significantly, statements found in Dr. Plattner's June of 2015 office note severely undermine a finding of ongoing causation. The doctor's notes reference an injection having been given to Petitioner. No records corroborate that, especially before September 16, 2013. There is also a reference to having seen Dr. Plattner a number of months before the 2015 visit but there are no earlier office notes found in the record. Additionally, Dr. Plattner referenced something happening "a year out." The Arbitrator reasonably infers from the foregoing that Petitioner may have had some treatment in 2014 but no records were introduced to substantiate that or tie the treatment into the August 15, 2013 accident. Given Petitioner had no right knee complaints or evidence of a problem when examined by Dr. Gindi in February of 2014 followed by the vague and uncertain history found in Dr. Plattner's 2015 office visit, the Arbitrator is unable to conclude that Petitioner's current condition of ill-being in his right knee is causally related to his August 15, 2013 accident.

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

****

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosanna Concepcion,
Petitioner,

vs.

Cavalier Logistics,
Respondent.

17IWCC0442

NO: 13 WC 38591

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, 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 September 22, 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.

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

DATED: JUL 14 2017
o6/29/17
KWL/rm
046

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

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

17IWCC0442

CONCEPCION, ROSANNA
Employee/Petitioner

Case# **13WC038591**

15WC014999

CAVALIER LOGISTICS
Employer/Respondent

On 9/22/2016, 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 0.50% 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:

2333 WOODRUFF JOHNSON & PALERMO
LEANDRO ALHAMBRA
4134 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0507 RUSIN & MACIOROWSKI LTD
JEFFREY E RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

17IWCC0442

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ROSANNA CONCEPCION
Employee/Petitioner

v.

CAVALIER LOGISTICS
Employer/Respondent

Case # **13** WC **38591**

Consolidated cases: **15 WC 14999**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **August 16, 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. ☒ 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

17IWCC0442

On the date of accident, **12/1/12**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$39,692.64**; the average weekly wage was **$763.32**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner failed to meet her burden of proof regarding the issue of accident. Therefore her claim for benefits is denied.

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

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

Signature of Arbitrator

9/21/16
Date

SEP 22 2016

17IWCC0442

FINDINGS OF FACT

This claim involves a Petitioner who has filed an Application for Adjustment of Claim for two dates of accident with both cases consolidated. This decision is on the first claim with an alleged accident date of December 1, 2012. Petitioner's second date of accident alleged was on April 7, 2015 (15 WC 14999) – which will be addressed in a separate decision. At trial the issues in dispute were: 1) accident, 2) causation, 3) medical expenses, and 4) prospective medical care.

Petitioner works for Respondent as an ocean export analyst. She was hired on December 14, 2011 and worked in the Wood Dale office. The majority of her job consisted of clerical work and documentation related to the preparation of exportation documents. Petitioner worked five days a week, Monday through Friday, and worked 40 hours a week. She worked from 9:00 a.m. until 6:00 p.m., with two 15 minutes break in the morning and afternoon, and a one hour lunch break. Petitioner testified that her job consisted of a desk job and she was using the computer approximately 95% of the time.

Petitioner testified that she worked for a number of companies wherein she was performing the same and/or similar type of job duties as she was for Respondent.

Petitioner testified as to her work station, referred to in Petitioner's Exhibit 7 (an alleged photograph of petitioner's prior work station). She testified that she worked at that work station from December of 2011 through May of 2013. She testified that her desk measured at 30.5 inches high. Petitioner testified as to two additional pictures which showed a tape measure documenting some measurements of the height of the desk and height of the chair (Px. 7-9). The Arbitrator notes that Petitioner's Exhibits 8 and 9, although authenticated by Petitioner, depict blurry images of a tape measure, and do not illustrate any specific measurements or authenticity of said measurements. Respondent objected to the truth and accuracy of said photos and corresponding measurements.

Petitioner testified that she stood at 5' tall and weighed approximately 110 pounds. Petitioner testified that due to her short stature, when she sat at her work chair, her feet did not touch the ground. Further, she testified that at her original station, the keyboard she was using was placed on top of the desk. Petitioner confirmed that the keyboard was not permanently stationed on the desk and the keyboard could be moved forward or backwards. Petitioner testified that she chose to place the keyboard at a distance from her so she could put her files that she was working on in front of her in order for her to look down and review the files, while keeping the keyboard at a distance in order for her to type. Petitioner agreed that she could have altered the position of the keyboard. Petitioner claimed that for her to type, she had to reach her arms out in a fully extended manner to type at the computer. Petitioner testified that her arms were reaching out at approximately chest level. When asked to demonstrate Petitioner's hand and arm positions while typing, the Arbitrator noted the Petitioner appeared to hold her arms straight out, almost at shoulder level.

Petitioner testified as to the other types of job activities that she is required to perform other than working at the computer. She denied that she had to perform any heavy lifting and/or overhead work. She confirmed that she was able to get up and move around the office as needed, and that she was able to change positions as needed. Petitioner testified that she was unaware that the desk that she was working at could be raised or lowered.

Petitioner testified that from the time she was hired in December of 2011 to December of 2012, she never complained of any pain or problems relating to the upper extremities. During that year period of time she never requested that her work station be accommodated or advised her supervisors that her work station was causing her pain. Petitioner testified that it was not until she sought medical treatment and the issue was raised by her therapist that she questioned and researched the ergonomic issue.

Petitioner testified that in December of 2012, she began to experience pain in both of her shoulders and elbows. She had stabbing pain to the shoulders in the front, top, and back of the shoulders. She also complained of tightness in and around her chest area as well. Petitioner testified that she initially thought that she was having some sort of a heart issue or heart attack due to the alleged pain that she was experiencing.

Petitioner testified that she reported the alleged complaints and problems to her supervisor and eventually sought treatment with a heart doctor in January of 2013. Petitioner testified that she was provided an accommodated or new work station in May of 2013.

Petitioner testified as to her eventual treatment with, Dr. Charles Carroll, in March of 2013 with complaints of pain to the bilateral elbows and bilateral shoulders. Petitioner admitted that she had previously treated with Dr. Carroll and underwent a bilateral carpal tunnel surgery back in 2002 or 2003. Petitioner testified that prior to March of 2013; she had previously treated with Dr. Carroll in March of 2010 for complaints of bilateral upper extremity pain.

In March of 2013, Petitioner testified that her pain in the elbows and shoulders prompted her to seek treatment with Dr. Carroll. Petitioner did not mention anything related to her work station and/or ergonomics. Petitioner agreed that Dr. Carroll did not opine that her symptoms were related to her work station. Petitioner testified that Dr. Carroll recommended that she undergo occupational therapy, which she did undergo therapy from March of 2013 through April of 2013. Petitioner continued to work full-duty during this period of time.

Petitioner testified that it was not until she began physical therapy did she become aware of the possibility of her work station ergonomics as a possible factor in the symptoms that she was having. Petitioner testified that she told the therapist that she worked with a stationary keyboard that could not be moved around as it was permanently on the desk. Petitioner's testimony regarding her belief regarding the causal relationship between her work and her condition went as follows:

> Q. So then it's your understanding that once you saw the therapist, that was when you connected the work station to your complaints?
>
> A. Right. That's when I figured out why when I'm at work and doing the typing, it's like a dagger on my chest and my shoulders when I'm typing this way so...
>
> Q. So after that, you then completed an Illinois Form 45 and initiated the workers' compensation process, right?
>
> A. No. I called the insurance company. I never filled out that form. I called the insurance company. (T. 62)

Petitioner testified to the verbal statement she gave to the insurance adjuster regarding her alleged claim in July of 2013. Petitioner advised the adjuster that none of her doctors indicated that her problems were due to her work related activities, but she believed that they were due to her independent research on the internet. Petitioner denied any mention of her therapist advising her about the possible ergonomic issue.

Petitioner stated in her statement that she attributed her pain to something she saw online and began researching ergonomics and her work station. Petitioner testified that she simply performed a Google search. She could not confirm whether she reviewed any authoritative and/or legitimate internet articles. Petitioner testified that in the verbal statement she denied any prior workers' compensation awards or settlements.

When asked about her prior workers' compensation claims, Petitioner confirmed that she had previously filed a workers' compensation claim for her bilateral wrists and arms stemming from an alleged accident in 2002 with case number 03 WC 15297 while working for I-Logistics. She testified that she did receive a settlement in that claim for her right hand totaling $39,500.00 (Rx. 4). However Petitioner did not recall the subsequent two claims that she filed. She denied having any recollection of her bilateral arm claim with case number of 04 WC 24095, which was litigated and resulted in the Arbitrator rendering a denial Decision in that matter. Petitioner denied any recollection of every appearing and testifying regarding the same. Lastly, Petitioner denied having any knowledge of the case of 06 WC 14977, which was dismissed against CBS International.

Petitioner testified that she underwent an MRI of the right shoulder, and other diagnostic scans of her bilateral upper extremities. She continued to undergo occupational therapy. She also testified as to the number of injections that she underwent in the bilateral shoulders that provided her with approximately four weeks of relief before the pain returned. Petitioner testified that all of her therapy was performed at Northwestern Medical Center. The initial physical therapy evaluation from March 11, 2013 documents that Petitioner exhibited symptom magnification and malingering.

Petitioner testified that in January of 2014, Dr. Carroll recommended that she undergo an arthroscopic surgical intervention relating to the right shoulder alone.

Thereafter, Petitioner testified that she began to treat with a chiropractor, Dr. Elahi, who she was referred to by her prior attorney. She admitted that she was not referred to Dr. Elahi by any of her treating physicians. Petitioner testified that she underwent approximately 2-3 months of therapy and chiropractic care with Dr. Elahi through approximately March of 2014. Petitioner testified that she only treated with Dr. Elahi for her upper extremity condition. She specifically denied having complaints and/or receiving treatment for her cervical spine or lumbar spine conditions.

Petitioner testified that she continued to undergo therapy and treatment with Dr. Carroll through March of 2015. She denied ever undergoing a surgery for the elbow or shoulder. She continued to receive injections, which provided limited relief for approximately four weeks. Dr. Carroll testified via evidence deposition on May 18, 2015. He diagnosed Petitioner with bilateral epicondylitis, bilateral wrist pain with numbness, and bilateral shoulder impingement. He attributed these conditions to the poor ergonomics of Petitioner's work conditions as described by the Petitioner herself.

Petitioner testified that she did not lose any time from work related to her alleged conditions and continued to work full-duty throughout her treatment.

Petitioner testified that currently she continues to have pain in the right upper extremity and wishes to undergo the surgical recommendation made by Dr. Carroll. Petitioner is seeking authorization for surgical intervention by Dr. Carroll for the right shoulder as she believes that surgery is the only way that her symptoms would be cured, as she does not wish to undergo any further injections into the shoulder.

Testimony of Ms. Flora Suner

Ms. Suner testified that she works for the Respondent as the district manager and is the Petitioner's direct supervisor since 2011. Ms. Suner testified as to her knowledge of Petitioner's job duties, confirming that the Petitioner performed clerical type duties and was not required to perform any heavy lifting, overhead lifting, or repetitive gripping or grasping.

Ms. Suner confirmed that the Petitioner initially complained of chest pain and Ms. Suner recommended that Petitioner seek treatment for the same. Ms. Suner testified that she was not made aware of the Petitioner's alleged ergonomic issues until sometime in early 2013.

Ms. Suner then testified as to a breakdown of Petitioner's work station where she was from 2011 until 2012. She confirmed that the work station was "as is", and that both the Petitioner's desk and chair were adjustable. Ms. Suner testified that the Petitioner did not make any complaints of pain of the bilateral upper extremities until January, 2013 and did not request any changes to her work station until January or February, 2013.

Ms. Suner testified that changes were made to Petitioner's work station and a new work station was provided to the Petitioner solely based on the Petitioner's subjective claim that the ergonomics of her work station were causing her symptoms and pain. Based on the same, Ms. Suner made the changes immediately. It was Ms. Suner's testimony that the Petitioner's new work station was provided to her prior to her seeking the medical treatment. Ms. Suner testified that the desk that Petitioner was placed at in January of 2012 was not changed and/or altered from when it was purchased and set up by the delivery people. Ms. Suner testified that the desk was not specifically set up for a taller person, specifically a person that was 5'9".

Ms. Suner testified that prior to Petitioner's medical treatment and physical therapy treatment, Petitioner had already been moved to a new work station.

Ms. Suner then testified as to the video that she prepared showing Ms. Suner performing Petitioner's job activities both at the Petitioner's new desk and her old desk. Ms. Suner was able to authenticate the video and testified that she was performing the job activities in the same speed and fashion that Petitioner was required to perform. Ms. Suner confirmed that the video was created in 2014 and that nothing in the video was modified.

On cross examination, Ms. Suner testified that she did not specifically recall seeing the petitioner work with her arms extended at chest level during the day.

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CONCLUSIONS OF LAW

1. Regarding the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. This finding is supported by both the testimony at trial and the medical evidence. Specifically, the Arbitrator finds Petitioner's description of what allegedly happened on or about December 1, 2012 to be confusing and incredible. Petitioner alleges injuries to both her elbows (epicondylitis) and shoulders (impingement) from the ergonomics of her work station. In support of that claim, Petitioner tendered photographs of a desk and blurry shots of what purports to be a tape measure. Coupled with her description of typing with arms fully extended at chest level and her Google research, Petitioner believes she sustained an accident at work. However, the Arbitrator does not find this evidence persuasive. Instead, the Arbitrator notes that the Petitioner's initial complaints around December, 2012 was that she thought she was having a heart attack with complaints of pain in her chest and her shoulders. Petitioner received a new work station in January or February, 2013 and then saw Dr. Carroll for her arm complaints in March, 2013. There was no evidence presented showing the Petitioner had complaints of arm pain until March, 2013. By Petitioner's own admission, she did not relate her problems to the ergonomics of her work station until she spoke with a therapist some time after seeing Dr. Carroll in March, 2013. And even then, she described her complaints like "a dagger on my chest and shoulders." By this account alone, the Petitioner would have the Arbitrator believe that what started as chest pain developed into bilateral elbow and shoulder pain. But even if the Arbitrator were so inclined to make such a bold leap in logic, Petitioner's claims of an "ergonomic accident" lack credibility.

In trying to assess what actually happened to the Petitioner on December, 2012, the Arbitrator notes the information provided to Dr. Carroll and the statement Petitioner provided to the adjuster (soon after the Petitioner's own Google research). Petitioner provides a description of her duties that depicts her using a stationary keyboard that cannot be moved, working on a chair that cannot be adjusted and requiring her to type with her arms fully extended at chest level. Dr. Carroll bases his opinions regarding causation on this description provided by Petitioner. However, the facts presented to the Arbitrator indicate Petitioner's description of her work condition were not accurate. For example, the Arbitrator notes that the keyboard Petitioner uses is not stationary, and could be placed closer to Petitioner – which would alleviate having to type with her arms fully extended at chest level. Furthermore, both Petitioner's chair and desk could be adjusted according to the unrebutted testimony of Ms. Suner. Also, Petitioner herself chose to type with her arms fully extended at chest level so that she could have her reports directly in front of her with her keyboard further back. Thus Petitioner's work station did not force or require her to type in such an awkward position, but instead, Petitioner chose to set up her work conditions in such an awkward, non-ergonomic manner. This leads the Arbitrator to conclude that the Petitioner's claims of ergonomic issues to both her treating physicians and to this Arbitrator lack credibility.

There are a number of other instances where Petitioner's credibility is challenged: 1) Petitioner did not remember her prior claim which was denied by another arbitrator; 2) documentation of Petitioner exhibiting symptom magnification and malingering at physical therapy; 3) Petitioner's denial of prior treatment for complaints of pain to her upper extremities; 4) the lack of any documentation in the physical therapy records regarding a causal relationship between Petitioner's condition and the ergonomics of her work place. However, the Arbitrator's decision is focused on the Petitioner's failed attempt at describing what she believes to be an accident. As such, the Arbitrator concludes that the Petitioner has failed to prove that she sustained an accident on December 1, 2012. Accordingly, the Petitioner's claim is denied.

17IWCC0442

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DIVISION

Petitioner,

vs. NO. 14 INC 93

JOSHUA HERION, individually, and
as LLC MEMBER d/b/a EXTERIOR CONSTRUCTION
SPECIALISTS, INC.,

Respondent,

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act) and Section 9100.90 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission (the Rules), codified as Title 50 of the Illinois Administrative Code, Chapter 6. Proper and timely notice was given to all parties.

An Insurance Compliance Hearing on the Merits was held before Commissioner Michael J. Brennan on February 24, 2017, in Chicago, Illinois. Respondent was not present at the hearing despite being personally served with notice of said hearing on December 14, 2016. PX.1.

Petitioner has requested penalties for a period of 2,011 days of non-compliance with the Act from March 22, 2006 through January 30, 2008 and February 1, 2009 through September 23, 2012. The Petitioner has asked for an additional award of $64,440.98 pursuant to Section 4(d) of the Act and Section 9100.85(a)(1) of the Rules as reimbursement for the amounts paid by the Injured Workers' Benefit Fund (IWBF) to an employee of the Respondent pursuant to the award entered in *Francisco Garcia v. Exterior Construction,* 2010 WC 35994, representing a total fine of $1,069,940.98.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent, JOSHUA HERION, individually and as LLC Member, and doing business as EXTERIOR CONSTRUCTION SPECIALISTS, INC., knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the

Rules during the period of March 22, 2006 through January 30, 2008 and February 1, 2009 through September 23, 2012.

As a result, Respondent shall be held liable for his non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act and 9100.90(b) of the Rules. The Commission hereby assesses the penalty of $1,069,940.98 against the above-named Respondent for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On July 18, 2014, Commissioner Michael J. Brennan issued an Order of Default against, Respondent, Joshua Herion, Individually, and as LLC Member d/b/a Exterior Construction Specialists, LLC. Per the Order, Respondent was duly served with a Notice of Non-Compliance on April 14, 2014. The Respondent was also served with a Notice of Hearing on June 4, 2014 advising of a hearing before the Commission on July 18, 2014. Respondent failed to appear and the Order of Default was issued. PX.1.

2. An Insurance Compliance Hearing was held before Commissioner Brennan on February 24, 2017. Notice of Hearing was personally served on Joshua Herion, Individually and as LLC Member d/b/a Exterior Specialists, LLC on December 14, 2016. PX.1. Respondent failed to appear at hearing. Chief of Investigations for the Insurance Compliance Division for the Illinois Workers' Compensation Commission, Frank Capuzi, testified on behalf of Petitioner.

3. On October 3, 2002, Articles of Incorporation were filed on behalf of Exterior Construction Specialists, LLC. Respondent, Joshua Herion, was listed as the Registered Agent. The Registered Agent's street address was listed as 31439 N. Liberty Road, Grayslake, IL 60030. The principal office was listed as 3920 W. Hawthorn Court, Waukegan, IL 60087. PX.9.

4. Records from the Illinois Department of Revenue showed that Exterior Construction Specialists paid compensation subject to income tax withholdings. PX.10.

5. Records from Illinois Department of Employment Security showed that Exterior Construction Specialists had employees during the first and second quarters of 2012, and the fourth quarter of 2012 through the fourth quarter of 2013, each of whom received certain wages. The record also specified Respondent as the employer of said business. PX.11.

6. Maria Sarli-Dehlin, of the Illinois Workers' Compensation Commission Office of Self-Insurance, certified that no certificate of approval to self-insure was issued

by the Illinois Workers' Compensation Commission to Exterior Construction. PX.7.

7. On February 9, 2015, Esteban Ortiz, Proof of Coverage Analyst for NCCI Holdings, Inc., conducted a thorough search of the NCCI database. The search revealed that the Respondent, Joshua Herion, Exterior Constructions Specialists, LLC., did not have workers' compensation insurance from January 31, 2009 through September 23, 2012. PX.8.

8. During the Insurance Compliance Hearing of February 24, 2017, Frank Capuzi testified that his investigation revealed that the Respondent did not have workers' compensation insurance between March 22, 2006 and January 30, 2008. T.26.

9. On July 9, 2010, Francisco Garcia, Respondent's employee sustained injury to his right leg. Garcia filed a claim against Respondent, Exterior Construction & the Injured Workers' Benefit Fund, case number: 10 WC 35994. Per Garcia's testimony, Joshua Herion was the owner of Exterior Construction. His job duties included knocking down roofs, dumping debris, washing away debris, and repairing roofs. He would take a van to the job site. He worked with various tools including hammers, blades, pressure hoses, and small handheld blades. The matter proceeded to arbitration before Arbitrator Edward Lee on April 21, 2016. Respondent, Exterior Construction, did not appear. In his Decision dated June 14, 2016, the Arbitrator awarded temporary total disability benefits of $373.33 for 74 weeks in addition to all reasonable and necessary medical expenses. The Arbitrator further awarded permanent partial disability benefits of $336.00 per week for 32.25 weeks, representing 15% loss of use of the right leg pursuant to Section 8(e) of the Act. PX.6.

10. During the Insurance Compliance hearing, it was noted that the IWBF has paid $64,440.98 in the matter of *Francisco Garcia v. Exterior Construction*, 10 WC 35994. T.43.

11. Frank Capuzi testified that he visited the business location of the Respondent and observed at least five employees loading trucks. Capuzi testified that the Respondent's business was a standalone building on an acre lot with equipment and vehicles. T.36. He spoke to Alberto Guadalupe through a Spanish interpreter, who informed him that there were 15 employees that worked there. Through his investigation, Capuzi learned that Joshua Herion was the owner of the business. T.37. Capuzi also learned that Respondent has two other business names: ECS Roofing and ECS Sales and Marketing, LLC. T.39. None of which have workers' compensation insurance. *Id.*

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including: "the erection, maintain, removing, remodeling, altering or demolishing of any structure" 820 ILCS 305/3(1); "Construction, excavating or electrical work" 820 ILCS

305/3(2); "the operation of any warehouse or general or terminal storehouses" 820 ILCS 305/3(4); "any enterprise in which sharp edged cutting tools, grinders or implements are used, including all enterprises which buy, sell or handle junk and salvage, demolish or reconstruct machinery" 820 ILCS 305/3(8); and, "any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof." 820 ILCS 305/3(15).

The Commission finds that Respondent's business falls under Sections 3(1), 3(2), 3(4), 3(8), and Section 3(15) of the Act. While there was no direct testimony as to the nature of the business during the period of non-compliance, the Commission takes judicial notice of the findings by the Arbitrator in this regard and as contained in the Decision rendered 10 WC 35994. The testimony therein established that Respondent owned a construction business that remodeled commercial and residential buildings. They were transported to the job site by a van and used sharp edged cutting tools. Per Capuzi's testimony, the Respondent's business was operated out of a standalone building on a large lot. The Respondent has offered no evidence to the contrary. By application of Section 3, Respondent was required to maintain workers' compensation insurance.

The Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to

> comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 9100.90 of the Rules speaks to the language of the Act, and describes the notice of non-compliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, was provided to Respondent. Section 9100.90(d)(3)(D) of the Rules indicates that "A certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." Petitioner's Exhibit 8 contains the certification from NCCI Holdings, Inc. indicating that Respondent did not have workers' compensation insurance from January 31, 2009 through September 23, 2012. Further, Frank Capuzi, Chief of Investigations, offered unrebutted testimony that Respondent did not have workers' compensation insurance between March 22, 2006 and January 30, 2008. Respondent failed to offer any evidence of compliance with the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the period of time during which the Respondent violated the Act by failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 2,011 days, from March 22, 2006 through January 30, 2008, and February 1, 2009 through September 23, 2012. The Respondent employed up to 15 employees. In fact, one of Respondent's employees, Francisco Garcia, did sustain a work injury. As Respondent failed to have workers' compensation insurance, IWBF paid benefits to Garcia as a result of the injury. Respondent was notified of his non-compliance under the Act by the Insurance Compliance Department of the Illinois Workers' Compensation and elected to not obtain workers' compensation insurance.

Having reviewed the record, the Commission finds no evidence as to Respondent's inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

Pursuant to Section 9100.85(a)(1) of the Rules, the Commission shall have the right to obtain reimbursement for any compensation obligations paid by the Injured Workers' Benefit Fund (IWBF) from any individual employer/owner, corporate officer, director of a corporate employer, partner of an employer partnership, or member of an employer limited liability company.

The Commission finds Respondent knowingly and willfully failed to comply with the Act. Based on the significant period of time that Respondent failed to comply with the Act, the Commission assesses a penalty of $1,069,940.98 against Respondent, JOSHUA HERION, individually and as LLC Member, and doing business as EXTERIOR CONSTRUCTION SPECIALISTS, INC.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, JOSHUA HERION, individually and as LLC Member, and doing business as EXTERIOR CONSTRUCTION SPECIALISTS, INC., is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 9100.90 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $1,069,940.98 pursuant to Section 4(d) of the Act and Section 9100.90 of the Commission Rules. This amount represents 2,011 days of non-compliance with the Act, at $500.00 per day, from March 22, 2006 through January 30, 2008, and February 1, 2009 through September 23, 2012, as well as the arbitration award previously paid by the IWBF in the amount of $64,440.98.

Pursuant to Commission Rule 9100.90(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

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: JUL 2 1 2017
MJB/tdm
D: 6/20/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY HOUSTON-SULLIVAN,

Petitioner,

vs. NO: 14 WC 23160

GET FRESH PRODUCE,

Respondent,

ORDER

This matter comes before the Commission on Respondent's Motion to Reinstate Petition for Review and Dismiss Petitioner's Petition for Penalties. A hearing was held before Commissioner DeVriendt on March 7, 2017, and a record was made.

This matter was originally heard by the Arbitrator on January 15, 2016. The Arbitration Decision was filed on March 9, 2016. Respondent filed its Petition for Review on April 15, 2016. The Return Date for Review was set for July 15, 2016. Respondent did not file and/or authenticate the transcript. On September 29, 2016, the Commission dismissed Respondent's Petition for Review following a Rule to Show Cause Hearing. Respondent did not appear for the Rule to Show Cause Hearing and later argued it never received notice for same.

In its Motion to Reinstate Petition for Review, Respondent argues it had not received notice of the Show Cause Hearing date and was therefore denied due process. However, this argument is flawed as Respondent never perfected its Review under 820 ILCS 305/19(b) and 50 Ill.Adm.Code 9040.10(c). Respondent's Petition for Review was appropriately dismissed as Respondent never filed a transcript, nor perfected its review as required by statute and Rules governing practice before the Commission.

Respondent argued Petitioner's Petition for Penalties was moot as its Petition for Review should be reinstated. As Respondent's Motion to Reinstate is denied, its Motion to Dismiss Petitioner's Petition for Penalties is also denied. Hearing on Petitioner's Petition for Penalties is set for Oral Argument on August 11, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Reinstate Petition for Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss Petitioner's Petition for Penalties is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties is set before Commissioner DeVriendt on August 11, 2017, Chicago Review Call.

DATED: JUL 19 2017

Charles J. DeVriendt

Joshua D. Luskin

CJD/dmm
R: 03/07/17
49

DISSENT

"If at any time before the hearing [*336] a properly authenticated stenographic report is filed with the Industrial Board this is all that is required by the statute. The date fixed by the statute as to the filing of such report is directory, -- not mandatory, -- and is not jurisdictional." *The Illinois Midland Coal Company vs. The Industrial Board of Illinois*, 277 Ill. 333, 335-36 (1917). I respectfully dissent.

Respondent argued it did not receive the Notice of the Rule to Show Cause set for September 29, 2016. Upon learning of the dismissal of its review, Respondent filed its Motion to Reinstate its Review evidencing its willing to file a properly authenticated transcript. Further at the time of the January 15, 2016 hearing, both parties agreed to the stenographic stipulation- agreeing if a transcript was not timely filed, jurisdiction would not be raised as a defense. *See Ingrassia Interior Elements v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110670WC.

To date the Commission has not set this matter for hearing (oral argument). As such in the Commission's discretion, I would grant Respondent's Motion to Reinstate its Petition for Review, allow Respondent to file the authenticated transcript, and hear the Petition for Review on its merits.
Accordingly, I dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Ballard,

Petitioner,

17IWCC0440

vs. NO: 14 WC 118

Milestone,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, medical 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 25, 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.

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

DATED: JUL 14 2017
KWL/vf
O-7/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0440

BALLARD, JACQUELINE
Employee/Petitioner

Case# **14WC000118**

14WC000119

MILESTONE
Employer/Respondent

On 2/25/2016, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2027 WIEDNER & McAULIFFE LTD
JEFF SALISBURY
2990 N PERRYVILLE RD STE 4300
ROCKFORD, IL 61107

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0440

Jacqueline Ballard
Employee/Petitioner

v.

Milestone
Employer/Respondent

Case # 14 WC 118

Consolidated cases: 14 WC 119

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **January 20, 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. ☒ 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$24,573.64**; the average weekly wage was **$472.57**.

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

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

Respondent has paid **$7,881.39** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$5,725.92** for other benefits, for a total of **$13,607.31**.

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on September 25, 2013, and failed to prove by a preponderance of the evidence that her condition of ill being is causally connected to any such alleged accident on September 25, 2013, 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

February 24, 2016
Date

ICArbDec19(b)

FEB 25 2016

Statement of Facts

Petitioner filed two separate Applications for Adjustment of Claim 14 WC 118 (accident date: September 25, 2013) and 14 WC 119 (accident date: July 6, 2013) alleging accidental injuries to her left shoulder. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to these claims.

Petitioner Jacqueline Ballard testified that in July, 2013, she worked for Respondent Milestone as a team leader at the Old Golf Road Group Home. She had worked for Respondent approximately 11 years, becoming a team leader in April, 2012. As team leader, she supervised staff and cared for mentally challenged adult residents of the group home. Petitioner testified that this was a hands-on position. The Old Golf Road facility was home to six residents from 50 to 82 years old. Her work involved assisting residents getting into and out of bed, showering, dressing, feeding and transporting residents for skills training at other facilities, or for medical appointments. Petitioner testified that one resident required almost total care.

Petitioner's payroll records were admitted as Respondent's Exhibit 1. Regarding her hours, Petitioner testified that her overtime was mandatory. She testified that there were a certain amount of hours that needed to be covered per week. Staff members were allowed to choose additional hours to work. If the hours were not filled, Petitioner, as the team leader, was expected to cover the excess hours. It was her responsibility to make sure that the home had sufficient coverage. Jeana Jones, Petitioner's supervisor, testified for Respondent. Ms. Jones testified that overtime was completely voluntary. She testified that staff would get together every two weeks, at which time the staff picked their shifts. She testified that if there was not sufficient coverage, individuals not specifically placed at the particular home would be called in to fill the shifts. Overtime was never assigned. Aisha Brown testified that overtime was voluntary.

Petitioner testified that on July 6, 2013, while assisting a resident with cerebral palsy, the battery on a lift lost power and she was required to get the resident out of bed. While doing so, she felt a "pull" in her shoulder. She got him into his chair and continued her shift. The petitioner acknowledged she did not report the incident on July 6, 2013 to her employer. She testified that she did not report the accident because she did not want to lose her job.

Petitioner testified that she continued to have pain in her shoulder while she was working through September 25, 2013. Petitioner testified that her job also required her to lift wheelchairs to transport passengers. Patients would be transported in a minivan or a 15 passenger van. Some wheelchairs weighed up to 75 pounds, others weighed less. They had to be lifted into the minivan or van. Petitioner testified that there was a lift on the 15 passenger van. Petitioner testified that when the lift came out, it was rusted and left a gap. The wheels would get caught and jar her around. It was dangerous and unsafe. Petitioner testified that she experienced ongoing pain in her left shoulder while lifting wheelchairs and patients. Petitioner testified that she complained about the issue with the van to Jeana Jones, but nothing was done. Petitioner testified that she called Stan Posley, the maintenance supervisor. Thereafter, Bob Moore, the Residential Services Director, came to the facility, took pictures of the van, and informed her it would be taken care of. Petitioner testified that shortly thereafter, the van was removed from the home.

Stan Posley testified for Respondent. He testified that he was the warehouse manager and mechanic in 2013. He testified that he had no knowledge of Petitioner's alleged work related injury. He testified that he was not

sure if Petitioner had reported a faulty lift on the 15 passenger van in July of 2013. He testified to the vehicles used by Respondent. All of the lifts work basically the same. Robert Moore testified for Respondent. He worked as a Residential Services Director for Respondent in 2013. Mr. Moore testified that Petitioner never reported a work related injury to him. He testified when told about an injury, the policy was that he referred people to HR to fill out an incident report.

Respondent offered Respondent's Exhibit 7, a video of the job duties described by Petitioner. The Arbitrator has viewed the video which depicts using the lift to move a patient, transporting patients by van, lifting a wheelchair into the van, performing paperwork and exercising a patient. Petitioner testified the video was inaccurate in that the demonstration did not use a real patient who would be dead weight, did not show the 15 passenger van, and used a lighter wheelchair. Aisha Brown also testified that the video was not accurate in depicting lifting a patient.

Petitioner testified she went to see a physician at Brookside Immediate Care Clinic on July 6, 2013 or the following day. Petitioner testified she continued to work, but her shoulder kept bothering her so she went to her personal doctor, Dr. Choi on August 6, 2013. Dr. Choi's records were admitted as Petitioner's Exhibit 1.The record contains a history of onset of left shoulder pain for two weeks. It was initially only at night but it has been worse now to the point she experiences pain even during the daytime. Petitioner did not recall a precipitating event. Petitioner reported she works 12-13 hours per day 7 days per week. She carries wheelchairs weighing 70-80 pounds. The teaching attestation of Dr. Ironsides also notes no known injury, but Petitioner does a lot of heavy lifting at work. Petitioner was diagnosed with possible left rotator cuff tendinitis and advised to avoid heavy lifting, specifically wheelchairs.

Petitioner testified that on September 25, 2013, while transporting a patient, she felt another pull in her shoulder. She testified that the wheel of the wheelchair got caught on the van's lift, causing a jerking motion and increasing pain in her shoulder. Petitioner was seen by Dr. Choi on September 25, 2013. The petitioner complained of interval worsening of the left shoulder pain and limited range of motion due to pain. It was noted that she carried wheelchairs and sometimes had to lift patients off of a bed. There is no history of incident or trauma. The petitioner was to be referred to physical therapy and was given work restrictions of no lifting beyond 10 pounds for six months. Petitioner testified she was seen at Swedish American Hospital on that date, but PX 1 confirms that she was sent by Dr. Choi solely to have x-rays after her office visit.

Petitioner testified that she provided the 10 pound restriction to April Adams in Human Resources. Petitioner was told that work with a 10 pound restriction would not be accommodated. Petitioner was given short term disability paperwork. Petitioner filled out the short term disability paperwork (RX 5). The question "is your disability caused by an illness or injury" is answered "N/A." The form states the condition is work related noting how the injury occurred was getting individual onto an E-Z lift, lifting wheelchairs, and pulling and pushing wheelchairs to get them off a lift van. Ms. Adams received the short term disability paperwork, acknowledging that Petitioner was alleging a work related injury, on October 17, 2013 (RX 5). Petitioner did not return to work after September 25, 2013. She did receive temporary total disability benefits for a period of time and received short term disability (RX 2).

Jeana Jones testified that Petitioner never notified her of any work-related injury. She did recall having a conversation with Petitioner in September 2013 when Petitioner told her that the doctor said she may not be able to work for at least 6 months. She testified that Petitioner stated this was not work related. She had pulled something in her shoulder while reaching behind into the backseat of a car to retriever her purse. Ms. Jones

testified she prepared an email to April Adams about that conversation with Ms. Ballard, on April 15, 2014 (RX 3). Petitioner denied that she ever told Ms. Jones about any such personal incident.

April Adams testified on behalf of respondent. She worked in the HR Department at the time of the alleged injuries. She was responsible for paperwork associated with both short-term disability benefits and workers' compensation benefits. Ms. Adams testified that the petitioner was initially off on Family and Medical Leave and that she communicated by letter with petitioner dated October 14, 2013 regarding the need to receive portions of the short-term disability forms (RX 4). Ms. Adams testified that she first became aware that Petitioner was alleging a work-related condition after receiving a fax from UNUM on October 17, 2013, with portions of the short-term disability paperwork. She then called the petitioner by telephone to obtain more information about the claim. Ms. Adams testified that she prepared a memorandum that day documenting her conversation with petitioner and receipt of the short-term disability forms indicating the condition was work-related (RX 5). Ms Adams' memo documents the conversation with Petitioner on that date. Petitioner related her conversation with Dr. Choi. Petitioner stated that she had not filled out an incident report. April Adams testified that Petitioner did not fill out an accident report for either alleged injury. She testified that she did not ask for one once she became aware the condition was allegedly work-related, because it had been treated as a group disability claim.

Respondent offered Respondent's Exhibit 8, a staff incident/injury report from an incident on December 21, 2012 involving the right knee and low back, as well as Respondent's Exhibit 9 consisting of a medical report from Brookside Immediate and Occupational Care Clinic of treatment for that alleged injury on December 21, 2012. Petitioner acknowledged that when she reported that incident, Respondent had her seen at Brookside Immediate and Occupational Care Clinic.

The petitioner returned to Dr. Choi on October 24, 2013 and an MRI was ordered. An MRI of the left shoulder on November 18, 2013 revealed moderate to severe hypertrophy of the osteoarthritic AC joint exerting mild mass effect upon the myotendinous junction of the supraspinatus. The impression was no evidence of a rotator cuff tear or discrete labral tear. Petitioner underwent physical therapy. Petitioner was seen by Dr. Choi on December 11, 2013 and January 17, 2014. An injection of corticosteroid was performed on January 29, 2013. Dr. Choi referred Petitioner to Rockford Orthopedic Associates (PX 1).

The records of Rockford Orthopedic Associates were admitted as Petitioner's Exhibit 2. On March 25, 2014, Petitioner was seen by Dr. Scott Trenhaile. His record noted that her symptoms had begun in April of 2013 when she was trying to get a wheelchair out of a van, jerking her shoulder forward away from her. He assessed impingement syndrome of the left shoulder. He recommended an EMG to evaluate the suprascapular nerve. The EMG, performed on March 27, 2014, was reported as normal. Petitioner received another injection on April 1, 2014. On April 29, 2014, Petitioner reported the injection was not beneficial. Dr. Trenhaile recommended a left shoulder arthroscopy, subacromial decompression, distal clavicle excision, joint debridement, possible rotator cuff repair, and possible biceps tenodesis. Surgery was scheduled for May 5, 2014, but it was not approved by Respondent's insurance carrier.

On June 9, 2014, Petitioner was seen by Dr. Pietro Tonino for a Section 12 examination at Respondent's request (RX 6). Dr. Tonino's recorded history from Petitioner included an injury to her left shoulder on July 6, 2013 while lifting a wheelchair. Dr. Tonino reviewed records of Dr. Choi and noted that those records indicate Petitioner had left shoulder pain for approximately two weeks and did not identify any trauma. Dr. Tonino assessed rotator cuff tendinopathy and a possible rotator cuff tear. He indicated that it appears that Petitioner

is describing normal duty activities causing her left shoulder pain. He could not determine causation until reviewing a job video. His recommendation for further treatment was consistent with the recommendation of Dr. Trenhaile. He also agreed that Petitioner would require restrictions of lifting no more than 5 pounds and no overhead or repetitive use of the left arm (RX 6).

Dr. Tonino then reviewed a job video. The second report of Dr. Tonino dated June 9, 2014 contains his characterization of the four video clips he reviewed, and which were admitted as RX 7. Dr. Tonino noted that he did not see the activity described by Petitioner, of lifting patients and 60-70 pound wheelchairs, depicted in the video. Therefore, he opined that her left shoulder condition was not related to her work activities (RX 6).

Petitioner was examined by Dr. Jeffrey Coe at her attorney's request on January 20, 2015 (PX 3). Dr. Coe's history included transferring of patients from chairs to beds, assisting patients in bus or van transportation, and in daily care. Petitioner told Dr. Coe that on July 6, 2013, she was assisting a patient who required a motorized wheelchair into a transportation van. As she stood on the chair, attempting to lift the patient's arms to adjust the chair seatbelt, she felt a strain in her shoulder. Petitioner indicated that she continued working; developing increasing left shoulder pain and stiffness.

Dr. Coe discussed the job video with Petitioner. Petitioner stated that lifting equipment was available, although not always utilized due to patient positioning or urgency. She noted that the van in the video was not the one used at the time of her employment with Respondent. She noted that she used a 15 passenger van, which required transferring patients into seats and then manually shifting the wheelchairs onto lifts to load them into the van. She noted that the wheelchairs often got stuck on the edge of the lift of the van. Petitioner also notes that the video had no information directly related to the "specific injury" she suffered on July 6, 2013 (PX 3).

Dr. Coe opined that Petitioner sustained an injury to her left shoulder on July 6, 2013 while assisting a patient in a motorized wheelchair. He agreed with the surgical procedure recommended by Dr. Trenhaile and recommended a 5 pound lifting restriction with no overhead work with the left arm (PX 3).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident, the Arbitrator finds as follows:

Petitioner is seeking compensation for an injury to her left shoulder which she alleges occurred on September 25, 2013. Petitioner testified that on September 25, 2013, while transporting a patient, she felt pull in her shoulder. She testified that the wheel of the wheelchair got caught on the van's lift, causing a jerking motion and increasing pain in her shoulder. Other that Petitioner's trial testimony, this incident does not appear in any testimony or medical histories. Petitioner was already under active treatment for her left shoulder since August 6, 2013 with Dr. Choi. Dr. Choi's records from that date state that there was no incident of trauma and that symptoms began two weeks earlier. Petitioner was seen by Dr. Choi on September 25, 2013 with no history of incident or trauma. Thereafter, Petitioner's medical histories record a claimed date of accident on July 6, 2013, although reporting multiple different mechanism of injury. (A more complete analysis of the alleged July 6, 2013 accident is contained in the decision of consolidated claim 14 WC 119).

The Arbitrator also notes other inaccuracies and exaggerations in Petitioner's testimony and records. Petitioner advised Dr. Choi that she works 12-13 hours per day, 7 days per week, but the payroll records

document an average week of about 50 hours. Petitioner testified to an undocumented medical visit on July 6, 2013. She testified that she was seen at Swedish American Hospital on September 25, 2013 when this was a visit just to obtain x-rays. Petitioner's testimony was replete with comments on the inadequacy of the equipment at Respondent's facility and her valiant but ineffective efforts to remedy these perceived failures.

Jeana Jones and April Adams both testified that Petitioner did not report the alleged accident and when initially questioned about her condition, Petitioner denied that it was work related. Ms. Jones documented Petitioner's statement that she injured herself reaching for her purse in her car. Petitioner's ultimate claim of a work related condition in the Unum short term disability form does not allege a specific injury or date but is rather a listing of her job duties. The subsequent conversation documented by Ms. Adams indicates that she did not have an accident, but was told by Dr. Choi that continued lifting would worsen her symptom. Petitioner's claim that she did not initially report the accident because of fear for her job is contradicted by her reporting of the December, 2012 injury without repercussions.

Petitioner bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. Petitioner's uncorroborated trial testimony is not persuasive and contradicted by her own statements and medical histories as well as the testimony of Respondent's witnesses.

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained specific accidental injuries arising out of and in the course of her employment with Respondent on September 25, 2013.

Petitioner also presented testimony of the multiple heavy lifting activities that she performs during her job duties for Respondent. She specifically described moving patients from their beds to chairs, lifting wheelchairs, and transporting patients into the various vehicles and raised a theory of a repetitive trauma. An employee who suffers a repetitive trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. Absent credible evidence, the burden of proof, which is on claimant, is dispositive.

As noted above, the Petitioner's testimony is replete with exaggeration and inaccuracies raising serious questions as to her credibility. The incidents that she described are not the accumulation of repetitive normal job duties, but rather specific episodes of equipment malfunction such as the lift battery being dead or the 15 passenger van lift being rusted and catching the wheelchair wheels. She testified that the wheelchairs that she had to lift were of different weights. The Arbitrator viewed the job video, and while it may not demonstrate the most extreme efforts required as claimed by Petitioner, did provide a visual explanation of the tasks involved. Petitioner's testimony, even putting aside her credibility issues discussed above, described several discrete events, not a repetitive injury. In reviewing the video with Dr. Coe, she specifically states that the video had no information directly related to the "specific injury" she suffered. Although Dr. Tonino may not have viewed the specific mechanism alleged, his opinion with respect to whether the job duties caused the left shoulder injury is persuasive.

Based upon the record as a whole, the Arbitrator finds that the Petitioner has failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on September 25, 2013, either based upon a specific injury or a theory of repetitive trauma.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner is alleging an injury to her left shoulder arising out of her employment with Respondent on September 25, 2013. Petitioner testified to a specific event on that date when the wheel of the wheelchair got caught on the van's lift, causing a jerking motion and increasing pain in her shoulder. She has also raised the issue of a repetitive trauma manifesting on that date. As more fully discussed in the Arbitrator's finding with respect to Accident, the Petitioner's unpersuasive testimony about this accident is contradicted by the medical histories and the testimony of the witnesses presented by Respondent.

Petitioner bears the burden of showing by a preponderance of credible evidence that her current condition of ill-being is causally related to the workplace injury. Neither Dr. Choi nor Dr. Trenhaile provides a causal connection opinion. In fact, neither took a history of the accident testified to.

Dr. Coe takes a history of a completely different event occurring on July 6, 2013 (See the decision in case 14 WC 119). Dr. Coe provides an opinion that that it is that event described by Petitioner which caused her condition. Although Petitioner included a history of various job duties performed, she is clear that it is the "specific injury" that occurred on July 6, 2013 which injured her shoulder. There is no opinion of causal connection to an incident on September 25, 2013. There is not even a history of that event recorded.

Repetitive trauma claims generally rely upon medical testimony to establish the causal connection between the work performed and the claimant's disability. Although Dr. Coe took a history of various job duties from Petitioner, he provides no opinion to support causation based upon a theory of repetitive trauma. The only opinion presented concerning a causal relationship to Petitioner's work activities is from Dr. Tonino. While the job video did not document equipment malfunctions, Dr. Tonino was able to opine that the job duties did not cause Petitioner's shoulder condition.

Based upon the record as a whole, and consistent with the Arbitrator's finding with respect to Accident, the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that her condition of ill being in the left shoulder is causally connected to any accidental injury or repetitive trauma arising out of or in the course of her employment with Respondent on September 25, 2013.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Although this issue is moot based upon the Arbitrator's findings with respect to Accident and Causal Connection, the Arbitrator finds that the petitioner did give notice to April Adams on October 17, 2013 claiming that the condition of her left shoulder was work-related when Ms. Adams received a copy of the short-term disability claim form from UNUM and had a telephone conversation with Petitioner that day.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Respondent's Exhibit 1 documents Petitioner's hours including overtime hours beyond 40 hours per week in the majority of weeks from September 28, 2012 through September 25, 2013. The number of hours per week

varied. Petitioner testified that, as team leader, she was under an obligation to pick up any extra shifts that were not accounted for during the group meeting to decide shifts. Jeana Jones, Petitioner's supervisor, testified the extra hours were available to those who wanted them, including other workers not specifically assigned to the Old Golf Road Group Home. Aisha Brown testified that overtime was voluntary. The Arbitrator finds the testimony of Jeana Jones and Aisha Brown persuasive. The Arbitrator also does not find the hours worked were regular.

Based on the record as a whole, the Arbitrator finds that overtime hours were voluntary and should not be included in the calculation of average weekly wage pursuant to the provisions of Section 10 of the Act. Based on record as a whole and the stipulated calculations of the parties, the Arbitrator finds the petitioner's average weekly wage is $472.57.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, and (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident, Notice and Causal Connection, the issues of Medical, Prospective Medical and Temporary Compensation are moot. Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Ballard,

Petitioner,

17IWCC0439

vs.

NO: 14 WC 119

Milestone,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, medical 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 25, 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.

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

DATED: JUL 14 2017
KWL/vf
O-7/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0439

BALLARD, JACQUELINE
Employee/Petitioner

Case# **14WC000119**

14WC000118

MILESTONE
Employer/Respondent

On 2/25/2016, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
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STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0439

Jacqueline Ballard
Employee/Petitioner

v.

Milestone
Employer/Respondent

Case # 14 WC 119

Consolidated cases: 14 WC 118

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Rockford**, on **January 20, 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. ☒ 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 _____

17IWCC0439

FINDINGS

On the date of accident, **July 6, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$24,573.64**; the average weekly wage was **$472.57**.

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

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

Respondent paid **$7,881.39** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$5,725.92** for other benefits, for a total of **$13,607.31**.

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on July 6, 2013, failed to prove notice pursuant to the provisions of the Act, and failed to prove that her condition of ill being is causally connected to any such alleged accident on July 6, 2013, 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

February 24, 2016
Date

ICArbDec19(b)

FEB 25 2016

Statement of Facts

Petitioner filed two separate Applications for Adjustment of Claim 14 WC 118 (accident date: September 25, 2013) and 14 WC 119 (accident date: July 6, 2013) alleging accidental injuries to her left shoulder. These matters were consolidated for hearing and a single transcript was prepared. The Arbitrator has issued separate decisions with respect to these claims.

Petitioner Jacqueline Ballard testified that in July, 2013, she worked for Respondent Milestone as a team leader at the Old Golf Road Group Home. She had worked for Respondent approximately 11 years, becoming a team leader in April, 2012. As team leader, she supervised staff and cared for mentally challenged adult residents of the group home. Petitioner testified that this was a hands-on position. The Old Golf Road facility was home to six residents from 50 to 82 years old. Her work involved assisting residents getting into and out of bed, showering, dressing, feeding and transporting residents for skills training at other facilities, or for medical appointments. Petitioner testified that one resident required almost total care.

Petitioner's payroll records were admitted as Respondent's Exhibit 1. Regarding her hours, Petitioner testified that her overtime was mandatory. She testified that there were a certain amount of hours that needed to be covered per week. Staff members were allowed to choose additional hours to work. If the hours were not filled, Petitioner, as the team leader, was expected to cover the excess hours. It was her responsibility to make sure that the home had sufficient coverage. Jeana Jones, Petitioner's supervisor, testified for Respondent. Ms. Jones testified that overtime was completely voluntary. She testified that staff would get together every two weeks, at which time the staff picked their shifts. She testified that if there was not sufficient coverage, individuals not specifically placed at the particular home would be called in to fill the shifts. Overtime was never assigned. Aisha Brown testified that overtime was voluntary.

Petitioner testified that on July 6, 2013, while assisting a resident with cerebral palsy, the battery on a lift lost power and she was required to get the resident out of bed. While doing so, she felt a "pull" in her shoulder. She got him into his chair and continued her shift. The petitioner acknowledged she did not report the incident on July 6, 2013 to her employer. She testified that she did not report the accident because she did not want to lose her job.

Petitioner testified that she continued to have pain in her shoulder while she was working through September 25, 2013. Petitioner testified that her job also required her to lift wheelchairs to transport passengers. Patients would be transported in a minivan or a 15 passenger van. Some wheelchairs weighed up to 75 pounds, others weighed less. They had to be lifted into the minivan or van. Petitioner testified that there was a lift on the 15 passenger van. Petitioner testified that when the lift came out, it was rusted and left a gap. The wheels would get caught and jar her around. It was dangerous and unsafe. Petitioner testified that she experienced ongoing pain in her left shoulder while lifting wheelchairs and patients. Petitioner testified that she complained about the issue with the van to Jeana Jones, but nothing was done. Petitioner testified that she called Stan Posley, the maintenance supervisor. Thereafter, Bob Moore, the Residential Services Director, came to the facility, took pictures of the van, and informed her it would be taken care of. Petitioner testified that shortly thereafter, the van was removed from the home.

Stan Posley testified for Respondent. He testified that he was the warehouse manager and mechanic in 2013. He testified that he had no knowledge of Petitioner's alleged work related injury. He testified that he was not

sure if Petitioner had reported a faulty lift on the 15 passenger van in July of 2013. He testified to the vehicles used by Respondent. All of the lifts work basically the same. Robert Moore testified for Respondent. He worked as a Residential Services Director for Respondent in 2013. Mr. Moore testified that Petitioner never reported a work related injury to him. He testified when told about an injury, the policy was that he referred people to HR to fill out an incident report.

Respondent offered Respondent's Exhibit 7, a video of the job duties described by Petitioner. The Arbitrator has viewed the video which depicts using the lift to move a patient, transporting patients by van, lifting a wheelchair into the van, performing paperwork and exercising a patient. Petitioner testified the video was inaccurate in that the demonstration did not use a real patient who would be dead weight, did not show the 15 passenger van, and used a lighter wheelchair. Aisha Brown also testified that the video was not accurate in depicting lifting a patient.

Petitioner testified she went to see a physician at Brookside Immediate Care Clinic on July 6, 2013 or the following day. Petitioner testified she continued to work, but her shoulder kept bothering her so she went to her personal doctor, Dr. Choi on August 6, 2013. Dr. Choi's records were admitted as Petitioner's Exhibit 1.The record contains a history of onset of left shoulder pain for two weeks. It was initially only at night but it has been worse now to the point she experiences pain even during the daytime. Petitioner did not recall a precipitating event. Petitioner reported she works 12-13 hours per day 7 days per week. She carries wheelchairs weighing 70-80 pounds. The teaching attestation of Dr. Ironsides also notes no known injury, but Petitioner does a lot of heavy lifting at work. Petitioner was diagnosed with possible left rotator cuff tendinitis and advised to avoid heavy lifting, specifically wheelchairs.

Petitioner testified that on September 25, 2013, while transporting a patient, she felt another pull in her shoulder. She testified that the wheel of the wheelchair got caught on the van's lift, causing a jerking motion and increasing pain in her shoulder. Petitioner was seen by Dr. Choi on September 25, 2013. The petitioner complained of interval worsening of the left shoulder pain and limited range of motion due to pain. It was noted that she carried wheelchairs and sometimes had to lift patients off of a bed. There is no history of incident or trauma. The petitioner was to be referred to physical therapy and was given work restrictions of no lifting beyond 10 pounds for six months. Petitioner testified she was seen at Swedish American Hospital on that date, but PX 1 confirms that she was sent by Dr. Choi solely to have x-rays after her office visit.

Petitioner testified that she provided the 10 pound restriction to April Adams in Human Resources. Petitioner was told that work with a 10 pound restriction would not be accommodated. Petitioner was given short term disability paperwork. Petitioner filled out the short term disability paperwork (RX 5). The question "is your disability caused by an illness or injury" is answered "N/A." The form states the condition is work related noting how the injury occurred was getting individual onto an E-Z lift, lifting wheelchairs, and pulling and pushing wheelchairs to get them off a lift van. Ms. Adams received the short term disability paperwork, acknowledging that Petitioner was alleging a work related injury, on October 17, 2013 (RX 5). Petitioner did not return to work after September 25, 2013. She did receive temporary total disability benefits for a period of time and received short term disability (RX 2).

Jeana Jones testified that Petitioner never notified her of any work-related injury. She did recall having a conversation with Petitioner in September 2013 when Petitioner told her that the doctor said she may not be able to work for at least 6 months. She testified that Petitioner stated this was not work related. She had pulled something in her shoulder while reaching behind into the backseat of a car to retriever her purse. Ms. Jones

testified she prepared an email to April Adams about that conversation with Ms. Ballard, on April 15, 2014 (RX 3). Petitioner denied that she ever told Ms. Jones about any such personal incident.

April Adams testified on behalf of respondent. She worked in the HR Department at the time of the alleged injuries. She was responsible for paperwork associated with both short-term disability benefits and workers' compensation benefits. Ms. Adams testified that the petitioner was initially off on Family and Medical Leave and that she communicated by letter with petitioner dated October 14, 2013 regarding the need to receive portions of the short-term disability forms (RX 4). Ms. Adams testified that she first became aware that Petitioner was alleging a work-related condition after receiving a fax from UNUM on October 17, 2013, with portions of the short-term disability paperwork. She then called the petitioner by telephone to obtain more information about the claim. Ms. Adams testified that she prepared a memorandum that day documenting her conversation with petitioner and receipt of the short-term disability forms indicating the condition was work-related (RX 5). Ms Adams' memo documents the conversation with Petitioner on that date. Petitioner related her conversation with Dr. Choi. Petitioner stated that she had not filled out an incident report. April Adams testified that Petitioner did not fill out an accident report for either alleged injury. She testified that she did not ask for one once she became aware the condition was allegedly work-related, because it had been treated as a group disability claim.

Respondent offered Respondent's Exhibit 8, a staff incident/injury report from an incident on December 21, 2012 involving the right knee and low back, as well as Respondent's Exhibit 9 consisting of a medical report from Brookside Immediate and Occupational Care Clinic of treatment for that alleged injury on December 21, 2012. Petitioner acknowledged that when she reported that incident, Respondent had her seen at Brookside Immediate and Occupational Care Clinic.

The petitioner returned to Dr. Choi on October 24, 2013 and an MRI was ordered. An MRI of the left shoulder on November 18, 2013 revealed moderate to severe hypertrophy of the osteoarthritic AC joint exerting mild mass effect upon the myotendinous junction of the supraspinatus. The impression was no evidence of a rotator cuff tear or discrete labral tear. Petitioner underwent physical therapy. Petitioner was seen by Dr. Choi on December 11, 2013 and January 17, 2014. An injection of corticosteroid was performed on January 29, 2013. Dr. Choi referred Petitioner to Rockford Orthopedic Associates (PX 1).

The records of Rockford Orthopedic Associates were admitted as Petitioner's Exhibit 2. On March 25, 2014, Petitioner was seen by Dr. Scott Trenhaile. His record noted that her symptoms had begun in April of 2013 when she was trying to get a wheelchair out of a van, jerking her shoulder forward away from her. He assessed impingement syndrome of the left shoulder. He recommended an EMG to evaluate the suprascapular nerve. The EMG, performed on March 27, 2014, was reported as normal. Petitioner received another injection on April 1, 2014. On April 29, 2014, Petitioner reported the injection was not beneficial. Dr. Trenhaile recommended a left shoulder arthroscopy, subacromial decompression, distal clavicle excision, joint debridement, possible rotator cuff repair, and possible biceps tenodesis. Surgery was scheduled for May 5, 2014, but it was not approved by Respondent's insurance carrier.

On June 9, 2014, Petitioner was seen by Dr. Pietro Tonino for a Section 12 examination at Respondent's request (RX 6). Dr. Tonino's recorded history from Petitioner included an injury to her left shoulder on July 6, 2013 while lifting a wheelchair. Dr. Tonino reviewed records of Dr. Choi and noted that those records indicate Petitioner had left shoulder pain for approximately two weeks and did not identify any trauma. Dr. Tonino assessed rotator cuff tendinopathy and a possible rotator cuff tear. He indicated that it appears that Petitioner

The records which do include a claim of injury have various times and activities described. Dr. Scott Trenhaile noted that her symptoms had begun in April of 2013 when she was trying to get a wheelchair out of a van, jerking her shoulder forward away from her. Dr. Tonino's recorded history from Petitioner included an injury to her left shoulder on July 6, 2013 while lifting a wheelchair. Petitioner told Dr. Coe that on July 6, 2013, she was assisting a patient who required a motorized wheelchair into a transportation van. As she stood on the chair, attempting to lift the patient's arms to adjust the chair seatbelt, she felt a strain in her shoulder.

The Arbitrator also notes other inaccuracies and exaggerations in Petitioner's testimony and records. Petitioner advised Dr. Choi that she works 12-13 hours per day, 7 days per week, but the payroll records document an average week of about 50 hours. Petitioner testified to an undocumented medical visit on July 6, 2013. She testified that she was seen at Swedish American Hospital on September 25, 2013 when this was a visit just to obtain x-rays. Petitioner's testimony was replete with comments on the inadequacy of the equipment at Respondent's facility and her valiant but ineffective efforts to remedy these perceived failures.

Jeana Jones and April Adams both testified that Petitioner did not report the alleged accident and when initially questioned about her condition, Petitioner denied that it was work related. Ms. Jones documented Petitioner's statement that she injured herself reaching for her purse in her car. Petitioner's ultimate claim of a work related condition in the Unum short term disability form does not allege a specific injury or date but is rather a listing of her job duties. The subsequent conversation documented by Ms. Adams indicates that she did not have an accident, but was told by Dr. Choi that continued lifting would worsen her symptom. Petitioner's claim that she did not initially report the accident because of fear for her job is contradicted by her reporting of the December, 2012 injury without repercussions.

Petitioner bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. Petitioner's uncorroborated trial testimony is not persuasive and contradicted by her own statements and medical histories as well as the testimony of Respondent's witnesses.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on July 6, 2013.

In support of the Arbitrator's decision with respect to (E) Notice, the Arbitrator finds as follows:

Petitioner is alleging an accidental injury on July 6, 2013. She has testified to a specific event on that date. Petitioner admitted to failing to report the accident to her supervisor Jeana Jones. The first reporting to April Adams in HR was the receipt of the Unum forms on October 17, 2013, 102 days after the alleged event. Even that form did not report a specific date and event. Petitioner's testimony of complaints to Stan Posley concerning the condition of the lift on the 15 passenger van is contradicted by Mr. Posley and did not include a claim of injury. Further, Petitioner testified to an accident while lifting a patient out of bed and not while using the van, making her testimony of reporting the accident in conjunction with complaints about the van lift nonsensical.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she provided timely notice of an accident as required by the provisions of the Act.

is describing normal duty activities causing her left shoulder pain. He could not determine causation until reviewing a job video. His recommendation for further treatment was consistent with the recommendation of Dr. Trenhaile. He also agreed that Petitioner would require restrictions of lifting no more than 5 pounds and no overhead or repetitive use of the left arm (RX 6).

Dr. Tonino then reviewed a job video. The second report of Dr. Tonino dated June 9, 2014 contains his characterization of the four video clips he reviewed, and which were admitted as RX 7. Dr. Tonino noted that he did not see the activity described by Petitioner, of lifting patients and 60-70 pound wheelchairs, depicted in the video. Therefore, he opined that her left shoulder condition was not related to her work activities (RX 6).

Petitioner was examined by Dr. Jeffrey Coe at her attorney's request on January 20, 2015 (PX 3). Dr. Coe's history included transferring of patients from chairs to beds, assisting patients in bus or van transportation, and in daily care. Petitioner told Dr. Coe that on July 6, 2013, she was assisting a patient who required a motorized wheelchair into a transportation van. As she stood on the chair, attempting to lift the patient's arms to adjust the chair seatbelt, she felt a strain in her shoulder. Petitioner indicated that she continued working; developing increasing left shoulder pain and stiffness.

Dr. Coe discussed the job video with Petitioner. Petitioner stated that lifting equipment was available, although not always utilized due to patient positioning or urgency. She noted that the van in the video was not the one used at the time of her employment with Respondent. She noted that she used a 15 passenger van, which required transferring patients into seats and then manually shifting the wheelchairs onto lifts to load them into the van. She noted that the wheelchairs often got stuck on the edge of the lift of the van. Petitioner also notes that the video had no information directly related to the "specific injury" she suffered on July 6, 2013 (PX 3).

Dr. Coe opined that Petitioner sustained an injury to her left shoulder on July 6, 2013 while assisting a patient in a motorized wheelchair. He agreed with the surgical procedure recommended by Dr. Trenhaile and recommended a 5 pound lifting restriction with no overhead work with the left arm (PX 3).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (D) Date of Accident, the Arbitrator finds as follows:

Petitioner is alleging an injury to her left shoulder arising out of her employment with Respondent on July 6, 2013. Petitioner testified to a specific event on that date when the battery on a lift lost power and she felt a "pull" in her shoulder when she was required to get the resident out of bed. The Arbitrator finds that this testimony is contradicted by all of the other evidence including the medical histories and testimony of the Respondent's witnesses.

Petitioner testified that she sought treatment on the day of the accident or the day after, but no evidence to document that treatment was offered. Petitioner admits she did not report the injury to Respondent and sought no further medical treatment until August 6, 2013. Dr. Choi's records state that there was no incident of trauma and that symptoms began two weeks earlier, not July 6, 2013, which is a month prior to the visit. Although Petitioner testified that on September 25, 2013, while transporting a patient, she felt another pull in her shoulder, Petitioner was seen by Dr. Choi on September 25, 2013 with no history of incident or trauma.

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner is alleging an injury to her left shoulder arising out of her employment with Respondent on July 6, 2013. Petitioner testified to a specific event on that date when the battery on a lift lost power and she felt a "pull" in her shoulder when she was required to get the resident out of bed. As more fully discussed in the Arbitrator's finding with respect to Accident, the Petitioner's testimony about this accident is contradicted by the medical histories and the testimony of the witnesses presented by Respondent.

Petitioner bears the burden of showing by a preponderance of credible evidence that her current condition of ill-being is causally related to the workplace injury. Neither Dr. Choi nor Dr. Trenhaile provides a causal connection opinion. In fact, neither took a history of the accident testified to.

Dr. Coe takes a history of a completely different event. Dr. Coe provides an opinion that that this different event described by Petitioner caused her condition. Expert opinions must be supported by facts and are only as valid as the facts underlying them. The Arbitrator has more fully addressed the credibility of Petitioner's accident history in the findings with respect to Accident above. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Based upon the record as a whole, and consistent with the Arbitrator's finding with respect to Accident, the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that her condition of ill being in the left shoulder is causally connected to an accidental injury arising out of and in the course of her employment with Respondent on July 6, 2013.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Respondent's Exhibit 1 documents Petitioner's hours including overtime hours beyond 40 hours per week in the majority of weeks from September 28, 2012 through September 25, 2013. The number of hours per week varied. Petitioner testified that, as team leader, she was under an obligation to pick up any extra shifts that were not accounted for during the group meeting to decide shifts. Jeana Jones, Petitioner's supervisor, testified the extra hours were available to those who wanted them, including other workers not specifically assigned to the Old Golf Road Group Home. Aisha Brown testified that overtime was voluntary. The Arbitrator finds the testimony of Jeana Jones and Aisha Brown persuasive. The Arbitrator also does not find the hours worked were regular.

Based on the record as a whole, the Arbitrator finds that overtime hours were voluntary and should not be included in the calculation of average weekly wage pursuant to the provisions of Section 10 of the Act. Based on record as a whole and the stipulated calculations of the parties, the Arbitrator finds the petitioner's average weekly wage is $472.57.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, and (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident, Notice and Causal Connection, the issues of Medical, Prospective Medical and Temporary Compensation are moot. Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Fabsits,
Petitioner,

vs.

NO: 14 WC 001396

Ruan Transportation,
Respondent,

17IWCC0464

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUL 21 2017
O062917
DLG/mw
045

David L. Gore

Kevin Lamborn

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FABSITS, RICHARD
Employee/Petitioner

Case# **14WC001396**

RUAN TRANSPORTATION
Employer/Respondent

17IWCC0464

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0926 LEONARD LAW GROUP LLC
MATTHEW J LEONARD
300 S ASHLAND AVE SUITE 101
CHICAGO, IL 60607

1120 BRADY CONNOLLY & MASUDA PC
WILLIAM P DEWYER
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

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
NATURE AND EXTENT ONLY

RICHARD FABSITS
Employee/Petitioner

v.

RUAN TRANSPORTATION
Employer/Respondent

Case # 14 WC 1396

Consolidated cases: _____

17IWCC0464

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Kankakee**, on **December 22, 2016**. By stipulation, the parties agree:

On the date of accident, **September 27, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$90,464.40**, and the average weekly wage was **$1,739.70**.

At the time of injury, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$16,899.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,899.45**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$712.55**/week for a further period of **37.5** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **the loss of use of the person as a whole to extent of 7.5% thereof pursuant to Section 8(d)(2) of the Act.**.

Respondent shall pay Petitioner compensation that has accrued from **September 27, 2013** through **December 22, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Robert E Johnson — January 5, 2017

Signature of Arbitrator — Date

JAN 6 - 2017

STATE OF ILLINOIS)
) SS
COUNTY OF KANKAKEE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD FABSITS,
Petitioner,
vs.
RUAN TRANSPORTATION,
Respondent.

No. 14 WC 01396

17IWCC0464

ADDENDUM TO PROPOSED FINDINGS

On September 27, 2013, the Petitioner, a 34 year old tractor trailer driver for Respondent, testified that while alighting from the ladder on his tractor trailer, he slipped sustaining injury to his right arm/shoulder. Petitioner testified that he notified his employer and was able to complete his work duties in the state of Iowa after his delivery. Upon returning back to the state of Illinois, he underwent care and treatment at Physicians Immediate Care. Petitioner then was seen by his orthopedic specialist, Dr. Corcoran, who had treated the Petitioner previously for his right knee injury. The Petitioner had ongoing right shoulder complaints and eventually underwent surgical intervention on January 27, 2014 for a right shoulder arthroscopic procedure indicating the rotator cuff was simply debrided and not repaired. The Petitioner had fraying and disruption of the long head of the biceps and a tenotomy was performed. After a course of physical therapy, the Petitioner was released to his regular duties without restrictions as of March 26, 2014.

On July 11, 2014, Dr. Corcoran released the Petitioner from his care to return on an as-needed basis pronouncing the Petitioner at MMI.

On July 29, 2015, Petitioner was seen by Dr. Bryan Neal, a board certified orthopedic surgeon, who performed an evaluation and review of records including his opinions relative to causation, impairment, and an AMA Rating. (RX. NO. 1)

In support of the Arbitrator's decision regarding "what is the nature and extent of the injury"? The Arbitrator finds as follows:

As the only issue is the nature and extent of the alleged injury, the Arbitrator notes the Petitioner underwent uneventful post-surgical right shoulder care from January 27, 2014 and was released to his regular work duties of a heavy duty level as of March 26, 2014, a period of approximately two months. Petitioner did return to his regular heavy duty driving abilities and was under no medical restrictions eventually pronounced at MMI by his treater, Dr. Corcoran, on July 11, 2014. No further records were entered into evidence regarding any ongoing complaints or problems that Petitioner eventually claimed from his March 27, 2013 injury.

Pursuant to Section 8.1(b); Determination of Permanent Partial Disability (PPD), the following criteria is noted in the evidence deposition transcript of Dr. Bryan Neal in the form of an AMA Guide to Permanent Impairment using the five factors of determining the level of impairment.

The Arbitrator notes that the factors indicate the reported level of impairment are minimal based upon the examination performed by Dr. Neal on July 29, 2015 concurrent with review of the treating records of Dr. Corcoran noting a very good post-operative follow up with the ability to return to his regular duties without restrictions and the only claim of disability is indicated by the Petitioner's subjective complaints of pain on good days and bad days.

The Petitioner was able to return to the same occupation as prior to the injury and in fact was able to work his regular tractor trailer delivery duties as a transport chemical driver without any formal restrictions and did not follow up with any care after July 11, 2014 pursuant to the medical records of OAK Orthopedics and Dr. Corcoran.

Petitioner was 54 years old at the time of the injury and was able to go back to his regular work duties without any formal restrictions.

The Petitioner did not testify to any diminution or any loss of future earning capacity and in fact voluntarily resigned from his employment duties and is now working out of the state of Florida as he relocated voluntarily and is still gainfully employed in the same occupation as a tractor trailer driver.

The evidence of disability indicated by the treating medical records note a right shoulder arthroscopic procedure with debridement of the rotator cuff and a biceps tenotomy was performed which resulted in uneventful follow up care and Petitioner's ability to return to his regular work duties without any medical restrictions after two months of post-operative care.

Based upon all of the five factors in determination of permanent partial disability, Dr. Neal, in his evidence deposition testimony of February 12, 2016, opined on an impairment level of 4% loss of use of the right upper extremity or a corresponding 2% person as a whole pursuant to the most recent AMA Guidelines of Impairment.

Based upon all the factors, including the testimony of the Petitioner and evidence admitted in this claim, the Arbitrator finds that Petitioner suffered loss of use of the person to the extent of 7.5% person as a whole.

Chicago, IL 60603
(312) 425-3131

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SCOTT WOBBE,

Petitioner,

vs. NO: 14 WC 003824

STATE OF ILLINOIS
ILLINOIS STATE POLICE,

17IWCC0449

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

The Commission modifies the award to find continuing causal connection and the petitioner is not at MMI. Accident is stipulated. Petitioner is a State Patrol officer. On March 24, 2013 petitioner received a call reporting a car had slid down an embankment. As petitioner descended the embankment to give assistance he twisted his left knee on accumulated ice and snow. He experienced increased swelling and pain as the day progressed. He was referred for physical therapy.

Petitioner reported increased pain with his second round of physical therapy. He reported having pain with greater range of motion. This prompted his treating providers to recommend petitioner see an orthopedic specialist. Petitioner was first seen by Dr. Lehman. Dr. Lehman told petitioner that he thought there was a problem with the cartilage on his kneecap but he needed an MRI with contrast. Subsequently, petitioner elected to consult Dr. Miller in early 2014. Dr. Miller recommended based upon the MRI and physical examination the petitioner undergo a diagnostic arthroscopy.

The arbitrator ruled that petitioner was at MMI effective May 1, 2014 based upon the June 24, 2014, Section 12 report of Dr. Williams. Dr. Williams is a specialist in physical medicine. He does not perform diagnostic arthroscopies. It was Dr. Williams' opinion that petitioner's symptoms were due to de-conditioning in the left knee. He recommended no further medical treatment and suggested the petitioner engage in unsupervised strengthening exercises for the affected knee.

Dr. Miller, an orthopedic specialist recommended a diagnostic arthroscopy in light of the persistent symptoms and MRI. Dr. William's recommendation for increased exercise carries little weight when viewed in the context of petitioner's symptoms becoming more pronounced during his second course of physical therapy and continuing thereafter. Dr. Williams' recommendation for unsupervised strengthening of the affected leg invites more pain and possibly further damage to petitioner's left knee joint.

Petitioner's testimony does not reflect an individual who exaggerates or inflates his symptoms. There is no evidence offered of a cause for the left knee pain other than the work injury of 2013. Early in treatment petitioner expressed his concern that with his knee problem he could get into a situation where his job required him to run and the knee did not feel reliable. Petitioner testified that since his injury when he takes his annual physical training test that he now walks instead of runs.

The safety of petitioner, as well as the safety of the general public, depend upon the physical performance of its law enforcement officers. The Commission gives considerable weight to the judgment of this officer who continues to serve and is in the best position to appreciate his own knee pain and associated limitations. Petitioner has continued to work and has not sought to over-treat or run up medical expenses. The Commission modifies the arbitrator's decision on the issue of medical expenses post May 1, 2014 and awards all reasonable and necessary medical expenses incurred after May 1, 2014 to petitioner. The Commission further awards prospective medical care in the form of diagnostic and medical procedures for petitioner's left knee recommended by Dr. Miller, as well as any reasonable and necessary rehabilitation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 2016 is hereby modified as stated herein, and otherwise affirmed and adopted.

17IWCC0449

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all outstanding medical bills, if any, related to Petitioner's left knee as set forth in Petitioner's exhibit 1 up to and including May 1, 2014, and all reasonable and necessary medical expenses incurred after May 1, 2014 under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay Petitioner for all prospective diagnostic and medical procedures recommended by Dr. Miller, as well as all reasonable and necessary rehabilitation, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

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

Pursuant to Section 19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: JUL 17 2017
o-06/08/17
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

WOBBE, SCOTT
Employee/Petitioner

Case# **14WC003824**

ST OF IL/ILLINOIS STATE POLICE
Employer/Respondent

17IWCC0449

On 5/5/2016, 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 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5060 EVANS & BLASI
PETER S BLASI
1512 JOHNSON RD
GRANITE CITY, IL 62040

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

MAY 5 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)SS.

COUNTY OF MADISON)

17IWCC0449

- [ ] 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)

SCOTT WOBBE
Employee/Petitioner

v.

STATE OF ILLINOIS/ILLINOIS STATE POLICE
Employer/Respondent

Case # **14** WC **003824**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **2/25/16**. 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] Were the 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 _____

17IWCC0449

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**74,496.24**; the average weekly wage was $**1,432.62**.

On the date of accident, Petitioner was **31** 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 $**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 $**ALL AMOUNTS PAID** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being is causally related to the accident at work on March 24, 2013. Petitioner reached maximum medical improvement on May 1, 2014. All benefits after that date are denied.

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

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

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

Signature of Arbitrator

May 1, 2016
Date

ICArbDec19(b)

MAY 5 - 2016

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

17IWCC0449

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

SCOTT WOBBE
Employee/Petitioner

v.

Case #: 14 WC 003824

STATE OF ILLINOIS/ILLINOIS STATE POLICE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on March 24, 2013, Petitioner sustained an accident which arose out of and in the course of his employment. The parties further stipulated that Respondent is entitled to a credit for medical bills previously paid, including those paid pursuant to Section 8(j), and that Petitioner is not currently entitled to any period of temporary total disability.

On the date of accident, Petitioner was 31 years of age, married, with two dependent children. He was employed as a patrolman for the Illinois State Police. On that date he was responding to a call to assist a motorist in a stranded vehicle that had slid down an embankment during a snowstorm. Petitioner testified that while walking down the embankment he lost his footing and twisted his left knee. He was able to catch himself before he fell to the ground. After assessing the condition of the motorist and their vehicle, Petitioner returned to his vehicle and noted throbbing and discomfort in his left knee. He reported the incident at that time to his boss, over the computer. Petitioner testified he continued working his shift and noticed his knee was getting stiffer and was starting to swell. At the end of shift he noticed a sharp pain in his knee when exiting his squad car. He sent a message to his boss that he would be seeing his chiropractor on his first day off, to get his knee checked out.

Petitioner testified he sought treatment with Dr. Smith, his chiropractor, who ordered an x-ray and physical therapy. He had two rounds of physical therapy and testified that the pain was increasing and his mobility was decreasing. Dr. Smith then referred him to Dr. Lehman, who he saw only one time, in August 2013. Dr. Lehman ordered an MRI with contrast. Petitioner testified it took some time to get the MRI approved, due to several changes in case workers. He ultimately did get the MRI, but testified did not return to Dr. Lehman because of the lack of patient care. Rather, he went to see Dr. Miller, who recommended a scope of the knee. He followed up with Dr. Miller in July 2015, who continued to recommend surgery.

Petitioner testified that after sitting for a long period of time with his knee bent it starts to throb and be painful. The only way to relieve the pain is to straighten out his leg. He testified the pain has never gone away since the day of the injury and that over the past five to six months he has noticed there is more continual pain. He is not able to play simple games with his kids on the floor for long periods of time because he can't keep his knee in a bent position for long periods. He testified that after he teaches and stands for long periods, his knee throbs afterward when he is sitting at home. Petitioner testified that while he is able to run, it is painful to do so.

Petitioner testified that he has paid some of his medical bills, including co-pays, and that his group insurance and worker's comp have paid some.

On cross-examination, Petitioner confirmed he gave all physicians a complete and accurate history of how he was feeling and his symptoms at the time he saw them. He further confirmed that he had two visits with his chiropractor, numerous visits with physical therapy, one visit with Dr. Lehman, two visits with Dr. Miller, and one visit with Dr. Williams (IME). The last medical appointment he had was July 16, 2015, with Dr. Miller. Petitioner acknowledged he has not received any medical care since that time and is not taking any prescription medication. He testified he wears a knee brace for added support if he knows he's going to run or if there is a training day at work and there is potential for any kind of twisting, uneven surfaces, going up and down steps, and the like. He testified he does not feel there is structural weakness in his knee, but the knee brace gives compression and support. It does not relieve any pain, but rather is a preventative measure he takes to prevent twisting of the knee.

Petitioner acknowledged that his work assignment has not changed since his accident. He may teach more, but still works patrol, handles calls, and works on the road. His shift toward teaching more is not related to his accident, rather he just took on more instructional tasks. Petitioner testified he has been able to complete his annual physical fitness tests, but now walks instead of running. He is still compliant and meets the standards of his employer. He acknowledged there are no job tasks he is unable to do other than running for the physical fitness test. He does not believe this restriction has been an occupational hindrance as far as his potential for a promotion or advancement of his career.

Petitioner could not recall if Dr. Smith noted any swelling in his knee, but testified that the physical therapist noted it. He had swelling for awhile, but does not ever notice it now. His knee does not ever give out. Currently he has just discomfort or pain, as well as some popping in his knee. He testified, "Other than that I don't ever notice anything."

Following his accident, Petitioner presented for treatment at Smith Chiropractic & Sports Medicine Clinic on March 28, 2013. He gave a consistent history of the incidents at work and complained of left knee pain. He had no radiating pain, no paresthesias in either lower extremity, and no swelling in the left knee. His range of motion was good, but there was crepitus noted when he extended his left knee. Lateral McMurray's test was negative, and medial McMurray's was questionable. There was no palpable tenderness in the left knee. Dr. Smith diagnosed acute knee sprain/strain and ordered an x-ray of the left knee. He advised Petitioner to rest, not have much weight on his knee, and continue to ice it. PX2.

Petitioner had x-rays of his left knee on March 28, 2013, at Christian Hospital, which were interpreted as normal. PX2. He returned to Dr. Smith on April 4, 2013, at which time he reported his left knee was not any better. He related when he would get out of his squad car he had pain and spasm. Examination revealed no restriction in range of motion flexion or extension, negative medial and lateral McMurray's testing, negative Lachman's test, and no swelling. Dr. Smith noted the only tenderness he could find was over the medial portion of the left knee. He assessed the injury as most likely a strain, but could not definitively rule out cartilage involvement. He recommended physical therapy. PX2.

Petitioner presented to physical therapy on April 11, 2013, at Dr. Smith's facility. He related that if he sat for awhile he had intense, sharp pain in his knee, and that getting out of a chair or his squad car increased the pain. He stated he was wearing a knee brace at work but could not tell difference with it. He rated his pain at 1/10 while resting and 6-7/10 after sitting awhile. On examination, it was noted Petitioner's active range of motion was equal bilaterally, as was his strength and circumference measurement. Anterior and posterior drawer test was negative, lateral McMurray's was negative, and medial McMurray's was questionable. It was noted Petitioner had an antalgic gait immediately after a sitting to standing position, but the gait improved after he took several steps. The therapist assessed Petitioner's signs and symptoms as consistent with a left medial knee sprain. Petitioner advised the therapist he would be unable to attend therapy for three weeks, due to work. He was given a home exercise program to do. PX2.

Petitioner returned to therapy on April 12, 2013, and noted no change in his pain since the day before, with possibly some increased muscle soreness. He performed the exercises from his home exercise program and it was noted he had a good understanding of them. He next attended therapy on May 6, 2013, and reported things were not getting any better, and actually were a little worse. He noted his pain increased with sitting to standing position, getting out of his car, and squatting. On examination, his left knee active range of motion was slightly decreased, from 145 to 140. The medial McMurray's test was questionable. Petitioner was tender to touch along the left medial joint line, but had good patella mobility. Petitioner reported he had been doing his home exercise program but that the pain was not getting better. PX2.

Petitioner underwent a left knee MRI on May 8, 2013, at Christian Hospital. The medial meniscus and lateral meniscus were intact, there was no focal chondrosis or subchondral edema, and the patellofemoral articular cartilage was normal. The MRI was noted to be normal. PX2.

Petitioner returned to therapy on May 15, 2013. He reported no change in his knee pain and noted, if anything, it was getting worse. He related any knee bending made the pain worse, and sitting for five to twenty minutes increased pain. Following therapy exercises there was noted a slight discoloration just medial and superior to the left patella. There was minimal tenderness to palpation. Petitioner again returned to therapy on May 20, 2013. He reported he had attempted to jog about 400 yards but his leg felt limp, which increased the more he ran. He believed his knee was getting worse instead of better. It was noted there was tenderness to palpation along the medial aspect of his left patella. There was discussion regarding an orthopedic consultation. PX2.

Following therapy on May 20, 2013, Petitioner was examined by Dr. Tebbe, in Dr. Smith's absence. It was noted that his active range of motion had decreased and that he had pain with flexion. The Arbitrator notes there were no measurements in the record as to Petitioner's actual range of motion, but simply an indication that it had decreased. There was palpable tenderness noted on the medial aspect of the knee. Lachman and McMurray tests were negative, as was medial and lateral stability testing. There was no swelling. Dr. Tebbe diagnosed a sprain and indicated Petitioner would be referred to an orthopedic specialist. PX2.

On August 8, 2013, Petitioner presented to Dr. Richard Lehman for evaluation. He reported a consistent history of the work accident and his treatment to date. He complained of pain when his knee was in a flexed position and when going from sitting to standing position. He related none of his treatment had helped and his pain was not relieved. He denied any swelling, locking, catching, instability, or nighttime pain in his left knee. Dr. Lehman noted there were no abnormalities on the MRI. On examination, he noted there was no swelling, erythema, or ecchymosis. Petitioner's knee was tender along the medial patellar facet and slightly tender along the medial plica. The remainder of the knee was nontender. Petitioner had full range of motion without discomfort, and had good quadriceps strength with very slight atrophy. Dr. Lehman conducted several tests, including Lachman's, anterior Drawer, patella apprehension, McMurray, and Apley tests. All were negative. The patella compression test was positive and there was mild retropatellar crepitus. Petitioner's gait was normal. Dr. Lehman's impression was possible osteochondral patellar fracture, and patellofemoral pain with questionable medial plica inflammation. He recommended an MRI arthrogram. PX5.

On February 3, 2014, Petitioner underwent an MRI arthrogram. The findings were: (1) subtle, small area of Grade I chondromalacia in the lateral patellofemoral compartment; (2) slight lateral patellar subluxation; and (3) no meniscal or ligamentous tear. PX4.

Petitioner next sought treatment on May 1, 2014, with Dr. Mark Miller of The Orthopedic Center of St. Louis. He reported a consistent history of the work accident and his treatment to date. On examination, Dr. Miller noted Petitioner had no antalgic gait, no effusion, and good patellar mobility. He noted crepitus with flexion and extension, and indicated Petitioner's range of motion was 0 to 142 degrees. There was no medial or lateral joint line tenderness. McMurray test was negative and the ligamentous exam was stable. Dr. Miller reviewed the MRI arthrogram and noted there appeared to be a bit of thickening of the fat pad, but it was not inflamed. He further noted some chondral changes of the patella and mild lateral translation. Dr. Miller's assessment was left knee injury. Dr. Miller noted that Petitioner's twisting injury occurred more than a year prior and that he continued to have difficulty with twisting movements and squatting. Petitioner pointed to the anteromedial knee location as painful, which Dr. Miller opined was consistent with pathologic plica or fat pad syndrome. With regard to treatment, Dr. Miller opined Petitioner had two treatment options, either injections or diagnostic arthroscopy. Given Petitioner's mechanical symptoms and the duration of time since the injury, Dr. Miller believed the best and most definitive intervention would be surgery. PX3.

On June 24, 2014, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. James Williams. He gave a consistent history of the accident and his treatment. He related to Dr. Williams that it had taken approximately six months to obtain approval for the MRI

arthrogram that Dr. Lehman had requested. He further related that he did not return to Dr. Lehman for treatment because he had waited over three hours to see him at the first appointment. Instead, he went to Dr. Miller, who told him he could get injections or have surgery. Petitioner's primary complaint was left knee pain located primarily on the inside of the knee, and occasional pain on the outside. He related his pain got better if he straightened his knee and got worse if he bent his knee or sat for a long period of time. The only change Petitioner noted was he noticed more pain with less range of motion. Petitioner advised Dr. Miller that he had gotten used to the pain over time and that it was not as intense or bothersome because he knew it would go away if he changed position or gave it a little time. He further advised that initially he had significant problems with pain if he tried to twist his knee, but that currently the motion didn't really hurt much, and that his pain was restricted to when he was flexing his knee. Petitioner reported he had not missed any work and had continued to do all of his regular job duties. RX2.

Petitioner related to Dr. Williams that he no longer ran or jogged for exercise. He advised he did resistance training, but that it was limited to upper body exercises and that he no longer performed lower body resistance training because of the knee pain. He stated he was able to run but chose not to because he did not want to have the pain associated with it. It was noted Petitioner played soccer and ran track in high school and played club soccer in college. RX2.

Dr. Williams conducted several tests, including straight leg raise, McMurray, anterior and posterior Drawer, Lachman, and patellar grind. All tests were negative bilaterally. Petitioner's muscle strength was 5/5 bilaterally, his muscle tone and bulk were normal and symmetric bilaterally, and circumference measurements of his thigh and calf were equal bilaterally. RX2.

Dr. Williams reviewed all medical records, including the MRI and MRI arthrogram films. Based on his review of records, Petitioner's complaints, and Petitioner's physical examination, Dr. Williams opined that there were no objective findings other than confirmation of normal anatomy and function. He further opined that neither the MRI nor MRI arthrogram showed significant anatomic pathology at the site of Petitioner's symptoms. He opined that the findings on the MRI arthrogram did not correspond to Petitioner's symptoms, and therefore were incidental findings. Dr. Williams opined that there were currently no objective findings to support Petitioner's subjective complaints. He found Petitioner to be at maximum medical improvement as of May 1, 2014, the date of consultation with his second orthopedic surgeon, Dr. Miller. Dr. Williams opined that Petitioner's persistent pain could be explained by his suboptimal performance of, and follow through with, the rehabilitation exercises provided in physical therapy, as well as his cessation of resistance training and running. He opined that the gradual introduction of rehabilitation exercises and eventual generalized conditioning of the lower limbs was necessary to be able to return to physically demanding activity with minimal discomfort after injuries such as Petitioner's. Dr. Williams opined that Petitioner was capable of working without restrictions, as he had been doing so for over a year, and that he needed no further diagnostic studies. RX2.

Having found Petitioner to be at MMI, Dr. Williams provided an impairment rating of 0% impairment of the whole person, pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. His rating process started with the category of "muscle/tendon: strain" on page 509, though he noted one could also use the category of

"ligament/bone/joint: collateral ligament injury" and the Class and impairment would be the same. He noted Petitioner had no significant objective abnormal findings of muscle or tendon injury, or instability of the knee, and that his condition was considered a Class 0 problem, using the Knee Regional Grid on page 509. The Grade Modifier for Functional History was 1, a mild problem, in that Petitioner's PDQ score of 45 out of 150 indicated a mild disability or symptoms with strenuous physical activity. The Grade Modifier for Physical Exam was 1, a mild problem. This was based only on Petitioner's consistent reports of tenderness on exam, which is a subjective finding. The Grade Modifier for Clinical Studies was 0, as there was no evidence of pathology on Petitioner's x-ray, MRI or MRI arthrogram to explain his symptoms. The Adjustment Grid and Grade Modifiers were not applicable for a Class 0 problem; therefore, that calculation was not used. Dr. Williams noted that on page 525 of the Guides, Example 16-7 was a very similar case which outlined the same type of impairment rating process and calculation. RX2.

Dr. Williams testified by way of deposition on July 6, 2015. He is Board Certified in Physical Medicine & Rehabilitation and Electrodiagnostic Medicine. He has a certification in Evaluation of Disability & Impairment Rating, is a Certified Independent Medical Examiner, and a Certified Health Fitness Specialist. He is in private practice and is a physical medicine and rehabilitation specialist. He sees patients who have illnesses and injuries that involve impairments in function, which include head injuries, strokes, spinal cord injuries, and orthopedic problems. As part of his practice he evaluates patients to determine if they need to be referred to a surgeon. The majority of his care is for the spine, but he also sees patients for problems with shoulders, wrists, hands, knees, hips, ankles, and the like. Independent Medical Examinations and records reviews are a very small part of his practice. RX2.

Dr. Williams testified consistent with his report. Petitioner's physical examination was essentially normal. He had a normal gait and full range of motion, and was able to perform a full squat. All of the special testing done for the knee was normal. He had intact ligaments at the knee, normal strength in the lower limbs, and the circumference measurements were symmetric on both sides in the lower limbs. The neurological examination was normal. The only positive finding was that Petitioner had some mild tenderness on the inside of his left knee. Dr. Williams pointed out, however, that "This was actually symmetric compared to the right side so he also had some tenderness there as well." Dr. Williams' diagnosis was knee strain and/or sprain. With regard to causal connection, Dr. Williams opined that the only connection was that Petitioner had this injury in March 2013 and as a result of that he likely became weak and had problems. He opined that Petitioner's current complaints have to do with the fact that Petitioner appeared to not be doing his rehabilitation and did not have the same kind of strength and conditioning of the left leg that he used to. RX2.

Dr. Williams testified that there were no objective structural injuries in Petitioner's left knee related to the 2013 incident. He would not recommend any specific medical treatment, but would advise Petitioner to get back on the rehabilitation program he was given in physical therapy, and to gradually improve his strength, endurance, and activity. Dr. Williams was aware of Dr. Miller's recommendation that Petitioner undergo a diagnostic arthroscopy, but did not believe this would be beneficial. He explained that on a diagnostic arthroscopy you may be able to see tears or damage to the cartilage that could not be seen on imaging. He went on to explain,

however, that the quality of imaging now is much better than it was years ago, and the chances of finding something on a diagnostic arthroscopy that was not seen on imaging is "very, very low". For that reason, many physicians are hesitant to do a diagnostic arthroscopy. With regard to Petitioner, he underwent an MRI arthrogram, which Dr. Williams opined was "pretty much the best" test for looking at joint surfaces, ligaments, and soft tissue structures. RX2.

Dr. Williams testified that Petitioner was at maximum medical improvement as of May 1, 2014, and that he would not place any restrictions on him. With regard to the AMA rating, Dr. Williams testified he has had several different types of training for impairment ratings. He has training from the American Board of Independent Medical Examiners as well as the American Academy of Disability Evaluating Physicians. With regard to the AMA Guides Sixth Edition specifically, he has certification in evaluating disability and impairment through the Academy of Disability Evaluating Physicians. The AMA Guides Sixth Edition requires specific text be used in generating an impairment rating, which Dr. Williams used in this case. RX2.

Dr. Williams testified Petitioner had a 0% impairment rating. He explained that the AMA Guides require the physician to make a diagnosis and then look at the table that corresponds to that diagnosis. Petitioner best fit under the category of muscle/tendon: strain, on page 509; however, one could also look at another table if the diagnosis instead was ligament/bone/joint: collateral ligament injury. Dr. Williams testified that impairment ratings under both categories would be exactly the same in this case, but he opined that the strain was the best fit for the way Petitioner described his injury. RX2.

On cross-examination, Dr. Williams acknowledged that the history Petitioner gave him was consistent with the injuries he was complaining of following the accident. He conceded that an MRI and arthrogram are good but not necessarily perfect. However, he did not agree that a diagnostic arthroscopy would give a fuller image as to the status cartilage, ligaments, etc. He acknowledged that he did not perform arthroscopic procedures or orthopedic surgeries. He further acknowledged that he saw Petitioner only one time, on June 24, 2014, and did not know what his current complaints were. He conceded there was no specific indication that Petitioner was having complaints with regard to his left knee prior to this incident, and further conceded that he was still complaining of pain at the time of Dr. Williams' examination. Dr. Williams testified that the most likely explanation for Petitioner's current complaints was deconditioning of the knee. He was not aware whether Petitioner's knee was in a deconditioned state before the accident, but testified it was in a deconditioned state at the time of his examination. He testified that, while Petitioner might benefit from physical therapy, he did not need clinical physical therapy. Rather, he needs exercise and that is what he would benefit from. He opined that exercises may help Petitioner improve the symptoms he is currently having. RX2.

On July 16, 2015, Petitioner returned to Dr. Miller. On examination, Dr. Miller noted there was no tissue swelling, no atrophy of the quadriceps, no effusion, and no medial or lateral joint line tenderness. Range of motion was 0 to 140 degrees. It was noted there was crepitus at about 30 degrees of flexion. McMurray test was negative and the ligamentous examination was stable. Dr. Miller's assessment was "rule out pathologic plica, fat pad syndrome" and "rule out chondromalacia patella". He indicated that Petitioner's symptoms were most consistent with fat pad syndrome, pathologic plica and that surgery was the best option. The Arbitrator notes that

Dr. Miller did not indicate the etiology or causal connection of either of these possible conditions. In an Addendum to his report, Dr. Miller noted he had reviewed the IME by Dr. Williams and noted, "Dr. Williams gives a summary that appears to be accurate." PX3.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment on March 24, 2013, and the he injured his left knee as a result.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial* Commission, 260 Ill.App.3d 551 (1993). Liability cannot be premised upon imagination, speculation, or conjecture but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, (1st Dist. 1994).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that his current left knee condition is causally related to his work accident of March 24, 2013. In so finding, the Arbitrator finds significant the chronological chain of events, the lack of objective findings, and the degree to which Petitioner has sought medical treatment for his complaints.

It is undisputed that Petitioner sustained a compensable accident which caused an injury to his left knee. He sought medical attention within four days of the accident, with Dr. Smith. In Dr. Smith's initial examination of March 28, 2013, it was noted that Petitioner had no swelling, no palpable tenderness, and good range of motion. The only objective finding was crepitus under the kneecap when Petitioner extended his knee, and a questionable medial McMurray's test. Diagnosis was an acute knee sprain. Knee x-ray taken that day was negative. As well, in Dr. Smith's follow up examination of April 4, 2013, it was noted that Petitioner had no swelling, no restriction in range of motion, negative medial and lateral McMurray's, and negative Lachman's. The only objective finding was tenderness over the medial portion of the left knee.

As Petitioner progressed through physical therapy in April and May 2013, five sessions in total, the record consistently showed that all testing remained normal, with the exception of the medial McMurray's test, which vacillated between "questionable" and negative. The MRI done on May 8, 2013, was completely normal. The record also consistently showed no objective findings of swelling or decreased range of motion. The only objective finding was tenderness to

palpation over the medial portion of the left knee. Petitioner's treatment was based almost exclusively on his subjective complaints of pain.

When Petitioner saw Dr. Lehman on August 8, 2013, his subjective complaint was pain on the medial side when his knee was in a flexed position and when going from a sitting to a standing position. He denied any swelling, locking, catching, instability, or nighttime pain. On examination, there was no swelling, erythema or ecchymosis. Petitioner had full range of motion without discomfort, good quadriceps strength, and no antalgic gait. Lachman's, anterior Drawer, patella apprehension, McMurray, and Apley tests were all negative. The only positive objective findings were "slight" tenderness along the medial plica, mild crepitus, and a positive patella compression test.

Although Dr. Lehman questioned the possibility of other objective findings, the MRI arthrogram he ordered ultimately revealed no findings to the medial side of Petitioner's left knee, which was the location of his complaints. The only findings were a "subtle, small area" of chondromalacia and "slight" patellar subluxation, both of which were on the lateral side of the knee. Given that all of Petitioner's complaints were to the medial side, the findings on the MRI arthrogram clearly were incidental findings and not the cause of Petitioner's complaints, as explained by Dr. Williams.

Petitioner's complaints to Dr. Miller on May 1, 2014, were essentially the same as those to Dr. Smith and Dr. Lehmann. The objective findings, or lack thereof, by Dr. Miller were also essentially the same. Specifically, there was no antalgic gait, no swelling, no effusion, no medial or lateral joint line tenderness, negative McMurray exam, and stable ligamentous exam. Petitioner had good patellar mobility and full range of motion. The only positive objective finding was crepitus. Despite the essentially normal examination, Dr. Miller recommended a diagnostic arthroscopy. He had the same recommendation more than a year later, on July 16, 2015, despite the fact that Petitioner had not sought any medical treatment in those 14 months, and despite the fact that the objective findings were normal.

The Arbitrator finds significant that Petitioner sought medical treatment from March 28, 2013, through August 8, 2013, with virtually no objective findings. He attended only five physical therapy sessions in two months. The Arbitrator further finds significant that Petitioner sought no medical treatment from August 8, 2013, until May 1, 2014, a gap of nine months. He then sought no medical treatment from May 1, 2014, until July 16, 2015, a gap of over fourteen months. Treatment in 2014 consisted of only one office visit, as did treatment in 2015. In two years, Petitioner sought treatment on only two occasions. On both occasions, as detailed above, the records continued to reveal virtually no objective findings.

Dr. Williams testified as to the significance of the absence of objective findings in Petitioner's treating record. Further, while he noted there were some "slight" findings on Petitioner's MRI arthrogram, he testified that these findings were on the lateral side of Petitioner's knee, whereas his symptoms were on the medial side. As such, he testified the findings were incidental and did not correspond to Petitioner's complaints. The Arbitrator finds Dr. Williams' opinions to be persuasive.

In light of the chronology, lack of objective findings, minimal treatment for the past two and a half years, and the persuasive opinions of Dr. Williams, the Arbitrator finds that Petitioner's current condition and complaints with regard to his left knee are not causally related to his work accident of March 24, 2013. The Arbitrator further finds that Petitioner reached maximum medical improvement on May 1, 2014, which was the first treatment with Dr. Miller, and the first examination by any physician following the MRI arthrogram on February 3, 2014.

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

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill.App.3d 154 (1st Dist. 1992)).

In light of the Arbitrator's finding above that Petitioner was at maximum medical improvement on May 1, 2014, the Arbitrator finds that any and all bills for medical services rendered beyond that date are denied. The Arbitrator finds that Respondent is liable for outstanding medical bills, if any, related to Petitioner's left knee, as set forth in Petitioner's Exhibit 1, up to and including treatment on May 1, 2014. .

The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for medical benefits previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

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

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care for his left knee.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles W. King, Jr.

Petitioner,

vs.

NO. 14WC 06599
14WC 35190

State of Illinois - IEPA,

Respondent.

17IWCC0481

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, permanent 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 18, 2016 is hereby affirmed and adopted.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JUL 31 2017
SJM/sj
o-7/13/17
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KING JR, CHARLES W
Employee/Petitioner

Case# **14WC006599**

14WC035190

STATE OF ILLINOIS-IEPA
Employer/Respondent

17IWCC0481

On 8/18/2016, 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 0.44% 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:

2211 MILLS, STEVEN C
HEATHER MILLS
206 S 6TH ST
SPRINGFIELD, IL 62701

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

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

AUG 18 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0481

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

Charles W. King, Jr.
Employee/Petitioner

v.

State of Illinois - IEPA
Employer/Respondent

Case # 14 WC 06599

Consolidated cases: 14 WC 35190

An *Application for Adjustment 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 **Springfield**, on **July 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **December 31, 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 **$76,662.00**; the average weekly wage was **$1473.50**.

On the date of accident, Petitioner was **58** years of age, ***married*** with 0 dependent children.

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

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

Respondent shall be given a credit of $ 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

BECAUSE PETITIONER DID NOT SUSTAIN AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF EMPLOYMENT, ALL BENEFITS ARE DENIED.

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

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

D. Dyas McCarty

8/15/2016

Signature of Arbitrator

Date

AUG 18 2016

Arbitrator Findings of Fact:

Petitioner has filed two claims alleging repetitive trauma injuries to his wrists and left elbow. The claims were consolidated for trial. As both claims allege the same manifestation date and involve the same work duties, the Arbitrator will issue one decision for both claims.

Petitioner Testimony

Petitioner testified he was employed as an inspector and investigator for the Illinois Environmental Protection Agency. (T. 8). He had been employed there for 30 years and 1 month at the time of trial. (T. 9).

Petitioner testified he conducted hazardous waste, nonhazardous special waste, landfill and complaint inspections for his job with Respondent. (T. 9). Petitioner estimated he was out in the field on average one day a week though it could be two or more. (T. 10). Petitioner testified when he was not in the field, he would work on reports for what he inspected.

Petitioner testified some time around 2011 he began to feel pain in his hands. (T. 12). Petitioner testified over time the pain became more severe and he went to see Dr. Cecile Becker on December 30, 2013. (T. 12-15).

On cross-examination, Petitioner testified as time went on from the initial development of his carpal tunnel syndrome, he could feel symptoms in all types of things including something as simple as lifting a coffee cup. (T. 28-29).

Petitioner testified to the varying degree of his reports while explaining what they could look like by going through Respondent's Exhibits 4 and 5. Petitioner testified the size of his narrative reports could range from 4 to 20 pages depending on the size of facility and number of violations. (T. 51-52).

On re-direct, Petitioner testified he can type 70 words per minute. (T. 56).

Medical Records

On December 30, 2013, Petitioner met with Dr. Cecile Becker as a new patient. Petitioner had been diabetic for the last 15 years and was insulin dependent. Petitioner said he felt symptoms of feeling needles as well as burning in his hands and feet bilaterally. (PX 4).

On December 31, 2013, Petitioner had an EMG with Dr. Becker. Petitioner complained of burning in his hand and his feet bilaterally. The findings were severe median mononeuropathy at right wrist and moderate sensorimotor axonal polyneuropathy, which was most likely related to his longstanding history of diabetes. (PX 4).

On April 14, 2014, Petitioner had a right carpal tunnel release performed by Dr. Chris Wottowa. (PX 1).

On May 6, 2014, Petitioner had an EMG with Dr. Becker. The EMG found severe median mononeuropathy at left wrist and moderate to severe ulnar mononeuropathy. Both were demyelinating. (PX 4).

On June 26, 2014, Petitioner had left ulnar nerve decompression at elbow, left carpal tunnel release, and left index finger release performed by Dr. Chris Wottowa. (PX 1).

Dr. Chris Wottowa Deposition

Dr. Chris Wottowa deposition was taken on December 14, 2015 by Petitioner. (PX 2). Dr. Wottowa testified he had taken care of Petitioner as a patient for many years, having taken care of his shoulders, elbows, hands, and fingers in the past. Dr. Wottowa testified that Petitioner had pre-existing conditions including diabetes and hypertension, specifically pointing out Petitioner's diabetes would be a risk factor because of the nerve entrapments. (PX 2, pg. 6). Dr. Wottowa testified Dr. Becker's notes point to evidence of peripheral and compression neuropathies. (PX 2, pgs. 14-15). Dr. Wottowa opined that the Petitioner's work duties could be factors aggravating his carpal and cubital tunnel syndromes because the Petitioner told him that his symptoms got worse at work. (Id at 13)

When asked about Petitioner developing bilateral carpal tunnel and left sided cubital, Dr. Wottowa testified, "You could argue there's the aggravating factor for his work activities to – not causation, but aggravation of the condition." (PX 2, p. 15)

Dr. James Williams Independent Medical Examination and Deposition

Petitioner went to an Independent Medical Examination with Dr. James Williams on April 30, 2014. (RX 2). On January 15, 2015 his deposition was taken where he confirmed his independent medical examination report. (RX 2, ex 2).

Dr. Williams took a history from Petitioner including his job duties and ergonomics of his work space. Petitioner described being an inspector and investigator who would go out on the road in various counties to do inspections and then he would do writing, including narrative reports. Dr. Williams noted that this typing could be done intermittently and that Petitioner did not rest his wrist or elbows on the edge of his desk when he typed. (RX 2, ex 2).

Dr. Williams found Petitioner's job duties did not cause his development of carpal tunnel syndrome. Dr. Williams noted the significant factors for Petitioner developing his condition as his increased body mass index, hypertension, and especially the condition of his diabetes. (RX 2, ex 2).

The Arbitrator Findings on Issues:

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

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

Petitioner alleged he sustained an accidental injury of bilateral carpal tunnel syndrome and left cubital tunnel syndrome, due to his alleged repetitive work activities that arose out of and in the course of his employment by Respondent, and manifested itself on December 31, 2013.

In the case at bar, Petitioner is claiming December 31, 2013 as his manifestation date. The only thing that occurred on December 31, 2013 was Petitioner having an EMG on his right side. While this may work for his right hand carpal tunnel syndrome claim, December 31, 2013 has no relation to his left hand carpal tunnel syndrome or his left cubital tunnel syndrome manifestation and therefore there is no accident for left side carpal tunnel syndrome or cubital tunnel syndrome. Further, Petitioner's Exhibit 5 is a notice form that mentions nothing regarding left arm/cubital.

While the manifestation date could possibly work for the right hand carpal tunnel claim, the Arbitrator finds Petitioner's carpal tunnel syndrome did not arise out of and in the course of his employment based on

Petitioner's description of his job duties, description of his symptoms, and the superior medical testimony of Dr. James Williams.

Petitioner had diabetes, hypertension, and neuropathies into his hands and feet for years prior to developing carpal tunnel syndrome. The medical records constantly mention the severity of Petitioner's diabetes throughout the evidence. These factors all likely led to his development of carpal tunnel syndrome, not his work duties. Additionally, Dr. Williams pointed out Petitioner's increased body mass index is a factor in developing bilateral carpal tunnel syndrome.

Dr. Williams took an in depth history of work duties from Petitioner and formed the conclusion that those duties did not relate to Petitioner's development of carpal tunnel syndrome. Dr. Williams's opinion is superior due to the greater knowledge in Petitioner's workstation and duties. Dr. Williams's report shows Petitioner explaining the layout of his computer desk and mouse along with his typing style of not putting wrists of elbows on the end of the table. Dr. Williams also stated in his report that Petitioner's typing was intermittent. He also noted that the Petitioner told him that the vehicle which he drove had power steering with very little vibration in the wheel.

Dr. Wottowa acknowledged in his testimony Petitioner had pre-existing conditions including diabetes and hypertension, specifically pointing out Petitioner's diabetes would be a risk factor because of the nerve entrapments. (PX 2, pg. 6). Dr. Wottowa's causation opinion is quite weak with his testimony: "You could argue there's the aggravating factor for his work activities to – not causation, but aggravation of the condition." (Id at 15) In addition, Dr. Wottowa did not elaborate on any aspects of the Petitioner's job duties in support of his conclusion. He did not ask the Petitioner about any vibration from his steering wheel while driving nor ask him to demonstrate his body mechanics while keyboarding. He simply said the activities could be aggravating because the Petitioner told him that they were.

Additionally, while not showing all of the typing Petitioner would do, Respondent's 4 and 5 show that the typical report would not require a significant amount of typing, nor would the actual typing take that long given Petitioner's ability to type 70 words per minute. (T. 56). It is clear from the reports that the narrative portion represented only a small portion of said reports. The bulk of the reports showed the work involved filling in preprinted forms and providing photos of the job sites. (RX 4; 5)

Based on the above, along with the totality of the credible evidence, the Arbitrator finds Petitioner did not meet his burden of proof to show with a preponderance of the evidence that his bilateral carpal tunnel syndrome, nor his left sided cubital tunnel syndrome, arose out of and in the course of his employment at Illinois Environmental Protection Agency. Therefore Petitioner's current condition of ill-being is not related to his employment. Benefits are denied and therefore all other issues are rendered moot.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (L): What is the nature and extent of the injury?

Having found Petitioner did not sustain an accidental injury that arose out of and in the course of his employment, the Arbitrator finds the remaining issues moot.

14WC8970
17IWCC0340

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Donovan
Petitioner,

vs.

Illinois Bell Telephone Co.
d/b/a AT&T
Respondent.

No. 14WC 8970
17IWCC0340

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical error in which the matter was categorized, in error, as discussion only. Furthermore, the parties were not given notice of either the discussion date or that Oral Arguments had been denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated June 1, 2017, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner David L. Gore.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued upon the Commission hearing Oral Arguments in the matter.

David L. Gore

JUL 25 2017

DATED:

14WC8970
17IWCC0340

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Donovan)
Petitioner,)
)
vs.)
)
Illinois Bell Telephone Co.)
d/b/a AT&T)
Respondent.)

No. 14WC 8970
17IWCC0340

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical error in which the matter was categorized, in error, as discussion only. Furthermore, the parties were not given notice of either the discussion date or that Oral Arguments had been denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated June 27, 2017, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner David L. Gore.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued upon the Commission hearing Oral Arguments in the matter.

David L. Gore

DATED: JUL 18 2017
DLG/mw
045

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

Toni Livengood,

Petitioner,

vs.

NO. 14WC 12815

17IWCC0424

State of Illinois/Choate Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 20, 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.

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

17IWCC0424

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JUN 30 2017
SJM/sj
o-6/8/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

17IWCC0424

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

LIVENGOOD, TONI
Employee/Petitioner

Case# **14WC012815**

ST OF IL/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

On 6/20/2016, 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 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
NOCOLE WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUN 20 2016

GERALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0424

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)

Case # 14 WC 12815

Consolidated cases: _____

TONI LIVENGOOD
Employee/Petitioner

v.

STATE OF ILLINOIS/CHOATE MENTAL HEALTH 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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **April 12, 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. ☒ 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 12, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**79,128.00**; the average weekly wage was $**1,521.69**.

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

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to her right shoulder is causally related to the accident at work on December 12, 2013. Petitioner has not reached maximum medical improvement.

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 1 that remain unpaid, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for amounts paid, as agreed by the parties, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

Respondent shall pay for prospective medical treatment, including surgery, related to Petitioner's right shoulder pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

JUN 20 2016

June 17, 2016
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STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TONI LIVENGOOD
Employee/Petitioner

Case #: 14 WC 12815

v.

STATE OF ILLINOIS/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was 57 years old, married, with no dependent children. She was employed by Choate Mental Health as an Educator, and had been employed by Choate for 30 years. Petitioner testified that on December 12, 2013, she and co-workers were taking a Boy Scout crew for developmentally and mentally disabled adults to the Union County Senior's Home for Christmas caroling. This activity was done during normal working hours and was part of Petitioner's job duties. Petitioner testified when got out of the van at the Senior's Home she slipped on ice and her feet came out from under her. She attempted to stop the fall by grabbing the door jam of the van. As she went down, her buttocks hit the van's assistive step and her right side and shoulder hit the van.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of her employment which caused injury to her cervical spine, resulting in surgery. All benefits related to the cervical spine have been, or will be, paid. The parties dispute whether Petitioner's current condition with regard to her right shoulder is related to the accident.

Petitioner testified that prior to the accident she had never filed a worker's compensation claim for her right shoulder, never had any care or treatment to her right shoulder, never had any diagnostic tests such as an MRI or x-ray of her right shoulder, and had never been diagnosed with arthritis in her right shoulder.

Petitioner ultimately came under the care of Dr. Nathan Mall for her shoulder. He has recommended surgery and Petitioner would like to have the surgery.

Petitioner testified she attended an examination with Dr. Richard Lehman at her employer's request in November 2015. She reviewed Dr. Lehman's report and disagreed with

his statement that she had no pain in her right shoulder, as she does have pain. She testified she had no symptoms in her left shoulder and had not gotten any treatment on her left shoulder. She took her MRI's and other documents to the examination with Dr. Lehman, but he did not review them in her presence.

Petitioner testified that she currently had the same "original" pain that she had, in the front of her shoulder, on the top of her shoulder, and the cap of her shoulder. She complained of burning and shocks that go down to her elbow and sometimes into her hand and fingers.

Petitioner testified that as a result of the accident she also received treatment to her neck and ultimately had disc replacement surgery on C5-6 and C6-7. The surgery improved her neck symptoms tremendously. Prior to surgery she attended an examination by Dr. Robson at her employer's request.

On cross-examination, Petitioner acknowledged she was currently working full duty and had been so working since February 2015. She is able to perform her job satisfactorily and has received a good annual evaluation since her return. She testified she is currently unable to do her normal activities at home. She has not run a vacuum cleaner in over two years, and sweeping and mopping the house is an issue. She has difficulty lifting her grandson into her lap. She is currently taking daily medications, which include Gabapentin, Ibuprofen, and Methocarbamol. She saw Dr. Gornet the day before trial and was told he was going to release her for her neck.

Petitioner completed an Employee's Notice of Injury on December 13, 2013, gave a consistent history as to how the accident occurred, and noted injuries to her right buttock, side, arm, and shoulder. RX1. A Supervisor's Report of Injury was completed the same day and was consistent with Petitioner's Notice. RX2. A Witness Report, handwritten by Alisa Spiess, was completed the same day and was consistent with Petitioner's Notice. RX3. A "Critical Event Report" was completed by Petitioner the same day, and was again consistent with the other reports. RX5.

Following her accident, Petitioner sought treatment on December 13, 2013, with her family physician, Dr. Lori Moyers at Cape Family Practice. She gave a consistent history of falling on ice and had complaints of pain in her right arm and shoulder, right hip, right ribs, and lumbar spine. She had decreased range of motion in her right shoulder. Dr. Moyers' assessment was contusion of the shoulder region, contusion of the chest wall, and myalgia. Petitioner was given a prescription for pain medication, an.order for x-rays, and was instructed to return in one week. PX3.

That same day Petitioner underwent several x-rays. Rib x-rays were negative for any fracture. Right shoulder x-rays were within normal limits. Pelvis x-rays showed no acute changes but did reveal transitional L5 vertebra with partial sacralization on the left and mild sclerosis at pseudarthrosis. Lumbosacral x-rays showed no acute changes but did reveal levoscoliosis in the mid lumbar spine and multilevel degenerative spondylosis. PX4.

Petitioner returned to Dr. Moyers on December 20, 2013. She reported she was doing better but that her arm was still hurting her. Examination revealed decreased range of motion in

the right shoulder and pain over the right humerus. Assessment was contusion of the chest wall, rotator cuff sprain/strain, and myalgia. Dr. Moyers prescribed physical therapy three times a week for three weeks and advised Petitioner could return to work light duty on December 30, 2013. Petitioner followed up with Dr. Moyers on January 13, 2014, and reported she had continued pain in her right shoulder and arm. She was taking the medication to help control the pain, which sometimes helped and sometimes did not. Examination revealed continued decreased range of motion in the right shoulder, and an MRI was ordered. PX3.

On February 10, 2014, Petitioner underwent an MRI of her right shoulder. It revealed (1) moderate supraspinatus tendinopathy with no tear; (2) findings suggestive for adhesive capsulitis; (3) degenerative changes of the glenohumeral and acromioclavicular joints; and (4) red marrow conversion indicating a hypoxic state of the body with differential considerations including smoking, obesity, and anemia. PX6.

Petitioner followed up with Dr. Moyers on February 11, 2014, to go over the MRI results. She continued to have decreased range of motion of the right shoulder, and assessment was adhesive capsulitis. PX3.

On February 18, 2014, Petitioner presented to Dr. Patrick Knight at Advanced Orthopedic Specialists, upon referral by Dr. Moyers. She gave a consistent history of the accident and her treatment to date. She complained of pain around her upper arm, not so much around the shoulder, and down to her elbow. She denied any neck pain. She noted she had weakness and discomfort when pulling her pants up or down, which caused severe pain in her upper arm. It was noted, "She is not really having any significant shoulder symptoms." On examination, Petitioner had weakness in her right arm, poor strength, and poor range of motion. Shoulder x-rays were negative and cervical x-rays showed severe degenerative changes at C5-6. Dr. Knight's impression was that Petitioner's right upper arm pain was not anatomically consistent with anything with the shoulder. He noted she had multiple muscle groups and nerves involved in her complaints. Dr. Knight suspected that the accident aggravated a preexisting cervical spine issue, which could be causing the symptoms. He ordered a cervical MRI and instructed Petitioner to not use her right arm. PX7.

Petitioner underwent a cervical MRI on February 24, 2014. It revealed (1) right paracentral herniation at C5-6 with mild narrowing of the central canal and neural foramina bilaterally, right more than left; (2) herniation at C6-7 with mild narrowing of the central canal and neural foraminal bilaterally; (3) mild bulges at C3-4, C4-5, and C7-T1 without narrowing; (4) mild arthropathy; (5) minimal retrolisthesis of C5 over C6. PX6.

Petitioner followed up with Dr. Knight on February 28, 2014, and went over the results of the cervical MRI. Dr. Knight noted she had cervical disc issues and continued to have radicular symptoms, and he recommended a referral to Dr. Tolentino. PX7.

On March 26, 2014, Petitioner presented to neurologist Dr. Fakhre Alam upon referral from Dr. Knight for right shoulder and arm pain. She gave a consistent history of the accident and her treatment to date. Her primary complaint was pain in her right arm, and she also reported tingling and numbness involving her entire right hand. Dr. Alam reviewed the cervical

and shoulder MRI's, though the record is not clear whether he reviewed the actual films or the radiologists' reports. With regard to the shoulder, he noted the MRI showed moderate supraspinatus tendinopathy without a tear, and findings suggestive of adhesive capsulitis. He noted that although Petitioner had degenerative cervical spine disease, her symptoms were not typical for cervical radiculopathy. He prescribed Gabapentin and ordered an EMG/NCS to further evaluate. PX8.

Petitioner returned to Dr. Moyers on April 1, 2014, for evaluation of her cholesterol. However, she reported she was still having pain in her right arm and shoulder and that the orthopedist thought it was from her neck. She reported she had seen Dr. Alam as well. PX3.

On April 18, 2014, Petitioner presented to Dr. Nathan Mall at Regeneration Orthopedics. No referring doctor is listed on his record. Petitioner gave a consistent history of the accident and presented with complaints of right elbow pain and shoulder pain bilaterally, but mostly on the right. On examination, she had limited range of motion of the right shoulder as opposed to the left, some rotator cuff weakness, and some mild pain over the AC joint. She also had positive O'Brien's test on the right. Dr. Mall noted x-rays did not show evidence of significant osteoarthritis. He reviewed Petitioner's MRI and remarked that the quality was "extremely poor". He opined that it demonstrated what appeared to be a full thickness rotator cuff tear and possibly a superior labral tear. He also noted there was some edema within the AC joint and significant edema within the subacromial space and joint. His assessment was (1) frozen shoulder; (2) rotator cuff partial thickness versus full thickness tearing; (3) AC joint arthrosis; and (4) biceps tendinitis versus superior labral tear. With regard to treatment, Dr. Mall administered injections into Petitioner's glenohumeral joint and AC joint. She reported almost complete resolution of her pain following the injections. Dr. Mall recommended anti-inflammatory medication and a course of physical therapy. He opined that Petitioner's current symptoms with regard to her right shoulder injury were related to her work accident. PX12.

On April 23, 2014, Petitioner underwent an EMG/NCS of the right upper extremity by Dr. Alam. The study was normal. She followed up with Dr. Alam on April 30, 2014, and reported the Gabapentin she was taking was helping. It was noted she was also in physical therapy. In that Petitioner's symptoms were better, Dr. Alam recommended she continue with physical therapy and Gabapentin and return in one month. PX8.

Petitioner returned to Dr. Mall on May 16, 2014, at which time she reported she was doing much better. She reported decreased pain and increased range of motion in her right shoulder, but continued to have some back discomfort. On examination, she had improved range of motion but continued rotator cuff strength weakness and mild pain over the AC joint. O'Brien's test was still somewhat positive, but much more mildly so. Assessment was (1) frozen shoulder, improving; (2) rotator cuff partial thickness versus full thickness tearing; (3) AC joint arthrosis; (4) biceps tendinitis versus superior labral tear; and (5) cervical spine pathology. Dr. Mall recommended additional physical therapy and referred Petitioner to Dr. Matthew Gornet for her cervical pathology. PX12.

On May 28, 2014, Petitioner followed up with Dr. Alam and related she was treating with an orthopedist for her shoulder pain. She reported the Gabapentin was helping and that she

noticed a difference when she did not take it. Dr. Alam increased her dosage and asked her to return in three months. PX8.

On June 19, 2014, Petitioner returned to Dr. Mall. It was noted her range of motion improved substantially with physical therapy and the cortisone injection, but that she continued to have pain in her right shoulder. Dr. Mall noted he had not done a new MRI at Petitioner's last appointment, but due to her continued pain he ordered one at this visit. Petitioner was to continue physical therapy, especially for biceps and rotator cuff strengthening. Petitioner was to return in three to four weeks, after the MRI was performed. PX12.

On June 19, 2014, Petitioner also presented to Dr. Matthew Gornet for an initial spine examination, upon referral by Dr. Mall. She gave a consistent history of the accident, as well as her treatment to date. Her chief complaint was pain in her right shoulder and neck and intermittent significant pain down her right arm to the elbow and hand, with numbness and tingling. She also had low back pain to both sides and occasional left-sided trapezial pain. It was noted Petitioner was working with light duty restrictions. On examination, Petitioner motioned she had pain in her neck, base of her neck, right scapula, right trapezius, right shoulder, and intermittent pain down her right arm into her forearm and hand. She had decreased dorsiflexion in the biceps, triceps, and wrist, as well as decreased volar flexion. Sensation was decreased to C6 on the right and range of motion in her right shoulder was restricted. Dr. Gornet reviewed the cervical MRI of February 14, 2014, which he noted was of "moderate quality". He noted it revealed central herniations at C5-6 and C6-7, which correlated with her symptoms. There was also a disc osteophyte complex and possibly a foraminal disc herniation. Dr. Gornet had Dr. Mall come into the examination room at that time, and they developed a treatment plan for Petitioner. They agreed new MRI's of the cervical spine and right shoulder were warranted, as was a possible diagnostic injection in Petitioner's neck and/or shoulder. It was noted and discussed with Petitioner that her shoulder pain could come from two different sources—the cervical spine or the shoulder itself. Dr. Gornet opined that Petitioner's symptoms in her shoulder, arm, and cervical spine were causally connected to her work accident of December 12, 2013. Dr. Gornet renewed Petitioner's prescription for Mobic as well as her work restrictions and gave a prescription for physical therapy. PX9.

On July 10, 2014, Petitioner underwent cervical spine and right shoulder MRI's. The cervical MRI revealed C5-6 diffuse annular disc, right foraminal disc protrusion, mild to moderate central canal stenosis, severe right neural foraminal exit stenosis and moderate left neural foraminal exit stenosis. It also showed C6-7 diffuse annular bulge, mild central canal stenosis, and mild lateral neural foraminal exit stenosis. The shoulder MRI revealed mild to moderate right glenohumeral osteoarthritis, small glenohumeral joint effusion, and possible intra-articular loose bodies with the subcoracoid recess. There was no rotator cuff pathology. PX10.

Petitioner returned to Dr. Gornet on July 14, 2014, with continued complaints of substantial neck and shoulder pain. Dr. Gornet reported she had disc herniations at C5-6 and C6-7, which correlated to her neck pain. He further reported she had a herniation out into the foramen at C5-6, which correlated best with her shoulder pain. He recommended two cervical injections, and deferred to Dr. Mall with regard to the shoulder. PX9.

On July 16, 2014, Petitioner underwent a right C5-6 epidural steroid injection, and on August 13, 2014, she underwent a right C6-7 epidural steroid injection. PX11.

In between the injections, Petitioner returned to Dr. Alam on July 17, 2014. She reported continued pain and paresthesia in her right shoulder and arm, and reported she was seeing an orthopedic surgeon. The Gabapentin was reduced at her request. There were no new complaints. She returned to Dr. Alam on August 20, 2014, and reported that the pain was fairly well controlled. She believed it was partly due to the injections she received in her neck. PX8.

Petitioner followed up with Dr. Gornet on September 11, 2014, and reported that the injections gave her some relief of her shoulder and neck pain. Dr. Gornet was not sure if she would regress over time, and kept her on light duty for another two months. PX9.

On November 4, 2014, Petitioner returned to Dr. Alam, and reported she was still having tingling, numbness, and pain involving her shoulder. She requested an increase in Gabapentin and a prescription for Vicodin, both of which were given. PX8.

Petitioner returned to Dr. Gornet on November 10, 2014, at which time she still had significant neck pain with headaches, and pain in both shoulders, arms, and trapezius. Dr. Gornet noted, "We believe she may have a shoulder problem in addition to her neck complaints." He also commented that he did not have Dr. Mall's notes, and the Arbitrator notes that it does not appear Petitioner had been to Dr. Mall since June 19, 2014. Dr. Gornet noted Petitioner had tried and failed physical therapy and injections, and still had significant issues, and he recommended a two-level disc replacement. She was to remain on light duty. PX9.

On December 1, 2014, Petitioner returned to Dr. Mall. It was noted she had done some physical therapy and had an injection which helped for some time. Examination showed pain to palpation over the neck, pain with range of motion of the neck, weakness with rotator cuff testing, pain to palpation over the biceps tendon, and positive O'Brien's test of the right shoulder. Dr. Mall reviewed the MRI and noted there appeared to be a superior labral tear, as well as partial-thickness rotator cuff tearing. His assessment was right shoulder SLAP tear, partial thickness rotator cuff tear, and cervical spine pathology. Dr. Mall commented that the radiologist's MRI report did not mention any significant rotator cuff or labral pathology, which he disagreed with. He indicated he would call the radiologist to discuss this with him. It was noted that Petitioner was scheduled for a cervical CT myelogram on January 22, 2015, and that he would see Petitioner back six to eight weeks after. Dr. Mall recommended proceeding with neck treatment prior to shoulder treatment, given the significant pathology in the cervical spine, which could be contributing some to her shoulder symptoms. He opined, however, that some of her shoulder symptoms were coming from the shoulder, as she did see improvement with the injection, which would not be the case if the pain was related to the cervical spine. PX12.

On January 14, 2015, Petitioner was evaluated by Dr. David Robson, Respondent's Section 12 examiner for the cervical spine. Petitioner gave a consistent history of the accident and her treatment to date. Dr. Robson reviewed Petitioner's medical records and imaging studies and also conducted a physical examination. Petitioner reported no prior history of neck or shoulder pain. She stated her primary pain was in the right shoulder and secondarily in the neck

and right arm. She reported the neck pain as aching and it radiated into the right shoulder and into the radial aspect of the right arm. Examination revealed tenderness to palpation in the neck, decreased range of motion in both the cervical spine and the shoulder joints, and right deltoid weakness. Dr. Robson reviewed the cervical MRI's of February 24, 2014, and July 10, 2014, but it does not appear he reviewed the shoulder MRI's. Dr. Robson's assessment was herniated nucleus pulposis at C5-6 and C6-7 which had failed to respond to conservative treatment of epidural steroid injections, physical therapy, and medications. He recommended an anterior cervical discectomy and fusion, but noted that a total disc replacement would be a comparable and appropriate alternative. He opined that Petitioner's need for treatment of her cervical spine, including surgery, was related to the December 12, 2013, work injury, and that she was not at maximum medical improvement. RX6, PX16.

On January 22, 2015, Petitioner underwent a CT myelogram which revealed disc herniations at C5-6 and C6-7 resulting in spinal cord contact, and mild to moderate central spine canal stenosis at both levels and severe bilateral foraminal encroachment at C5-6. PX13.

Petitioner returned to Dr. Gornet on January 22, 2015, and discussed the findings of the CT myelogram. Dr. Gornet noted the findings correlated quite well with her neck pain, headaches, arm symptoms, and tingling. Examination showed decreased sensation at C6 on the right and decreased biceps and triceps strength on the right. Dr. Gornet recommended two-level cervical disc replacement at C5-6 and C5-6, given that conservative treatment had failed. PX9.

On February 3, 2015, Petitioner followed up with Dr. Alam, for refills of Gabapentin and hydrocodone, which were given. It was noted she was going to have cervical surgery. PX8. Petitioner presented to Dr. Steven Carr at Cardiovascular Consultants on February 5, 2015, for surgical clearance. Her EKG was normal and she was given clearance. PX15.

On March 23, 2015, Petitioner underwent a cervical MRI. It revealed C5-6 bulge with bilateral foraminal herniations and severe foraminal stenosis, right greater than left, as well as mild central canal stenosis. It also showed C6-7 bulge with central annular tear herniation, dural displacement, and mild central canal stenosis. PX10. Following the MRI, Petitioner presented to Dr. Gornet the same day. He explained the results of the MRI and noted Petitioner had been approved for the surgery. PX9.

On April 8, 2015, Petitioner underwent surgery with Dr. Gornet for disc replacement at C5-6 and C6-7. It was noted there was increased difficulty due to Petitioner's anatomy. PX11. She followed up with Dr. Gornet on May 4, 2015, and was doing well. She reported she had some "shockwaves" down her right shoulder and arm initially after surgery, but noted it was already improving. She was to begin gentle range of motion exercises. Petitioner returned to Dr. Gornet on May 28, 2015, and reported she was still having shockwaves into her shoulder, particularly her right shoulder. Examination showed full strength, and x-rays showed good position of her devices. Dr. Gornet believed a lot of Petitioner's shoulder pain was in large part due to significant improvement in the disc height at C5-6, relative to her preop status. PX9.

Petitioner returned to Dr. Alam on June 11, 2015, and reported that she had recently had surgery. She related she was going to see Dr. Mall for the spasms in her shoulder related to her

neck surgery. She was unsure what she was going to do about her shoulder. She was taking Flexeril for the shocks and spams in her right shoulder, which radiated down to her hand. She was also taking Gabapentin and Hydrocodone for her pain, both of which were refilled. PX8.

On June 26, 2015, Petitioner returned to Dr. Mall, and reported she had continued right shoulder complaints. She had some improvement from the cervical surgery, but the shoulder was still problematic. Examination revealed equal strength in all areas, but did show some weakness in the supraspinatus on the right side with rotator cuff testing. She had a positive O'Brien's test and mild pain over the AC joint. Dr. Mall's assessment was right shoulder labral tear and partial-thickness rotator cuff tear. He recommended additional home-based therapy to see if the shoulder would strengthen any further since the cervical spine had been addressed. He noted if there was not substantial benefit she may require right shoulder arthroscopy, biceps tenodesis for superior labra tear, and partial-thickness rotator cuff repair if greater than 50% of the tendon was involved. She was to return in four to six weeks. PX12.

Petitioner followed up with Dr. Gornet on July 23, 2015. She reported she was doing well but still had some pain into her right shoulder, which Dr. Mall was treating. Dr. Gornet recommended she begin a home exercise program and released her to return to work full duty on July 31, 2015. PX9.

On August 11, 2015, Petitioner followed up with Dr. Mall for her right shoulder. He noted she had undergone neck surgery with minimal improvement in her right shoulder pain. Examination revealed some loss of strength, positive O'Brien's, pain over the AC joint, pain over the biceps tendon, and reduced range of motion with pain. His assessment was right shoulder superior labral tear and partial-thickness rotator cuff tear with continued frozen shoulder and adhesive capsulitis. Dr. Mall recommended surgery of right shoulder arthroscopy, partial-thickness rotator cuff repair if needed, biceps tenodesis, and capsular release. PX12.

Petitioner returned to Dr. Alam on September 10, 2015, and reported she was continuing to treat with Dr. Gornet and Dr. Mall. It was noted she had a history of pain in the right sciatica, and she reported shooting pain that radiated down her right leg at night. She was given refills of Gabapentin and hydrocodone. PX8.

Petitioner followed up with Dr. Mall on September 22, 2015. Examination was consistent with the previous exam, and Dr. Mall continued to recommend surgery. PX12.

Petitioner returned to Dr. Alam on October 8, 2015, with continued complaints of right sciatica and low back pain. An MRI of the lumbar spine had been ordered but not yet approved through worker's compensation. Medications were refilled. PX8.

On October 22, 2015, Petitioner returned to Dr. Gornet and reported her neck was doing well. She was working full duty with no restrictions. She complained of lower back pain and pain down her buttocks into her legs. Dr. Gornet recommended a lumbar MRI. PX9.

On November 5, 2015, Petitioner followed up with Dr. Alam with complaints of right sciatica and low back pain "related to work incident". It was noted the lumbar spine MRI was denied through worker's compensation. PX8.

On November 19, 2015, Petitioner was evaluated by Dr. Richard Lehman, Respondent's Section 12 examiner for the shoulder. She gave a consistent history of the accident. On examination, Petitioner had full range of motion of her right shoulder. It was noted she had previously been diagnosed with frozen shoulder, and that it had resolved. Her motion appeared to be unrestricted, but she did have minor popping with internal and external rotation of the shoulder. It was noted she had radicular numbness going down her arm in abduction. She had no limitations with extension but did have mild discomfort. She has mild discomfort with rotation as well. There was no evidence of significant weakness with internal and external rotation strength. Apprehension test was negative. Petitioner had tenderness in the anterior aspect of the shoulder, in the biceps tendon, and in the area of the coracoid. RX7.

Dr. Lehman reviewed Petitioner's records and obtained new shoulder x-rays in the office. They showed degenerative arthritis and a spur in the inferior aspect of the shoulder, primarily the inferior aspect of the humeral head. They also showed degenerative changes in the shoulder. Dr. Lehman reviewed the shoulder MRI of July 10, 2014, and noted that the rotator cuff appeared normal. There was significant degenerative arthritis in the glenohumeral joint with some spurring, and spurring was significant as it related to the inferior aspect of the shoulder. There was a type 2 acromion. He also opined Petitioner had degenerative arthritis and multiple subchondral cysts inferiorly in the glenoid with a large spur in the humerus, and possibly some small loose bodies which appeared to be degenerative. RX7.

Dr. Lehman diagnosed Petitioner's condition as degenerative arthritis of the shoulder and opined there was no causal connection between her objective findings and her work accident. He opined that Petitioner's degenerative changes predated the work accident, that the changes were wear and tear and degenerative in nature, and that they were not traumatic in etiology. The adhesive capsulitis had resolved, and there was no evidence of a torn labrum or rotator cuff. He opined that the treatment to date had been reasonable and necessary for the preexisting degenerative arthritis and adhesive capsulitis, that Petitioner did not need any further medical treatment, and that she was at maximum medical improvement. Dr. Lehman opined that Petitioner had 1% impairment of her right shoulder, based on the Guides to the Evaluation of Permanent Impairment, 6th Edition. RX7.

On December 3, 2015, Petitioner returned to Dr. Alam for follow up of sciatica and back pain, which she related had subsided some. Her medications were refilled. PX8.

Petitioner returned to Dr. Gornet on January 7, 2016, for her lower back. She underwent a lumbar MRI at the same time. The MRI revealed annular bulges with left foraminal protrusions at L3-4 and L4-5, left foraminal L4-5 annular tear, and foraminal stenosis at both levels with left greater than right. The MRI also showed annular bulges at T12-L1 and L1-2. PX10. When she saw Dr. Gornet, it was noted she had multilevel facet arthritis, particularly on the right side at L3-4 and L4-5, where she had more significant lateral recess stenosis. There was stenosis to a lesser extent at L5-S1. Petitioner complained of having intermittent right

radicular pain down her leg. Dr. Gornet noted if he needed to treat her further, he would recommend a steroid injection at L4-5 on the right and facet rhizotomies at L3-4 and L4-5 on the right. Petitioner was allowed to continue working full duty and was to return in April for cervical x-rays and CT. PX9.

On February 4, 2016, Petitioner followed up with Dr. Alam. She reported she continued to take Gabapentin, Norco, and hydrocodone as needed for her bilateral leg pain, low back pain, and neuropathy pain. She also took Robaxin as needed for her sciatic nerve in her right hip. Medications were refilled. PX8.

Petitioner returned to Dr. Mall on February 9, 2016, and reported continued right shoulder pain and difficulty doing activities away from her body or at chest height or above. On examination, she continued to have rotator cuff weakness, positive O'Brien's test, pain to palpation over the AC joint, and limited range of motion. Dr. Mall continued to recommend surgery. He noted Petitioner brought Dr. Lehman's IME report, which she had concerns about. She outlined her concerns for Dr. Lehman, but they are not contained within his note. PX12.

Dr. Mall testified by way of deposition on March 18, 2016. He is Board Certified in orthopedic surgery and independent medical evaluations, and did a subspecialty fellowship in sports medicine and shoulder surgery. He sees about 100 patients a week in his office and conducts anywhere from seven to twenty surgeries in a week. Approximately half of his patients are treating from shoulder problems. Of his patient population, 30 to 40% are being treating for work related injuries and the remaining are privately insured patients. He performs independent medical evaluations on behalf of both employers and employees. PX17.

Dr. Mall testified consistent with his treating records. He had no medical records in his file that documented Petitioner had right shoulder complaints or treatment prior to her work accident. He testified his typical practice when performing a shoulder examination is to also perform a cervical spine examination. He conceded he did not see it very well documented in his first note. He performs both examinations because there is a lot of overlap between the cervical spine and the shoulder and it is important to evaluate the cervical spine as a potential source of the patient's symptoms. PX17.

When Dr. Mall examined Petitioner on the first visit he noted limited range of motion, decreased external rotation and forward elevation, and rotator cuff weakness. He reviewed x-rays and did not see any significant arthritis. He reviewed an MRI, which he found to be of fairly poor quality. It was hard to make a distinct diagnosis from the MRI, but there appeared to be a full-thickness rotator cuff tear and swelling in the AC joint. His diagnosis, within a reasonable degree of medical certainty, was frozen shoulder, at least partial-thickness rotator cuff tear, and possible biceps tendon pathology or superior labral injury. These diagnoses can be made clinically, but an MRI can be helpful to differentiate the possible injuries. Dr. Mall opined that Petitioner's shoulder injury was caused by her work accident on December 12, 2013, based on the mechanism of the injury and the fact that she was not having any shoulder pain prior to the work accident. His treatment recommendation at that time was a cortisone injection, to loosen up the frozen shoulder and to potentially reduce the inflammation from any labral tear

that may be present, and the injection was done at that time. The injection relieved almost all of Petitioner's pain, which indicated the areas injected were the source of her symptoms. PX17.

When Petitioner returned in a month she was doing much better. Her pain had decreased and her range of motion was better. She continued to have pain in her back, but her shoulder pain had improved quite a bit. Therapy was recommended and a referral was made to Dr. Gornet for her cervical spine. Dr. Mall next saw Petitioner in conjunction with Dr. Gornet on June 19, 2014. Both doctors generated notes, but Dr. Mall had not seen Dr. Gornet's note. Petitioner's range of motion had improved but her pain had returned, and a repeat MRI was done. Dr. Mall next saw Petitioner on December 1, 2014, at which time he went over the MRI results. PX17.

Dr. Mall testified his review of the MRI showed partial-thickness rotator cuff tearing, superior labral tear, mild arthritis, fluid in the joint, and fluid around the biceps tendon, which indicated tendinitis in the biceps sheath. Dr. Mall testified that his procedure is to review the radiologist's report as well as personally review the films, and most of the time he sees the films before the radiologist has read it. For most shoulders and knees, he believed he is usually pretty good at seeing the pathology on the MRI. In Petitioner's case, he had the report and did review it. Dr. Mall, however, disagreed with the radiologist's impression, and testified there was clear pathology on the MRI that was not in the radiologist's report. Dr. Mall testified he called the radiologist to discuss the difference in the findings, but he did not believe a new report was received following the discussion. Dr. Mall testified that he believed the radiologist agreed with him, but did not recall if the radiologist said he was going to redictate a report. PX17.

Dr. Mall provided printouts of the MRI films and during his testimony he made several marks on the printouts. Specifically, on number 14 he circled the undersurface and the outer surface of the rotator cuff, which showed two partial-thickness tears. On number 15 he circled an area of high signal with a little triangle black signal on top, which represented the superior labral tear on the socket side. Also on number 15 he circled on the ball side, which showed a little bit of partial tear. Also on number 15 he circled quite a bit of fluid around the biceps tendon, which is the more inferior circle. On number 16 he circled fluid around the biceps, between the superior labrum and glenoid, which indicated a tear because there should not be fluid present if there was no tearing. On all of the photos, the areas circled are lighter in color than the rest of the film. Dr. Mall testified that represented fluid, which indicated an injury or inflammation or the like. The fact that there was fluid in the joint, fluid around the biceps tendon, and fluid against the rotator cuff where there should be normal tendon, would indicate there is some tearing there. PX17, Dep. PX2.

Dr. Mall testified his review of the MRI confirmed his diagnosis within a reasonable degree of medical certainty. The diagnosis was right shoulder SLAP tear, partial thickness rotator cuff tear, biceps tendinitis, and AC joint inflammation. He explained that it is very common to have some edema in the AC joint, and as long as there is no pain it is not an issue. If there is pain, however, it would indicate a problem. Dr. Mall testified he relied on MRI films in treating and diagnosing his patients and in formulating a causation opinion. PX17, Dep. PX2.

Dr. Mall testified that the four major pain generators in the shoulder are the superior labrum, the rotator cuff, the biceps tendon, and the AC joint. In Petitioner's case, none of them

required any kind of emergency surgery. When there are problems with both the neck and the shoulder, Dr. Mall testified he usually will defer to the cervical spine specialist as to which problem should be addressed first. The exception is when there is a full-thickness retracted tear of the rotator cuff, which would require immediate treatment. In Petitioner's case, she went forward with cervical spine surgery first, then returned to see him about six months later, at which time she was still having some issues with her shoulder. PX17.

Dr. Mall testified when Petitioner returned to see him on June 26, 2015, she had significant improvement with the cervical spine but continued to have right shoulder pain. She had some weakness on exam and continued positive O'Brien's test. She also had pain over the AC joint and decreased strength. With regard to treatment, Dr. Mall wanted to try and strengthen the rotator cuff to see if it would improve Petitioner's symptoms and if it did not, she would probably need surgery. Petitioner underwent additional therapy and returned in August with continued right shoulder pain. Dr. Mall testified he recommended surgery at that time, as Petitioner had failed conservative treatment. Dr. Mall testified he had seen Petitioner three times since June 2015 and her pain remained consistent, though her range of motion improved. PX17.

Dr. Mall opined Petitioner's condition would not improve without the surgery at this point, as she has tried everything available from a conservative route and there is clear shoulder pathology that is causing her symptoms. He acknowledged Petitioner has a little underlying osteoarthritis, but opined it was nothing substantial that would be a major source of her symptoms. He testified that even if the osteoarthritis was the major source of Petitioner's symptoms, she was not having symptoms before the work accident and the problem has been persistent since then, which indicated an aggravation of an underlying problem. Dr. Mall testified he released Petitioner to full duty work on June 26, 2015. PX17.

Dr. Mall testified he had reviewed the report and deposition transcript from Dr. Lehman. He disagreed with Dr. Lehman that Petitioner's symptoms were from the arthritis in her shoulder, for several reasons. First, there was definite pathology in the superior labrum and rotator cuff. Second, he opined that even if Dr. Lehman were correct, Petitioner has failed conservative treatment for an aggravation of her underlying arthritis, which would demonstrate her symptoms started from the date of the aggravation. Dr. Mall testified he had nothing that showed Petitioner had problems with her right shoulder before the accident. Third, he further testified that a slip and fall is a significant injury mechanism to the shoulder, is considered a potential injury mechanism for both superior labral tears and for rotator cuff tears, and is a very common source for those problems. He concluded that the injury mechanism fit with an injury to Petitioner's shoulder. Fourth, the fact that Petitioner improved with the injections showed that her shoulder was a major part of the problem, and the fact that she did not get complete resolution of her symptoms from the cervical spine indicated the shoulder was part of her problem. Dr. Mall testified that for all of those reasons he disagreed that the problem was simply arthritis or that it had resolved. PX17.

Dr. Mall testified that he disagreed with Dr. Lehman's assertion that Petitioner's smoking was a source of her arthritis in her non-weightbearing joints. He testified he had never seen a study that showed that, and that in fact there was a big study done that looked at knee arthritis and multiple facets, and found the opposite to be true. Dr. Mall testified there is no cause-and-

effect relationship between smoking and development of arthritis in the shoulder, nor did Dr. Lehman reference any article or study showing there was any. PX17.

Dr. Mall opined that Petitioner's problems are not simply a continuation of degeneration of her shoulder, but rather started with her fall. There was an acute traumatic event, causing immediate shoulder pain, for which she sought treatment. Dr. Mall testified that his bills to date were rendered as a result of the care and treatment Petitioner required due to the work injury. He further testified that the light duty work recommendation he made, as well as the prospective treatment he recommended, including surgery, was causally related to her work accident of December 12, 2013. PX17.

On cross-examination, Dr. Mall testified he began practicing medicine in 2006 and began his current practice, Regeneration Orthopedics in 2012. He became board certified in July 2014, and began treating Petitioner in April 2014. He conceded that when he first began treating Petitioner he was not board certified. Dr. Mall testified that in addition to seeing patients for shoulder problems, he also treats problems with the knee, shoulder, hip, ankle, wrist and elbow, as well as some nonoperative conditions of the cervical and lumbar spine. His two major practice areas are the shoulder and knee. Dr. Mall conceded that Petitioner was referred to his office by her attorney. PX17.

Dr. Mall testified he typically performs a cervical spine evaluation when he first sees a new patient, but he did not have an independent recollection of whether he did so in this case. He typically reviews 40 to 50 MRI's a week and talks with other doctors and specialists when necessary. He testified he did talk to the radiologist who issued the MRI report, but that neither he nor the radiologist generated any addendum or additional report memorializing that conversation. The conversation was more than a year ago. PX17.

Dr. Richard Lehman testified by way of deposition on March 3, 2016, and March 17, 2016. He is a Board Certified Orthopedic Surgeon with a sub-qualification in sports medicine and has been in practice for 30 years. His practice is primarily sports related with a significant number of professional and college athletes. Dr. Lehman testified he performs 15 to 20 surgeries a week and less than one percent of his practice is IMEs or medical legal examinations. He performed an independent medical evaluation of Petitioner on November 19, 2015, which included a physical examination and review of medical records and imaging studies. RX8.

Dr. Lehman testified he reviewed both the report and films of Petitioner's right shoulder MRI done on February 10, 2014. His findings, based on his review of the films, were degenerative changes at the glenohumeral joint, AC arthritis, contraction of her capsule (frozen shoulder or adhesive capsulitis), mild degeneration of the rotator cuff, intact rotator cuff with no tear, and no abnormalities in the biceps, the biceps sling, or the intertubercular groove where the biceps sits. Dr. Lehman testified he also reviewed the MRI report and films of Petitioner's right shoulder taken on July 10, 2014, and that Petitioner's shoulder actually looked better at that time. The rotator cuff was normal, there was some degenerative arthritis primarily at the glenohumeral joint, and there were possibly two very small loose bodies within the subcoracoid recess. There was no abnormality in the biceps, the rotator cuff architecture was normal, and there was no impingement. RX8.

Dr. Lehman testified Petitioner gave a history of slipping on ice and falling on December 12, 2013. He testified he performed a physical examination and Petitioner had full unrestricted range of motion of her right shoulder. The medical records showed a history of a frozen shoulder, but it had resolved. Dr. Lehman testified Petitioner had 155 degrees of flexion, 150 degrees of abduction, 65 degrees of external rotation, and internal rotation of about 40 degrees, which was symmetrical and normal. Hawkin's and Neer tests were negative. Petitioner had some minor popping with internal and external rotation due to her arthritis, had no instability in her shoulder, and the testing for labral pathology was negative. Dr. Lehman testified Petitioner's strength was good, but she did have some mild tenderness in the rotator cuff interval, biceps tendon, and coracoid. RX8.

Dr. Lehman testified his diagnosis for Petitioner was mild degenerative arthritis of her right shoulder. He further testified this diagnosis was not related to Petitioner's work injury, as it takes a long time to develop degenerative arthritis and in addition Petitioner had a predisposing history of hypercholesterolemia and smoking. Dr. Lehman testified that smoking is one of the key factors in terms of degenerative arthritis in non-weight bearing joints because it decreases the vascularity in the joint. He further testified there was nothing on either of Petitioner's two MRI's to suggest an acute process. Dr. Lehman testified that frozen shoulder is an idiopathic process unless it is post-surgical, and that Petitioner had all the reasons to have the condition, with her age and smoking history. He testified that the studies show that smoking cigarettes decreases the blood flow to the articular cartilage which increases the chance of degenerative changes. RX8.

Dr. Lehman testified that the treatment Petitioner has undergone for her right shoulder was not related to her December 12, 2013 injury. He did not agree with Petitioner's treating doctor's diagnoses of a right shoulder labral tear and partial thickness rotator cuff tear. He testified he did not agree with Dr. Mall's surgical recommendation because Petitioner had two MRIs which showed her biceps tendon and rotator cuff were normal and she had full range of motion. There was no indication on two objective tests of anything wrong with the biceps tendon, no evidence of a partial thickness rotator cuff tear, and no corroborative evidence including her examination which suggested those diagnoses. Dr. Lehman testified Petitioner was capable of working full duty when he saw her, that she did not need any additional medical treatment for her right shoulder, and that she was at maximum medical improvement. He testified Petitioner had an AMA partial permanent disability rating of 1% at the level of the shoulder based on the AMA Guides to the Evaluation of Permanent Impairment 6th Edition, which was not related to her work injury. RX8.

On cross-examination, Dr. Lehman testified he performed one or two IMEs a month and that about 60% are on behalf of employers. He acknowledged that Petitioner filled out a patient intake questionnaire, on which she described her problem as a burning in the shoulder and shock pain down into her hand. He testified that he was not provided with any medical records of Petitioner's that predated the December 12, 2013 incident, and that Petitioner indicated on her patient intake questionnaire that she did not have any prior shoulder injury. Dr. Lehman testified that it was important to note that Petitioner indicated that she had burning in her shoulder and pain going down into her hand. Dr. Lehman testified that a normal shoulder exam, normal x-

rays, and two normal MRIs is suggestive that the problem is not coming from her shoulder. Dr. Lehman testified that he thought both MRIs were of fair quality, the second one being better than the first. He testified that you would see fluid in the rotator cuff and acute processes on even a poor quality MRI. Dr. Lehman testified that by convention a radiologist will always issue an addendum if his opinion changes. In his 30 years of practicing medicine, every time he has discussed a case with a radiologist and there is an alteration in what is believed to be the pathology, the radiologist will dictate an addendum and reissue the report to make the diagnosis correct. Dr. Lehman testified that this is the standard of care. RX8.

Dr. Lehman testified that Petitioner's radicular arm pain was residual from her cervical spine. He explained that burning pain was not related to a joint centered process, but is generally a nerve centered process, so he believed Petitioner still had some evidence of cervical spine pathology. He testified that a patient's symptoms have to be corroborated and that it is inappropriate to operate on someone just based on their symptoms when those symptoms are not corroborated by objective testing. He testified that perhaps one MRI might miss pathology, but not two. He testified that by today's standards it is below the standard of care to operate on someone based just on their subjective symptoms. RX8.

Dr. Lehman conceded he does not have any board certification or special training to perform AMA impairment ratings, but has read the book and been through it many, many times, including with previous editions. He agreed that the AMA Guides are based on objective criteria and typically do not take subjective complaints into consideration. Further, the Guides do say that subjective complaints that are not clinically verifiable are not ratable, and an incorrect diagnosis would lead to an incorrect impairment rating. He testified that the AMA Guides impairment ratings are the best opportunity the medical profession has to adequately or accurately reflect the loss of function in a patient. He testified that the AMA does not take into account future problems because no one can predict the future or disease process. RX8.

Dr. Lehman testified that if a patient complained of burning in their arm down to their hand, that would not indicate shoulder pathology, but generally a cervical spine problem or a herniated disc in the neck. He testified that it is possible for someone who suffers from arthritis to temporarily exacerbate their arthritis and return to baseline. RX8.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of her employment which caused injury to her cervical spine, resulting in surgery. All benefits related to the cervical spine have been, or will be, paid. The parties dispute whether Petitioner's current condition with regard to her right shoulder is related to the accident.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64 (1982).

The Arbitrator finds that Petitioner's current condition of ill-being with regard to her right shoulder is causally related to her work accident of December 12, 2013. In so concluding, the Arbitrator finds it significant that the record reveals no other cause for Petitioner's complaints other than the accident, reveals no complaints prior to the accident, and reveals no intervening accident or other cause of Petitioner's ongoing symptoms. The Arbitrator also finds it significant that the record is consistent throughout with regard to Petitioner's complaints and ongoing symptoms, which started immediately after the accident. Petitioner credibly testified that she attempted to stop her fall by grabbing the door jam, but her buttocks hit the step and she hit her right side and right shoulder on the van. She further credibly testified, which the record corroborated, that she had shoulder pain immediately after the accident, that has not gone away, and that she continues to have symptoms.

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 204-206 (2003). 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, 296 (1st Dist. 1986).

In this case, Petitioner sustained an undisputed accident, began having shoulder complaints immediately, had consistent shoulder complaints throughout her treatment, and continues to have consistent shoulder complaints. The record is void of any indication that Petitioner had shoulder pain or other symptoms prior to her fall on December 12, 2013. The Arbitrator is mindful of Dr. Lehman's opinion that Petitioner's symptoms are related to her osteoarthritis, but is not persuaded. The Arbitrator is persuaded by the record as a whole and by the opinions of Dr. Mall. The Arbitrator therefore finds that Petitioner has met her burden of proof on the issue of causal connection with respect to her right shoulder.

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

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill.App.3d 154, 164 (1st Dist. 1992)).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered to date with regard to Petitioner's right shoulder were reasonable and necessary in Petitioner's care and treatment relative to her accident of December 12, 2013. The Arbitrator finds that Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 1, with the following exceptions.

The Arbitrator declines to award charges billed by any medical provider for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports submitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them.

The Arbitrator declines to award any interest charges, to the extent that they are being claimed, in Petitioner's Exhibit 1. The record does not substantiate and Petitioner did not proffer evidence that interest was properly charged pursuant to Section 8.2(d)(3).

The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for medical benefits previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

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

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatments that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705 (2nd Dist. 1997).

The Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further care, including right shoulder surgery. Further, the Arbitrator finds that the need for prospective medical care is causally related to the work accident of December 12, 2013. In so concluding, the Arbitrator finds significant that Petitioner's symptoms and complaints with respect to her right shoulder have been consistent and constant since her accident. This is corroborated by the record and Petitioner's credible testimony, and the Arbitrator is persuaded by both.

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

Dedra Koehler,

Petitioner,

vs.

NO: 14 WC 16584

17IWCC0471

Murray 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 all of the issues, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the addition of the following supplemental analysis on the issue of whether Petitioner's injury arose out of and in the course of her employment:

> "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that [she] has suffered a disabling injury which arose out of and in the course of [her] employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). " 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Id.* There is no dispute that the accident in this case occurred in the course of Petitioner's employment; the issue here is whether the accident also arose out of her employment.
>
> "The 'arising out of' component is primarily concerned with causal connection" and is satisfied where the claimant shows "that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* The Appellate Court has devised three categories of risks to which employees 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." *Noonan v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152300WC, ¶19 (internal quotations omitted). Employment risks are compensable, and personal risks are not compensable. *Id.* Injuries resulting from a neutral risk are compensable only where the employee was exposed to the risk to a greater degree than the general public. *Id.*

Petitioner first argues that her knee injury was incurred as the result of an employment-related risk. "Risks are distinctly associated with employment when, at the time of the injury, 'the employee was performing acts [she] was instructed to perform by [her] employer, acts which [she] had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to [her] assigned duties.' " *Steak 'N Shake v. Illinois Industrial Comm'n*, 2016 IL App (3d) 150500WC, ¶35 (quoting *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). "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." *Caterpillar Tractor Co*, 129 Ill. 2d at 58.

Applying this definition, Petitioner notes that, as a cook, she was expected, and even required by regulation (see 77 Ill. Adm. Code 750.512 (now repealed)) to wash her hands after engaging in any activity that could contaminate her hands. She further points out that she chose the location of neither the hand-washing sink nor the trash can, so that her injury was caused by her "doing a duty she was required to do, at a location she was required to do it at." In support of her position, Petitioner cites the Appellate Court's recent decision in *Steak 'N Shake*, 2016 IL App (3d) 150500WC. In *Steak 'N Shake*, a case in which the claimant suffered an injury as a result of wiping down restaurant tables, the Appellate Court rejected the Commission's application of a neutral-risk analysis and instead held the activity to constitute an employment-related risk. *Steak 'N Shake*, 2016 IL App (3d) 150500WC, ¶37. In so doing, the Appellate Court relied on the claimant's credible testimony that her normal job duties included the habitual cleaning and busing of tables and was therefore distinctly associated with her employment. *Id.* at ¶38.

The mode of injury in this case, however, differs qualitatively from that in *Steak 'N Shake*. The task the *Steak 'N Shake* claimant performed at the time of her injury was a distinctly job-related task: wiping down restaurant tables. Here, by contrast, Petitioner was injured while discarding a paper towel. In cases where the claimant's injury is triggered by an everyday task that cannot be said to be distinct to the claimant's job, the Appellate Court's most recent precedent dictates application of neutral-risk analysis.

For example, in *Adcock v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130884WC, the claimant was injured while turning in a chair. The Appellate

Court reasoned that the risk associated with turning in a chair "was not 'distinctly associated' with the claimant's employment; rather, it was a neutral risk of everyday living faced by all members of the general public." *Adcock*, 2015 IL App. (2d) 130884, ¶33. In a similar case, *Noonan*, 2016 IL App (1st) 152300WC, the claimant was injured after he fell from his chair trying to reach for a pen he had dropped. The Appellate Court rejected the claimant's argument that his reaching for the pen was an act in furtherance of his duties and thus led to an employment-related risk, because the act of "reaching for a dropped item while sitting in a chair" was not "distinctly associated" with his employment (*Noonan*, 2016 IL App (1st) 152300WC, ¶21) but instead was a risk that he "would have been equally exposed to apart from his work for the employer" (*Noonan*, 2016 IL App (1st) 152300WC, ¶27). Thus, the Appellate Court applied a neutral-risk analysis. *Id.* at ¶27. In so doing, the court distinguished prior employment-risk cases that presented risks more closely associated with and distinct to the claimants' jobs:

> "Further, the facts in [*Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC, *Autumn Accolade v. Illinois Workers' Compensation Comm'n*, 2013 IL App (3rd) 120588WC, and *O'Fallon School District No. 90 v. Industrial Comm'n*, 313 Ill App. 3d 413 (2000)] each show that the claimant was performing acts his or her employer might reasonably have expected the claimant to perform when fulfilling his or her job duties—a parts inspector reaching into a box to retrieve a part for inspection (*Young*), a caregiver reaching to remove a safety hazard while holding onto an individual in the shower (*Autumn Accolade*), and a hall monitor turning and twisting to pursue a running student (*O'Fallon*)." *Id.* ¶26.

Based on this precedent, the risk that led to Petitioner's injury in this case—her turning to discard a paper towel—was an everyday occurrence that cannot be considered distinct to her employment even if it was undertaken in furtherance of her employment duties. Thus, the Commission must reject Petitioner's argument that her injury be considered the result of an employment-related risk.

Petitioner also argues that, if her injury is not the result of an employment-related risk, it nevertheless arose out of her employment with Respondent because it was a neutral risk to which she faced greater exposure than the general public. " 'Injuries resulting from a neutral risk generally do not arise of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public.' " *Noonan*, 2016 IL App (1st)152300WC, ¶19 (quoting *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014 (2011)). " 'Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public.' " *Id.* (quoting *Metropolitan*, 407 Ill. App. 3d at 1014). For

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example, in *Adcock*, the Appellate Court found an increased risk where the claimant undertook the everyday action of maneuvering in his chair on a "non-stop" basis. *Adcock*, 2015 IL App (2d) 130884WC, ¶34.

In this case, Petitioner offered no evidence that her job exposed her to any quantitatively or qualitatively unusual risk of injury due to turning to discard a paper towel. Although she points out in her brief that she was required to wash her hands (and incidentally required to discard her paper towel), she offers no evidence to quantify her exposure to this risk. In fact, her testimony establishes that she mopped the kitchen floor—the act she says triggers her duty to wash her hands—only once per shift, at the end of her workday. As a result, Petitioner has not carried her burden to establish that her job somehow gave her quantifiably greater exposure to the hand-washing or paper-towel-discarding risk. Neither did Petitioner offer any evidence to establish that her workplace somehow added a qualitative dimension to the risk. For these reasons, the Commission must find that Petitioner failed to carry her burden to show that her injury arose out of and in the course of her employment.

Petitioner also argues that the arbitrator erred in finding that she did not suffer a repetitive trauma injury, with a later onset date, as a result of her work. However, as the arbitrator observed, Petitioner offered no evidence that her injury was the result of repetitive trauma. For that reason, Petitioner's argument must be rejected.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/13/2016 is modified as stated herein.

DATED: JUL 25 2017
o:6/26/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOEHLER, DEDRA
Employee/Petitioner

Case# **14WC016584**

15WC014071

MURRAY CENTER
Employer/Respondent

17IWCC0471

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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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BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 13 2016

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0471

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEDRA KOEHLER
Employee/Petitioner

v.

MURRAY CENTER
Employer/Respondent

Case # **14** WC **16584**

Consolidated cases: **15 WC 14071**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nowak**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **11/5/2015**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 _____

17IWCC0471

FINDINGS

On **3/29/14**, 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.

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

In the year preceding the injury, Petitioner earned **$45,120.21**; the average weekly wage was **$867.70**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to establish that she sustained accidental injuries which arose out of and in the course of her employment on 3/29/14 benefits are denied.

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

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

Michael K. Nowak, Arbitrator

9/2/16
Date

OCT 13 2016

ICArbDec p. 2

FINDINGS OF FACT

Petitioner has two cases pending against Respondent. 14 WC 16584 alleges a single traumatic accident of March 29, 2014. (AX. 1) 15 WC 14701 alleges repetitive trauma injuries with a manifestation date on May 1, 2014. On the date of hearing the cases were consolidated without objection. The issues at trial were accident, causal connection, liability for medical costs, TTD, and Nature and extent of the Injury in both cases. In addition, notice was in dispute in 15 WC 14071.

Petitioner testified that she works at the Warren G. Murray Center where she has been employed since May 1st of 2008. At the time of her injury Ms. Koehler was working as a cook, and had been working in that position for about a year.

Petitioner testified that the kitchen was about half the size of football field. (T. 16) The kitchen included several different locations where materials were stored including a walk in cooler, freezer, ovens, and dry storage. (T. 16-17) As part of her job Petitioner was required to move from spot to spot gathering all the materials that were needed to prepare food for that day. (T. 16-17) Petitioner testified it was a fast paced job that required her to be on her feet and move around a lot. (T. 18) Her position also required a lot of lifting and carrying. (T. 17) After serving meals, Petitioner was required to clean up; moving all the pans to the dish room, cleaning all the tables, prep tables, stoves, and steam kettles. (T. 18-19) Petitioner would then sweep and mop the kitchen floor. (T. 19) Petitioner testified that her duties required her to be on her feet six hours out of her seven and a half hour day. (T. 20) Petitioner spent two to two and a half hours out of her day bending and squatting. (T. 20) Petitioner only spent one hour to one and a half hours of her workday sitting down or resting. (T. 20) Petitioner testified that when she got home from work after a typical day her feet and legs would be "tired, achy, and hurt." (T. 20)

Prior to March 29, 2014, Petitioner had been treating with chiropractor Dr. Michael Bowman for adjustments to her back. (T. 22) On March 25, 2014, Petitioner attended a regularly scheduled appointment with Dr. Bowman. (T. 22) On that date, Petitioner reported to Dr. Bowman that she had been having pain in her right knee for a couple weeks. (PX. 3) Petitioner testified that she was experiencing an "aching, dull pain behind her right knee" at that time and rated the pain a 2 out of 10. (T. 22-23) The medical record from this visit indicates that being on her feet for long periods of time made the pain worse, while resting with her leg up made the pain better. (PX. 3) The record further indicates that Dr. Bowman discussed the possibility of a Baker's cyst or degenerative joint disease of the knee with Petitioner. Petitioner testified that she had no injuries or treatment to her right knee prior to the March 25, 2014 visit with Dr. Bowman. (T. 25)

Four days after this visit to Dr. Bowman, on March 29th, 2014, Petitioner was working her regular duties as cook at Murray Center. (T. 25) Petitioner testified she had been at work for six and a half hours before the injury occurred. (T. 25) Petitioner had been on her feet for a majority of this time. (T. 25-26) Petitioner testified she had just mopped the floor, changed the mop head, and washed her hands. (T. 26) Petitioner went to throw a paper towel away after washing her hands, turning to her left toward the trash can, when she heard her right knee pop and felt a "very sharp pain" in the knee. (T. 26-28) Petitioner testified that she almost fell over having to catch herself on the sink because she could not put any weight on the knee. (T. 27) She testified that the pain was located behind and on the inside of her right knee, facing the interior. (T. 27) Petitioner rated the pain 10 out of 10, and stated it was a different pain than she had experienced prior to the accident. (T. 28)

A co-worker, Melodie Hall, witnessed the accident and reported it to their supervisor. The supervisor called a nurse on staff and Petitioner was directed to go to the emergency room at St. Mary's Hospital. Petitioner was rolled out of the facility in an office chair to a vehicle where co-worker Melodie Hall took her to the emergency room. (T. 30)

X-rays were performed at the emergency room at St. Mary's and Petitioner was diagnosed with a ruptured Baker's cyst. (PX. 2) Petitioner's leg was wrapped in ace bandages and she was given crutches. (PX 2) Petitioner was taken off work for three days. (PX. 6) Petitioner testified after leaving the hospital she could not put any weight on the knee and was directed to stay off it. (Tr. 30-31)

A Notice of Injury was filled out by Petitioner on March 29, 2014, and was received by Murray Center on April 3, 2014. (PX. 1)

On March 31, 2014, Petitioner returned to Dr. Bowman to have her knee evaluated. The record from this date indicates that Petitioner presented on crutches with swelling to both the anteromedial aspect and posteromedial aspect of the right knee. (PX. 3) She was diagnosed with internal derangement of right knee and a referred for an MRI. (PX. 3). She was taken off work until April 7, 2014. (PX. 6)

On April 4, 2014, Petitioner followed up with Dr. Bowman. (PX. 3) The record on this date indicates that Petitioner was off of crutches but notes swelling in the right knee and pain rated 6 out of 10. (PX. 3) This record indicates that Petitioner "still awaits the MRI – contingent on W/C." (PX. 3) Petitioner was taken off work until April 14, 2014. (PX. 6) Petitioner testified that she returned to Dr. Bowman for physical therapy for the right knee a few times before the MRI was taken. (T. 32-33) Petitioner was issued off work notes extending through this time. (PX. 6)

On April 4, 2014, Petitioner underwent an MRI of the right knee at InMed Diagnostic Services. (PX. 4) The MRI revealed fluid interspersed along the anterior aspect of the anterior cruciate ligament and "is noted suspicious for a partial tear…" (PX. 4) There was an increased signal in the posterior cruciate ligament and notes "It could represent a strain of that structure." (PX. 4) The MRI also indicates a slight elevation of the meniscus off of the anterior aspect of the tibia along the lateral aspect of the knee joint, and a possible contusion in the anterior aspect of the tibia. (PX. 4)

On April 21, 2014, Dr. Bowman referred Petitioner to Bonutti Clinic for evaluation and treatment. (PX. 3) Petitioner's first of two visits at Bonutti Clinic occurred on May 1, 2014. (PX. 5) Petitioner treated with physician's assistant Nickolas Williams. Upon reviewing the MRI, Mr. Williams noted edema in the intercondylar notch where the ACL attachment suggesting a grade I ACL sprain and questionable medial meniscus tear. (PX. 5) This record states "…this very likely is indeed a work related injury because of the new fluid collection around her ACL in ACL attachment site and intercondylar notch. In addition to this, there is a questionable medial meniscal tear." (PX. 5) Mr. Williams noted tenderness with Clarke compression. (PX. 5) The Arbitrator notes that this entry does not discuss repetitive stress to the knee, but instead indicates the condition is related to the incident on March 29, 2014. Further, even assuming Mr. Williams was referring to repetitive job duties as the source of Petitioner's condition, there is no description of Petitioner's job duties contained in the medical record. Mr. Williams simply states she worked as a cook. Petitioner was ordered to do physical therapy and was taken off work another 2-3 weeks, with a potential recommendation for injection or

arthroscopy if she failed to improve. (PX. 5) Petitioner continued physical therapy with Dr. Bowman through May 16, 2014. (PX. 3) Records through this period indicate that Petioner's condition was improving. (PX. 3).

On May 16, 2014, Petitioner phoned Bonutti Clinic and reported that she felt 80% better. (PX. 5) Physician's assistant, Nick Williams, extended her physical therapy and gave a return to work date for June 5, 2014. (PX. 5; PX 6) Petitioner testified she returned to work on this date. (T. 36) This is first date Petitioner had worked since the date of injury. (T. 36)

Petitioner continued her physical therapy with Dr. Bowman, and on June 12, 2014, Dr. Bowman ordered her to return as needed. (PX. 3) Petitioner returned to Dr. Bowman one final time on November 7, 2014. (PX. 3) The record on this date indicates that Petitioner was returning for a re-evaluation of her knee due to a mild exacerbation from work activities. (PX. 3) She was referred to Bonutti Clinic. (PX. 3)

Petitioner's second and final visit to Bonutti Clinic occurred on January 27, 2015. (PX. 5) These records note that Petitioner was still experiencing some slight instability in her right knee from time to time, "but it is very well tolerable." Petitioner was placed at maximum medical improvement. (PX. 5)

Petitioner testified that after returning to work she bid on and was transferred to a new position, property and supply clerk. Petitioner testified the main reason she wanted to transfer to this position was because of the injury to her knee and to avoid being on her feet so much. She stated, "It is a less paying job, but it is also less time on my feet." (T. 40) She testified that in her new position she is on her feet about half the time she was when she was a cook. (T. 40)

CONCLUSIONS

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of her employment. At the time of her injury, Petitioner was working in the kitchen on Respondent's premises. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of his employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. 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. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute,* 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

In this case, the Petitioner had finished washing her hands and simply turned to discard the paper towels into a trash container. There is evidence in the record tending to show that the she suffered from a physical condition prior to the accident. On March 25, 2014, four days before the alleged accident of March 29, Dr. Bowman had discussed the possibility of a Baker's cyst. When she went to the emergency department on the day of the alleged accident she was diagnosed with a ruptured Baker's cyst. This would seem to be, at least arguably, a risk personal to the employee. The risk associated with turning to throw paper towels away is clearly not a risk distinctly associated with employment as a cook. More compelling is the conclusion that the risk associated with risk associated with discarding paper towels is neutral in nature. See *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Injuries resulting from a neutral risk do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

While Petitioner asserts that the amount of time she spent on her feet created a quantitatively greater risk than that faced by the general public, there is not medical evidence to suggest that Petitioner's right knee injury is any way related to the amount of time she spent on her feet. Although PA Williams wrote "...this very likely is indeed a work related injury because of the new fluid collection around her ACL in ACL attachment site and intercondylar notch. In addition to this, there is a questionable medial meniscal tear," this simply indicates his opinion that the condition he diagnosed was related to the incident which occurred on March 29. It is not dispositive in determining whether an "accident" occurred under the Act. There is no evidence in the record to indicate Petitioner was exposed to any risk greater than that faced by the public at large. Turning to discard paper towels after washing ones hands is a risk to which the general public is exposed daily.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent on March 29, 2014. Benefits in 14 WC 16584 are therefore denied.

Likewise the record is bereft of any evidence indicating that Petitioner's condition is a result of repetitive trauma in any form. The Arbitrator further finds Petitioner has failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent on May 1, 2014. Benefits in 15 WC 14071 are therefore denied.

Because Petitioner failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent all other issues are moot.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Albright,
Petitioner,
vs.

NO: 14 WC 30055

17IWCC0470

John Deere,
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 May 3, 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 $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: JUL 21 2017
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALBRIGHT, DAVID
Employee/Petitioner

Case# **14WC030055**

JOHN DEERE
Employer/Respondent

17IWCC0470

On 5/3/2016, 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 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
ROBERT PAWLOWSKI
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0077 BOZEMAN NEIGHBOUR PATTON ET AL
DANIEL F HARDIN
1630 FIFTH AVE PO BOX 659
MOLINE, IL 61265

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID ALBRIGHT,
Employee/Petitioner

v.

JOHN DEERE,
Employer/Respondent

Case # 14 WC 30055

Consolidated cases: ____

17IWCC0470

An *Application for Adjustment 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 **Rock Island, Illinois** 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 ____

17IWCC0470

FINDINGS

On **June 3, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$71,808.36**; the average weekly wage was **$1,380.93**.

On the date of accident, Petitioner was **59** 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 **$1,465.40** for other (non-occupational) benefits, for a total credit of **$1,465.40**. Respondent is entitled to a credit of **$1,598.21** under Section 8(j) of the Act. Having found Petitioner failed to prove accident and that he failed to prove causal connection, all remaining disputed issues are hereby considered ***moot***.

ORDER

Petitioner failed to prove he sustained an accident arising out of and in the course of his employment. Further, Petitioner failed to prove his bilateral carpal tunnel and bilateral ulnar nerve entrapment are causally related to any repetitive trauma. All claims for compensation is hereby ***denied***.

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

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

Signature of Arbitrator

5-2-2016
Date

MAY 3 - 2016

17IWCC0470

FINDINGS OF FACT

David Albright ("Petitioner") testified that he worked as a quality inspector for John Deere ("Respondent") and was hired in August of 2003. He explained that his job as Inspector consisted of numerous tasks and duties, but foremost was to ensure Respondent's client received a quality product.

In doing so, Petitioner testified that for every inspection there is approximately 300 "touches." These "touches" include, but are not limited to, checking the quality of the welds, paint, detail quality, electrical connectors, electrical harness routing, pneumatic connectors, hydraulics, all the fittings and hosing and the accompanying devices they go into, and ensuring that every single connector on the planter such as bolts, screws, nuts, and washers are properly secured (T. 10). Petitioner testified that he would physically touch the planter in order to do his inspection. For instance, he would turn a bolt to make sure it was accurately seated, he would pull a lock back to ensure to is properly locked into position, he would twist the connect cufflinks to ensure they wouldn't blow off, and touch other connectors to ensure they were properly seated (T. 11). Petitioner also stated that to check certain hose fittings, he would have to grab the hose, twist it 18 degrees, and pull back to ensure it was seated properly (T. 11). Specifically, as to "hoppers," Petitioner testified he would touch, twist, and move, all 80 screws on that "hopper" (T. 13). Petitioner testified that when doing an inspection, he was not required to touch each planter in the manner that he did, but did so because that was the way he was trained to do an inspection by Larry Richardson and Beth Stokes (T. 33).

Petitioner's supervisor, Kelly Dolan, ("Dolan") testified on behalf of Respondent. She confirmed Petitioner's job duties and said Respondent was aware of the manner in which Petitioner performed his inspection and Respondent did not have any problem with it (T. 48). Nolan testified she believed Petitioner did excellent work and was a good and hard worker for the Respondent (T. 49).

The job description for Respondent's Inspector position was admitted into evidence. Rx2. Duties included checking quality of parts, subassemblies, complete assemblies and/or production gauges to specifications imprints and reporting findings for the terminating corrective and preventive action. Types of machines, tools and equipment used or operated varied by specific duties. These included but was not limited to gauges, measuring equipment, material handling equipment, blueprints, engineering and manufacturing specifications and various hand tools. Regarding job details, it was noted an Inspector inspects, accepts or rejects parts for accuracy, fit and finish by using various measurement equipment and processes. The inspector also records and maintains information. The Inspector also performs special investigations to determine causes and solutions to quality issues. An inspector also inspects production gauges for conformance to specifications. An Inspector also makes adjustments to gauges and equipment. The inspector records data and or keeps records for quality, maintenance and or preventative maintenance. The inspector also cleans work area and performs other miscellaneous duties inherent to the job. Employment records confirm Petitioner began his position as an Inspector around March 2009. Rx1.

Petitioner testified that near the end of May of 2014, he awoke from his sleep with an unknown sensation in his right arm (T. 14). When he woke up, Petitioner noticed his right arm was sticking straight in the air (T. 15). In addition to the weird placement of his arm, Petitioner felt numbness in his fingers and a sensation similar to a bug or a spider crawling underneath his skin up his right arm (T. 15). During this time, Petitioner also felt that his skin was sore from his right fingertips particular through his palm, wrist, elbow, shoulder, and scapula region (T. 15).

On 5/23/14, Petitioner went to see his primary care physician, Dr. Thomas Ade. Px4. Petitioner reported spasms in both of his hands. Positive right Tinel's was noted. A splint was recommended and an EMG/NCV

was ordered. On 6/3/14, EMG/NCV showed bilateral carpal tunnel entrapments, mild to moderate on the left and moderate on the right. There was also evidence of bilateral ulnar neuropathies at the elbows. Px1.

On 6/9/14, Petiioner presented to OHS and informed them his symptoms began 2 years prior. Rx3. On 6/10/14, Petitioner was seen by Dr. Milas for an initial evaluation. Px2:58. Petitioner reported a history of ongoing pain and numbness affecting his upper extremities. In particular, Petitioner had numbness and pain causing him to awaken at night, and had weakness in both hands, with the right being affected more than the left. Dr. Milas diagnosed bilateral carpal tunnel entrapment and bilateral ulnar nerve entrapment at elbow level. *Id.* at 59. The doctor noted Petitioner wanted to run his treatment through workers' compensation. Then, Dr. Milas opined that due to Petitioner's use of his upper extremities, he believed Petitioner's current state of ill-being was related to his job. *Id.* On 6/13/14, Petitioner presented to OHS and stated his symptoms began 4 years ago. Rx4.

On 6/18/14, Dr. Milas' office received a fax from John Deere's Carolyn Ferguson RN, stating "following investigation from safety department, this employee's bilateral hand complaints are not taken as work related." Px2:54. On 6/19/14, Petitioner returned to Dr. Milas. Px2:47. The doctor noted a 6 month history of pain and numbness affecting both upper extremities. Petitioner reported increased pain in his right extremity, so much so, that Dr. Milas noted that Petitioner was signing documents in his office with his left hand, even though Petitioner is right hand dominant. *Id.* Due to the great difficulty Petitioner was having, Dr. Milas reiterated his recommendation for carpal tunnel release and right ulnar nerve decompression. *Id.*

On 7/3/14, Petitioner underwent and Dr. Milas performed a right carpal tunnel release and decompression of right ulnar nerve at the elbow level at Trinity Medical Center. Px2:23. On 7/8/14, Dr. Milas noted that Petitioner had excellent relief from the surgery but noted some blisters in the ulnar area of Petitioner's right hand. Px2:35. Benadryl was prescribed. On 7/17/14, Petitioner returned to Dr. Milas, reporting excellent improvement of symptoms. Px2:19. The plan was for 4 weeks of physical therapy for the right carpal tunnel release and right ulnar nerve decompression.

On 7/22/14, Petitioner began physical therapy at Rock Valley Physical Therapy. Px3. Under history of injury was noted Petitioner started noticing hand weakness and arm pain about three months ago. He reported some tingling in the right hand in the 4th and 5th digits. He reported his arm pain was gone and that his primary complaint was that his right hand was not as strong as it used to be. It was noted that he had minimal writing use in which uses his left hand. He was noted to be independent with grasping, gripping, lifting and object manipulation although it required more time. Chief complaint was weakness. He was noted to be ambidextrous. The mechanism of injury noted was "gradual onset weightlifting."

On 7/24/14, Petitioner returned to Dr. Milas. Px2:17. Petitioner expressed his desire to return back to work. Dr. Milas released Petitioner to work effective 7/28/14. *Id.* On 7/29/14, Petitioner returned for physical therapy. Px3. He continued to report some right hand tingling, specifically in digits 4th and 5th. His arm pain was gone. The plan was to continue with regaining 4th and 5th digit dexterity. On 8/5/14, Petitioner returned to therapy. Px3. Petitioner reported no pain at that time and no difficulty in performing work tasks. He noted a slight increase in discomfort after highly repetitive work such as gardening, cooking but improvement after short rest break. Also noted was 1-2% numbness in the 4th and 5th fingers on the right hand.

On 8/8/14, Petitioner followed up with Dr. Milas. Px2:15. The wound area was well healed but had hyperkeratosis skin surrounding the incision site. Hand soaks, Doxycycline and to follow-up were ordered.

On 8/12/14, Petitioner no-showed his physical therapy appointment. Px3. On 8/13/14, Petitioner saw Dr. Milas. Px2:14. The doctor removed a small extruding suture. Petitioner was ordered to follow up as needed. On 8/26/14, Petitioner no-showed his physical therapy appointment. Px3.

On 8/28/14, Rock Valley Physical Therapy issued a summary of treatment. Px3. End diagnosis was right carpal tunnel release. Therapists noted Petitioner had no complaints of pain and was able to perform all work tasks and activities at home without symptoms. He demonstrated functional wrist motion and strength in all planes without symptoms. He had not shown for the two most recent appointments. Petitioner elected to self-discharge.

On 3/31/15, Petitioner was evaluated at the request of Respondent by Dr. Deignan. Rx3. He gave a history of work as an inspector and claimed that his symptoms must come from his previous job as a welder, since inspection only involves touching. He related symptoms going back 3 years. The doctor did not believe his job as an inspector caused his conditions. The doctor also provided an impairment rating.

On 5/8/15, Dr. Milas re-examined Petitioner and reviewed a job description in conjunction with a narrative report. Px2:5-7. Dr. Milas reiterated his opinion to a medical degree of certainty that Petitioner's condition of bilateral carpal tunnel syndrome and bilateral ulnar nerve entrapment were a direct result of Petitioner's work for Respondent. He noted Petitioner reported pain, numbness and weakness in the upper extremities beginning March 2014. On 2/18/16, Dr. Milas wrote an addendum addressing a clerical error in which he stated that Petitioner had been working for as a welder for the past 7-8 years, when in fact he had been working as an inspector for said time period.

Respondent also submitted at trial records from OHS indicating that Petitioner had right elbow complaints in 2010. Rx3.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner testified at the hearing. The Arbitrator found Petitioner's demeanor to be friendly and forthcoming. However, Petitioner's testimony regarding his job duties as they relate to the foregoing issues was not persuasive on the disputed issues as more fully explained below. Kelly Dolan also testified on behalf of Respondent. The Arbitrator finds her testimony credible on Petitioner's job duties as an inspector.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner alleges bilateral carpal tunnel and ulnar nerve compression resulting from his repetitive job duties as an Inspector for Respondent. Based on a preponderance of the evidence, the Arbitrator concludes Petitioner failed to prove he sustained an accident arising out of and in the course of his employment and further that his condition of ill-being is causally related to any alleged injuries occurring at work.

Petitioner's testimony regarding his job duties failed to specify which part(s) of his job duties were responsible for his bilateral carpal tunnel and/or bilateral ulnar nerve entrapment. He testified at length that his job as an Inspector involved various duties which he described as "touches" whereby he physically touched or handled various parts of machines during inspection. However, none of the touches were identified as responsible for any symptoms or as causing any symptoms. For example, Petitioner testified part of job involved twisting a bolt and another example involved turning a lock. He did not state how he used his hands or elbows in

these tasks, he did not state whether he pinched, gripped or otherwise used force. He did not say how much or how often he performed each duty and/or each touch. It does not appear he related any specific task, symptom or manipulation to Dr. Milas when Dr. Milas first opined a causal connection nor when Dr. Milas issued his narrative report. Dr. Milas simply concluded that Petitioner use of his upper extremities at work in a repetitive fashion caused his conditions.

Additionally, the Arbitrator notes inconsistencies in the record with respect to Petitioner's cause of his symptoms. In the physical therapy initial evaluation, the mechanism noted was gradual and as weight lifting. Such a notation belies Petitioner's claims of accident and Petitioner did not address this at trial. In another example, Dr. Milas noted Petitioner's symptoms were so "severe" such that Petitioner was using his left hand to write. Dr. Milas noted Petitioner was right handed. However, the physical therapy initial evaluation wrote that Petitioner was ambidextrous. There are also numerous conflicting histories as to when Petitioner's pain and/or symptoms began. Petitioner alleged a date of accident of 6/3/14. Ax1. In Dr. Milas' narrative report, Petitioner reported pain beginning March 2014. Px2. However, Petitioner testified his pain began May 2014. The physical therapy initial evaluation record says Petitioner's symptoms began 3 months prior to July 2014 or May 2014. The 6/19/14 note from Dr. Milas indicated a history going back 6 months, which would be January 2014 or slightly earlier. Petitioner told Dr. Deignan he had symptoms going back 3 years. Petitioner told OHS his symptoms began both 2 and 4 years prior to 2014, which would be both 2010 and 2012. Rx3. Petitioner did not address these discrepancies at trial. Finally, Petitioner's position at trial was that his job as an inspector resulted in his injuries. However, he related to Dr. Deignan that he believed his conditions were caused by his prior job as a welder. Rx3. Petitioner did not address this discrepancy at trial.

Thus, Dr. Milas' opinions regarding accident and causation are based on an inaccurate understanding of Petitioner's mechanism of injury, an incorrect understanding of Petitioner's hand dominance and an incomplete understanding of Petitioner's job duties and how they contributed to or caused Petitioner's conditions.

Based on the foregoing, the Arbitrator concludes that Petitioner failed to prove he sustained an accident arising out of and in the course of his employment with Respondent. Further, the Arbitrator concludes that Petitioner also failed to prove that his diagnosed bilateral carpal tunnel syndrome and bilateral ulnar nerve entrapment were caused by any alleged repetitive trauma. All claims for compensation is hereby denied.

ISSUE (J) ***Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?***
ISSUE (K) ***What temporary benefits are in dispute?***
ISSUE (L) ***What is the nature and extent of the injury?***

Having concluded Petitioner failed to prove accident and having further concluded that Petitioner failed to prove his bilateral carpal tunnel syndrome and bilateral ulnar nerve entrapment are work related, all remaining issues are hereby considered moot.

Signature of Arbitrator

5-2-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick McDougall,
Petitioner,

vs.

ABF Freight Systems,
Respondent.

17IWCC0444

NO: 14 WC 35603

DECISION AND OPINION ON REVIEW

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

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

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

DATED: JUL 14 2017
o6/29/17
KWL/rm
046

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0444

McDOUGALL, PATRICK
Employee/Petitioner

Case# **14WC035603**

ABF FREIGHT SYSTEMS
Employer/Respondent

On 6/29/2016, 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 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0444

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

Patrick McDougal
Employee/Petitioner
v.
ABF Freight System
Employer/Respondent

Case # 14 WC 035603

An *Application for Adjustment 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 **February 9, 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 **§ 25.5 Finding**

17IWCC0444

FINDINGS

On **September 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* sustain an accident that arose out 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 **$47,736.00**; the average weekly wage was **$918.00**.

On the date of accident, Petitioner was **62** 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 **$309.55** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$309.55**.

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

ORDER

Respondent shall pay Petitioner **temporary total disability benefits** of **$612.00 per week for 28-2/7 weeks, commencing 10/21/2014 through 5/7/2015**, as provided in **Section 8(b) of the Act**.

Respondent shall pay **reasonable and necessary medical services**, pursuant to the medical fee schedule, of **$187.00 to Fox Valley Orthopedics, $66,762.54 to Orland Park Orthopedics, $27,725.40 to South Chicago Surgical Center, $2,475.00 to Bob Rady, Inc., $250.00 to Dr. Chandra, and $259.00 to Dr. Malinski**, as provided in **Sections 8(a) and 8.2 of the Act**.

Respondent shall pay Petitioner **permanent partial disability benefits** of **$550.80 per week for 60 weeks**, because the injuries sustained caused the **12% loss of the person as a whole**, as provided in **Section 8(d)2 of the Act**.

Respondent shall pay Petitioner the compensation benefits that have accrued from 9/10/2014 through 2/9/2016, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

June 23, 2016
Date

JUN 29 2016

FINDINGS OF FACT

Petitioner, Patrick McDougall, is employed as a dockman/spotter for Respondent, ABF Freight System. He has been so employed fulltime since 1993, having started part-time in 1991. Petitioner's job duties include hooking and unhooking tractors to trailers, moving trailers to and from docks and loading and unloading freight, by forklift or by hand. He testified "more likely you are lifting 50, 60, 70 pounds at a time" but the weights could be over 150 pounds.

Petitioner felt great before work on September 10, 2014. He had no difficulty with his right shoulder and had no significant medical care to his right shoulder before that date. Petitioner did have a severe motorcycle accident about five years beforehand when he injured much of the left side of his body, including his left arm. He did not injure his right shoulder in the motorcycle accident.

On September 10, 2014, Petitioner worked a shift that began on the afternoon of the 10th and ended on the morning of the 11th. He was unloading a trailer that had pallets with long metal freight that was 18 feet long and weighed between 50 and 60 lbs. He testified that it was difficult to get leverage and he was in awkward positions. He was moving one of these pieces and felt a sharp pain in his right shoulder. He went to his locker to get some ibuprofen and was away from the trailer for about three to four minutes. He then came back and unloaded until his lunch break. After break, a co-worker was available to help Petitioner finish unloading the long freight from the trailer.

Petitioner gave a statement to Phillip Scoggins, an adjuster, on October 14, 2014. Mr. Scoggins asked about an accident on the 11th. Petitioner said, "The incident actually happened on the 10th, and the paperwork was written up on the 11th." Petitioner was asked to describe what happened and he stated, "I was moving some long pieces of freight from one trailer to another, restacking it, and as I pulled on a long box, I felt something in my shoulder, but you feel things quite often, so I didn't think too much of it. We were busy at the time, so, I just continued working." He estimated to Mr. Scoggins that the box was 16 feet long. He also told Mr. Scoggins about getting the ibuprofen. Petitioner told Mr. Scoggins that he is right handed. (Rx #10)

Petitioner told the midnight shift supervisor, Chris, that his shoulder hurt and why it hurt. Petitioner finished his shift on September 10/11, 2014 and went home. He did not seek medical treatment at that time, although his shoulder hurt.

Petitioner's next shift began at 5pm on September 11, 2014. He spoke with a supervisor, James Harding. He had the conversation just before Mr. Harding's shift ended at midnight. He told Mr. Harding about the accident and said he would see how things went over the weekend. Petitioner testified that Mr. Harding filled out an incident report before midnight on September 11. Petitioner and the other supervisor, Chris, were present when Harding typed up the report. Petitioner had pain and difficulty sleeping over the weekend. He did not seek medical care over the weekend. Petitioner reported to work at 5pm on Monday, September 15, and said he needed medical care. He was sent to Advocate Occupational Health.

The record from Advocate Occupational Health Center shows a visit on September 15, 2015, wherein the history was of Petitioner injuring his shoulder lifting freight on September 12, 2015. The record notes three days since the onset of symptoms and that Petitioner had difficulty sleeping. Petitioner testified that the doctors at Advocate wanted to give him work restrictions, but he persuaded them to allow him to return to full duty.

Respondent was short handed at that time. Petitioner was released to full duty. The supervisors agreed to limit Petitioner's lifting tasks.

Petitioner continued to treat at Advocate and his condition was documented as a work related injury for the next month. The diagnosis was right trapezial strain that was work related. At the September 30, 2014 visit, the doctors at Advocate prescribed an MRI. This test was done at Royal Open MRI on October 9, 2014 and revealed a tear of the supraspinatus tendon. At the October 13, 2014 visit, the doctors at Advocate recommended an orthopedic referral to see if surgery was necessary. Petitioner was given a restriction of no lifting above 5 lbs. (Px #1)

Petitioner began working in Respondent's Alternative Work Program (a modified duty program designed to keep injured employees engaged in the workplace), doing sweeping and clean-up on the dock.

Petitioner chose to see Dr. Vishal Mehta of Fox Valley Orthopedic Institute. He saw the doctor on October 20, 2014. The doctor's chart shows a date of accident of September 11, 2014 where Petitioner felt a sudden jerking of the right shoulder while lifting freight. Dr. Mehta reviewed the MRI and recommended surgery. He released Petitioner to work with restrictions of no lifting over 10 lbs. and no lifting over the shoulder. A nurse case manager was present. (Px #2)

Petitioner was given a note with the 10 lb. restriction. Petitioner testified that he brought that note to work on October 21, 2014. He testified that Greg Cutsinger and Rick Arsenic were in a room and he put the doctor's note contained in Petitioner's Exhibit 5 on Rick's desk. He spoke with Cutsinger and Arsenic about the fact that surgery was likely and they may need to rebid his job because he would be off work for several months. Petitioner testified that he did not discuss the restrictions with them. Petitioner denied altering the doctor's note and denied handing anybody a note with a 2 pound restriction. Petitioner testified that the restricted work duties that he was doing for Respondent involved picking up air bags which weighed about 5 ounces, pushing a broom with his left hand, and picking up pieces of garbage with his left hand. Petitioner testified that there would be no difference between working with a 2 lb. or 10 lb. restriction. Petitioner testified that his significant other faxed the note with the 10 lb. restriction to his lawyer. Petitioner's Exhibit 5 contains that note along with a fax cover page dated October 21, 2014 directed to Petitioner's attorney's office. The work restriction is noted to be 10 pounds. After the conversation, Greg went out to check the dock and Petitioner went to perform the same work he had been previously performing.

Gregory Cutsinger, the Branch Manager for Respondent in 2014, testified that Petitioner handed him the note and did not place it on a desk. He testified that he glanced at the note and saw that it contained a 2 lb. restriction. He handed the note to Rick, who later put it on Greg's desk. He testified that if there was a 2 lb. restriction there would be fewer duties that an injured worker could be assigned to do.

Radomir (Rick) Arsenic, the Operations Manager for Respondent, testified that Petitioner had handed the note to Greg. He agreed that they mainly spoke about rebidding Petitioner's job and that Petitioner went to perform the same duties he had been performing after the conversation. He agreed that at the time the note was handed over there was no discussion of the specific restrictions. He testified that 2 lb. would mean there were less available jobs for an employee to do. He had never seen a 2 lb. restriction before. He testified Greg gave him the note when Greg left to check the dock. Arsenic testified he put the note on Greg's desk.

Petitioner testified that 2 ½ hours after the conversation with Cutsinger and Arsenic, he was called to the office and confronted with an allegedly altered work restriction note and was terminated. Petitioner filed a grievance. He won the grievance and was reinstated. At the hearing on the grievance, Cutsinger mentioned being handed

the note and giving it to Mr. Arsenic but did not testify at the grievance hearing about looking at the note at that time. Petitioner first said that he gave the note to Rick, but later clarified that he put the note on Rick's desk. The grievance hearing was an informal process, transcribed by a court reporter, not under oath and taken after the parties (Company and Union) took part in a prescreening process. There were 3 labor members and 3 management members on the grievance committee. No evidence of the committee's findings was submitted, other than the fact that the discharge was not sustained. (Rx #5)

Respondent denied the entire claim after the incident regarding the altered work restriction note. Petitioner had no group insurance. Respondent did not pay further benefits and would not authorize treatment. Respondent did not pay Dr. Mehta's bill for the 10/20/2014 date of service. (Px #7)

Petitioner began treatment with Dr. Blair Rhode. Dr. Rhode was on a list that his attorney provided.

Petitioner's first visit with Dr. Rhode was on November 7, 2014. Dr. Rhode gave Petitioner an injection and recommended surgery if there was no significant improvement. Dr. Rhode performed a right rotator cuff repair and subacromial decompression on December 2, 2014. Petitioner was authorized off of work by Dr. Rhode from November 7, 2014 until May 8, 2015. He underwent physical therapy after surgery. Petitioner's last visit with Dr. Rhode's office was on June 5, 2015. (Px # 3)

Dr. Rhode testified via evidence deposition at the request of Petitioner. Dr. Rhode was of the opinion that the lifting incident of September 10, 2014 was a causative factor in Petitioner's shoulder injury, necessitating surgery, lost time and some permanent disability. (Px #3)

Petitioner was examined by Dr. M. Bryan Neal, at the request of Respondent, on February 14, 2015. Dr. Neal testified via evidence deposition. Dr. Neal had a long discussion with Petitioner regarding the circumstances of the accident. Dr. Neal opined that Petitioner experienced a progressive onset of pain in his shoulder, as opposed to the pain being related to one event. Dr. Neal opined that the surgery was not causally related to a work event. Petitioner's shoulder pathology was related to a degenerative condition only. He felt the findings on the MRI could have been preexistent, but admitted there is no documentation of any symptoms in the right shoulder before the accident. (Rx# 7)

Petitioner was released to regular work by Dr. Rhode on May 8, 2015 and has performed his regular job since that time. When it is real cold or damp, Petitioner gets a sharp pain in his right shoulder. There are certain things he does at work that are more difficult such as pulling a pintle hook on a trailer and pulling the fifth wheel release on a trailer. He does this by reaching down under the trailer and lifting a handle, pulling it back and locking into place. He then cranks down the legs. This is a strength move and he has difficulty releasing a pintle hook on the back of the trailer which holds a converter gear. He has difficulty removing a safety chain using a big hook and a locking mechanism. At home he had difficulty stacking and putting away Christmas decorations. He has pain after riding his motorcycle more than 50 miles. His arm starts to fall asleep. He never noticed these things before his work injury.

Respondent offered surveillance that showed Petitioner riding his motorcycle away from work on October 21, 2014, the date of his termination. Respondent also had surveillance showing Petitioner in November, 2014 driving a car at times. In seven days of surveillance there is nothing indicating any activities beyond Petitioner's stated capabilities. There is additional surveillance from April, 2015 describing observations of Petitioner swimming at a gym. This low impact activity is consistent with Petitioner nearing the end of his recovery and working to get himself in the better shape to return to his rigorous job. Petitioner had been released to light work in April, 2015. Respondent did not accommodate the limited duty restrictions. The investigator found

that Petitioner had been to the gym a number of times but had no information as to what Petitioner did at the gym on the other visits. (Rx #'s 4 & 6)

Petitioner's Exhibit 7 was the bills exhibit. Neither Party submitted the incident report that Harding filled out.

CONCLUSIONS OF LAW

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

The Arbitrator observed the demeanor and mannerisms of Petitioner at trial and finds his testimony to be credible. Having considered the testimony of all of the witnesses and having reviewed Respondent's Exhibit 5, the Grievance Hearing transcript, the Arbitrator does not believe that Petitioner altered the off work slip.

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 October 10, 2014, based upon the unrebutted testimony of Petitioner and the medical records. He injured his right shoulder moving freight on that date.

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

Petitioner gave timely notice of the accident, based upon Petitioner's testimony, Cutsinger's testimony, Arsenic's testimony and Respondent's Exhibits 1, 2, 3, 5 and 10.

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

Petitioner's current condition of ill-being regarding his right shoulder is causally related to the injury, based upon Petitioner's testimony, the medical records and the credible and persuasive opinions of Dr. Rhode.

No evidence of any prior right shoulder injuries or treatment was submitted. Dr. Neal's opinion is not persuasive in this case and does not comport with the medical records which do show that Petitioner had an onset of shoulder pain while lifting heavy freight. Petitioner's testimony comports with the medical records and does not lead the Arbitrator to find that Petitioner merely experienced symptoms while working, as Dr. Neal posits. There was a clear nexus between the awkward and heavy lifting that Petitioner was engaged in and the onset of shoulder pain. Dr. Rhode's opinion is correct.

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 medical services that were provided to Petitioner were reasonable and necessary to cure or relieve the effects of the injury and are causally related to the accident of October 10, 2014. Accordingly, the bills claimed in Petitioner's Exhibit 7 are awarded, as set forth in the Order portion of this Decision.

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 is entitled to TTD benefits from October 21, 2014 through May 8, 2015, a period of 28-2/7 weeks. Petitioner was given a work restriction from Dr. Mehta, effective October 20, 2014. Respondent fired Petitioner on October 21, 2014 and refused to accommodate any restricted duty. Dr. Rhode took Petitioner off work, effective November 7, 2014 and released him to work at full duty, effective May 8, 2015.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Thus, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that Petitioner was employed as a dockman/spotter at the time of the accident and he was able to return to work in this occupation. Petitioner

testified that he has some difficulty performing some of his job duties, but he was able to return to work at his normal job. This factor is given some weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 62 years old on the date of accident. This factor is given some weight in determining PPD, as Petitioner will likely have a few years left in the work force and he will have some limitations as a result of his injury.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that Petitioner may be at a risk for a loss of earning capacity due to his injury. The likelihood is that he will continue to work for Respondent until he retires. This factor is given some weight in determining PPD.

With regard to subsection (v) of §8.1b(b), the Arbitrator notes that Petitioner experiences some residuals from the surgery and he will have a scar interface, per Dr. Rhode. This factor is given great weight in determining PPD.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12% loss of use of a person as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (O), § 25.5 FINDING, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds no fraudulent behavior by Petitioner in this matter.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH HENDRICKSON,

Petitioner,

vs.

NO: 15 WC 21892

CATERPILLAR, INC.,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to Respondent's Motion to Supplement the Record of proceedings taken below, on Arbitration; said record having been previously filed on June 14, 2017. The Respondent appeared before Commissioner Brennan on July 14, 2017, at his Chicago Review Call, and requested the entry of an Order consistent with said Motion. And the Petitioner herein offered no objection to said Motion.

Pursuant to said Motion, Respondent alleged that Respondent's Exhibit 2, which contains a three page weekly disability benefit form, is the same document that was offered and admitted into evidence by the Arbitrator at the time of arbitration, but was inadvertently omitted from the transcript of proceedings that was filed on June 14, 2017. Petitioner subsequently filed his response to said motion, indicating that he has no objection to Respondent's Motion.

It is, therefore, the Order of the Commission:

1. That Respondent's Motion is hereby granted. The record is hereby supplemented by the inclusion of Respondent's Exhibit 2, as described above and as attached to Respondent's Motion.

DATED: JUL 21 2017
MJB/tdm
7/18/17

Michael J. Brennan

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 KANKAKEE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cory Wilson,

Petitioner,

17IWCC0443

vs.

NO: 15 WC 2610

Clausen Structures Inc,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

17IWCC0443

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: JUL 14 2017
o6/29/17
KWL/rm
046

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

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

17IWCC0443

WILSON, CORY
Employee/Petitioner

Case# **15WC002610**

CLAUSEN STRUCTURES INC
Employer/Respondent

On 9/28/2016, 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 0.42% 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:

0013 DUDLEY & LAKE LLC
THOMAS M LAKE
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

2965 KEEFE CAMPBELL BIERY & ASSOC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0443

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
19(b)/8A

Cory Wilson
Employee/Petitioner

v.

Clausen Structures, Inc.
Employer/Respondent

Case # 15 WC 2610

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Kankakee**, on **08/18/2016**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **10/21/2014**, 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 **$58,572.28**; the average weekly wage was **$1,126.39**.

On the date of accident, Petitioner was **25** 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 **$22,420.61** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $. ARB EX 1

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

ORDER

Respondent shall pay Petitioner the reasonable, necessary and causally related medical services incurred pursuant to Sections 8(a) and 8.2 of the Act. PX 1.

Respondent shall authorize and pay for the surgery and its attendant care currently recommended by Petitioner's treating physician Dr. Obermeyer pursuant to Sections 8 and 8.2 of the Act.

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

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

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

Caerlyn M. Doherty

Signature of Arbitrator

9/22/2016

Date

SEP 28 2016

ICArbDec19(b)

FINDINGS OF FACT

At trial, the parties stipulated to the issues of accident and notice. ARB EX 1. Petitioner, a 27 year old ironworker, testified that he began working for Respondent, Clausen Structures, Inc. in October 2014 as a union ironworker. On 10/21/14, Petitioner was working on a bridge deck over a highway moving and lifting rebar. His duties required him to climb, lift and carry from 40 to 150 pounds. On 10/21/14, Petitioner was carrying a large piece of steel with another worker. When the co-worker stumbled, the steel began to fall. Petitioner testified that he tried to catch the steel and felt a rip in his left shoulder. Petitioner is right hand dominant. Petitioner further and credibly testified that he had a prior left shoulder dislocation in 2013 which was reduced.

On December 2, 2014, Petitioner's treating physician, Dr. Obermeyer, performed left shoulder surgery including an arthroscopic Bankart repair and repair of the ligaments and debridement of the Type IV superior labrum anterior to superior tear, a Slap tear.

Thereafter, Petitioner attended physical therapy 3 times per week, followed by work conditioning. Petitioner was kept off work by Dr. Obermeyer during PT. Petitioner was paid TTD benefits while off work. ARB EX 1. On May 11, 2015, Petitioner saw Dr. Obermeyer in follow up. Petitioner's physical therapist was present as well. Dr. Obermeyer's records note, "Mr. Wilson is a 26 year old male who presents for post operative evaluation of left shoulder pain. He presents with pain on the left side. He states that the symptoms have been acute traumatic and began on 10/21/2014. .... Currently the patient states that the symptoms are mild. The pain is described as dull. The symptoms occur with activity. The pain does not radiate. The symptoms are aggravated by no specific activity. Cory states that the symptoms are relieved by rest, physical therapy and surgical intervention. He denies having any associated symptoms. The patient has been attending a work conditioning program. He states that he feels that he is ready to return to work. Surgery/procedure: left shoulder videoarthroscopy with labral repair, date: 12/02/2014, time since surgery 5 months 1 week 2 days. "no pain" able to complete 15/15 tasks for return to work." RX 1. Following an examination, Dr. Obermeyer ordered that Petitioner could return "... back to work without restrictions. Physical therapist Jaime accompanied the patient today and believes he will benefit from 4 weeks of additional therapy, ordered. ... he is to schedule a follow-up visit for reevaluation in 3 months. Refer to physical therapy." PX 1, RX 1.

The physical therapy order dated 5/11/15 indicate an ordering diagnosis of "aftercare following surgery; labral tear; shoulder joint instability; shoulder pain." The diagnosis description reads "work hardening program" and the Pt was "3 times per week for 4 weeks therapy to start on or after 5/11/15." The treatment was to include "range of motion, strengthening, modalities PRN, home exercise program." PX 1. A second set of PT orders from Dr. Obermeyer dated 5/12/15 indicates the same ordering diagnosis indicating the surgical procedure had on 12/2/14 and an order for PT 3 times per week for 4 weeks to start on or after 5/12/15. PX 1.

Dr. Obermeyer authored a separate letter "to whom it may concern" dated May 11, 2015. He noted that he discussed Petitioner's job duties and responsibilities with Petitioner and determined that Petitioner could return to "regular work without restrictions" based on Petitioner's condition. He noted "the patient's work status is regular work/activity and may return to work on 5/12/2015." RX 1. Petitioner received TTD benefits through May 18, 2015. ARB EX 1.

Petitioner testified that after surgery Dr. Obermeyer told him he would be in PT for 6 to 8 months. However, Petitioner testified that he "felt better" during his course of post surgical PT and work conditioning. Petitioner testified that during work conditioning he could do the heavy lifting with minimal discomfort because he only did a small amount of lifting. Petitioner testified that he did not engage in activity simulating iron working

while in pt or work conditioning. Petitioner testified that knowing no light duty would be available for an ironworker, Petitioner requested that Dr. Obermeyer release him to full duty. He testified that Dr. Obermeyer agreed he could "give it a try."

Petitioner testified that he had been laid off by Respondent so he found ironwork with another company, Black Swamp, and that he returned to full duty iron work on May 19, 2015, two weeks after his 5/11/15 visit to Dr. Obermeyer. Petitioner testified that during the two weeks after his release and before starting his new job, his shoulder "felt fine." Petitioner testified that immediately upon starting his work at Black Swamp during the first 8 hour day he had pain in his left shoulder. Petitioner testified that was the first day he "pushed" the use of his left shoulder since the surgery. Petitioner testified that he returned to physical therapy within a week of starting work at Black Swamp. He testified that he attended physical therapy for approximately 6 weeks at Newsome while working full duty 40 hours per week. He attended PT 3 days per week after work. Petitioner testified that his pain and discomfort continued but he continued working and took pain medication. Petitioner testified that the Pt did not help his mobility or ability to perform overhead work.

Petitioner completed 6 weeks of physical therapy and then returned to Dr. Obermeyer on August 10, 2015. At that visit, Dr. Obermeyer noted Petitioner was "... presents for evaluation of left shoulder pain. He presents with pain and decreased ROM on the left side. He states that the symptoms have been acute traumatic and began 10 months ago. He indicates the injury occurred at work. He is on Worker's [sic] Comp. The problem is better. The symptoms are aggravated by reaching overhead. Cory states that the symptoms are relieved by ice and physical therapy. Pt reports that that [sic] his shoulder is feeling better, but some stiffness with terminal flexion. He reports that he is full duty at work and able to complete the days work without pain. Denies numbness/tingling/loss of sensation." Following an exam of the left shoulder Dr. Obermeyer noted an impression of "good result following labral repair" and returned Petitioner to full duty without restrictions. Petitioner was instructed to perform "activity as tolerated and therapy; HEP and information on condition given. He is to schedule a follow up visit PRN." PX 1 RX 1.

Petitioner worked for Black Swamp from May through August 2015 and testified that he did not sustain a new accident or injury to his left shoulder. Petitioner testified that his left shoulder problems returned immediately after working the first day for Black Swamp and then gradually increased thereafter while Petitioner continued to work.

Petitioner testified that Black Swamp shut down at end of August 2015 but that he was "set up" with a job at Mega Steel which he started in the Fall 2015. Petitioner returned to Dr. Obermeyer on 9/23/15. At that visit, Dr. Obermeyer noted, "... presents for follow up of left shoulder pain. He presents with pain on the left side. The problem is worse. The patient indicates that the pain is located in the anterior shoulder on the left side. The symptoms are aggravated by moving the arm suddenly and reaching overhead. Cory states that the symptoms are relieved by ice and rest. Pt reports that he started to develop increased left shoulder within the past couple of weeks. Pt was PRN on 8/10/15. PT states that since returning to work he has started to develop left shoulder pain again while at work when he was reaching down and tying boxes about 2 weeks ago. Denies numbness/tingling/loss of sensation. Surgery/procedure: left shoulder videoarthroscopy with labral repair, date:12/2/14, time since surgery: 9 months 3 weeks.

Dr. Obermeyer noted an impression of "recurrence of pain and activity limitation following SLAP repair. Discussed his reinjury and conversion to biceps tenodesis may be a good option if he is unsatisfied with his progress but there is no rush to have this done. Plan continue with use as tolerated, HEP, RTC 3 months." The patient plan was listed as " PT instructed to continued HEP. Discussed biceps tenodesis, pt wished to defer this time. RTC in 3 weeks." Petitioner was prescribed MOBIC.

Petitioner testified that he continued working full duty for Mega Steel. Petitioner returned to Dr. Obermeyer for follow up on December 4, 2015. Petitioner reported stable pain on the left side with mild to moderate symptoms. Petitioner reported the home exercises and the MOBIC did not help and stated "I can't continue my line of work with pain like this." RX 1, PX 1. Dr. Obermeyer noted and impression of "pain after SLAP repair with injury to the biceps root." Dr. Obermeyer noted "plan MR arthrogram. Discussed option of conversion to subpectoral tenodesis. Will plan to call with results of the MRI." He ordered a left shoulder MRI without contrast which was performed on 12/16/15. The findings stated " there are new surgical changes of anterior labral repair. No evidence of a recurrent labral tear. The long head biceps tendon is unremarkable. A chronic Hill-Sachs fracture deformity is similar compared to prior study. No acute fracture is identified. The glenohumeral joint effusion. The inferior glenohumeral ligament is unremarkable. The rotator cuff tendons are normal. No muscle edema or fatty atrophy. There is a type II acromion. No subacromial spur. The coracoacromial ligament is unremarkable. There is no significant acromioclavicular joint osteoarthritis. No significant fluid in the subacromial/subdeltoid bursa." The impression noted "interval glenoid labral repair. No evidence of recurrent labral tear. The rotator cuff is intact."

Petitioner testified that Dr. Obermeyer recommended a second surgery in December 2015 and Petitioner wants to undergo the surgery. He testified that he has continued working full duty at various employers as an ironworker and was so working at the time of trial. Petitioner testified that after working for Mega Steel, he worked for Mayo Structures, Amber Construction and currently with Gateway Construction. Petitioner testified that he continues to taking medication for pain to get through the work day. He states his pain has progressed since December 2015 and wants to have the recommended surgery to resolve his shoulder problem. Petitioner testified that a typical work day requires him to perform overhead movement such as ladder climbing and climbing elevator pits and that he has more problems with mobility than with overhead lifting.

Dr. Obermeyer testified via evidence deposition on June 8, 2016. PX 1. Dr. Obermeyer testified that he performed left shoulder surgery on 12/2/14 including a Bankart repair to ligaments damaged during the traumatic disclocation and debridement of the Type IV superior labrum anterior to posterior tear. PX 1, p. 13. He opined that Petitioner's need for surgery was directly related to the injuries Petitioner suffered in the work accident on 10/21/14. He testified that Petitioner underwent physical therapy following surgery, progressed within normal limits, and returned to work full duty no restrictions on May 12, 2015. PX 1, p. 15. Dr. Obermeyer testified that Petitioner returned in August 2015 reporting some stiffness with terminal flexion and overhead activity but that he could complete most days of work without any pain. Petitioner was told to return as needed as he develops pain or problems. Petitioner returned in September 2015 reporting interval increased soreness in the left shoulder and that he had been performing reaching and tying boxes for two weeks prior to that visit. Dr. Obermeyer concluded that Petitioner's condition was worsening based on the fact that Petitioner called to make an appointment. PX 1, p. 17. Dr. Obermeyer attributed the worsening condition to the "high demands and use of the arm at work." PX 1, p. 17.

In September 2015, Dr. Obermeyer "suspected at that time that he had increasing symptoms related to superior labrum pathology that related to his initial injury that he sustained at work." PX 1, p. 18. Dr. Obermeyer testified that he discussed Petitioner having another procedure to his left arm but that he also discussed home and home activity modifications and exercise in the hope that another procedure could be avoided. Petitioner returned in December 2015 and upon exam Dr. Obermeyer noted characteristic pain with provocation of the superior labrum and the proximal long head of the biceps. Dr. Obermeyer offered Petitioner another MR arthrogram with the option of converting his proximal biceps debridement to a subpectoral tenodesis. Petitioner underwent the MRI arthrogram to evaluate the Bankart repair to decide whether it was the cause of the current problems. Following the MRI, Dr. Obermeyer determined that the Bankart lesion repaired in the first surgery

was healed but that Petitioner had diminutive long head of the biceps in the shoulder joint that was likely a source of his ongoing symptoms coupled with his physical examination findings. PX 1, p. 21. Dr. Obermeyer explained that Petitioner's original superior labral tear extended into the actual long head of the biceps root and that particular tendon was at increased risk of having ongoing damage and problems for Petitioner given the high demands placed on his arm at work.

Dr. Obermeyer testified that the initial SLAP tear included an injury that went into the biceps tendon so Petitioner's current problem was a part of the original injury in his opinion. Dr. Obermeyer did not treat the biceps injury during the first surgery because the initial biceps injury did not involve more than 20 percent of the actual width of the tendon and " in those cases where it's not a majority of the tendon involved, it's a very appropriate treatment option to debride part of the damaged tendon." Patients with more severe tendon injury involving a higher fraction of the tendon are treated primarily with tenodesis. Dr. Obermeyer opined that the biceps tendon causing Petitioner's continued complaints was injured in the work accident of October 2014 and that the tenodesis surgery he is currently prescribing is also related to the work accident. PX 1, p. 22-23. He further explained that the initial injury caused injury to the biceps root making it increasingly susceptible to ongoing pain. PX 1, p. 26. The purpose of the proposed surgery is to improve Petitioner's pain level and to restore full use of the arm. PX 1, p. 25.

On cross exam, Dr. Obermeyer testified that the Bankart lesion and disclocation aspect of his injury was fully healed and recovered. Petitioner's current problem stems from the superior labrum and biceps. PX 1, p. 31. Dr. Obermeyer further testified that the discussion of tenodesis did not arise until the September 2015 visit. He was asked "... In September, the aggravation that he had is what led to the recommendation for the tenodesis that doesn't look like it appeared before that?" Dr. Obermeyer answered "correct." PX 1, p. 34-36. On redirect, he was asked to clarify whether he considered the pain Petitioner complained of at the September 2015 visit to be ongoing pain from the original work accident and he responded "I think that's a reasonable assumption, yes." PX 1, p. 36.

CONCLUSIONS OF LAW

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

F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to prospective medical care?

At trial, the parties stipulated to an accident causing injury to Petitioner's left shoulder arising out of and in the course of Petitioner's employment for Respondent on October 21, 2014. ARB EX 1. Petitioner testified that he believed he made a good recovery from the initial surgery to repair the diagnosed SLAP tear and Bankart lesion and requested a full duty return to iron work in May 2015. Specifically, the 25 year old Petitioner testified that he knew light duty was not an option for his trade so he requested permission to full duty return from Dr. Obermeyer who agreed Petitioner could "give it a try." Petitioner testified that his arm was not pushed to full use capacity in work hardening and that his left shoulder symptoms reappeared on his first full day return to iron work. Petitioner testified that his symptoms persisted and that he returned to physical therapy for 6 weeks subsequent to his May 2015 return to work while continuing to work full duty and taking pain medication.

Petitioner testified that he completed 6 weeks of physical therapy and then returned to Dr. Obermeyer on August 10, 2015. At that visit, Dr. Obermeyer noted Petitioner was "... presents for evaluation of left shoulder pain. He presents with pain and decreased ROM on the left side. He states that the symptoms have been acute traumatic and began 10 months ago. He indicates the injury occurred at work. He is on Worker's [sic] Comp.

The problem is better. The symptoms are aggravated by reaching overhead. Cory states that the symptoms are relieved by ice and physical therapy. Pt reports that that [sic] his shoulder is feeling better, but some stiffness with terminal flexion. He reports that he is full duty at work and able to complete the days work without pain. Denies numbness/tingling/loss of sensation." Following an exam of the left shoulder Dr. Obermeyer noted an impression of "good result following labral repair" and returned Petitioner to full duty without restrictions. Petitioner was instructed to perform "activity as tolerated and therapy; HEP and information on condition given. He is to schedule a follow up visit PRN." PX 1 RX 1.

Petitioner credibly testified that he did not sustain a new accident or injury to his left shoulder. Petitioner testified that his left shoulder problems gradually increased while he continued to work through the Fall of 2015. Petitioner testified that physical therapy did not completely alleviate his symptoms. Petitioner returned to Dr. Obermeyer on 9/23/15. At that visit, Dr. Obermeyer noted, "... presents for follow up of left shoulder pain. He presents with pain on the left side. The problem is worse. The patient indicates that the pain is located in the anterior shoulder on the left side. The symptoms are aggravated by moving the arm suddenly and reaching overhead. Cory states that the symptoms are relieved by ice and rest. Pt reports that he started to develop increased left shoulder within the past couple of weeks. Pt was PRN on 8/10/15. PT states that since returning to work he has started to develop left shoulder pain again while at work when he was reaching down and tying boxes about 2 weeks ago. Dr. Obermeyer noted an impression of "recurrence of pain and activity limitation following SLAP repair. Discussed his reinjury and conversion to biceps tenodesis may be a good option if he is unsatisfied with his progress but there is no rush to have this done. Plan continue with use as tolerated, HEP, RTC 3 months." The patient plan was listed as " PT instructed to continued HEP. Discussed biceps tenodesis, pt wished to defer this time. RTC in 3 weeks." Petitioner was prescribed MOBIC.

The Arbitrator specifically finds that Petitioner did not sustain a new injury in September 2015 resulting in a new injury to his biceps tendon and is not persuaded to find otherwise based on the verbiage used in Dr. Obermeyer's September notes referencing a reaching down and tying boxes two weeks earlier. Rather, the Arbitrator notes that at his deposition, Dr. Obermeyer testified that in September 2015, he "suspected at that time that he had increasing symptoms related to superior labrum pathology that related to his initial injury that he sustained at work." PX 1, p. 18. Further, Dr. Obermeyer clearly testified that the biceps was involved in the original SLAP tear and that he chose to debride the tendon during the first surgery based on the low percentage of tendon involved. Dr. Obermeyer opined that the biceps tendon causing Petitioner's continued complaints was injured in the work accident of October 2014 and that the tenodesis surgery he is currently prescribing is also related to the work accident. PX 1, p. 22-23. He further explained that the initial injury caused injury to the biceps root making it increasingly susceptible to ongoing pain. PX 1, p. 26. Dr. Obermeyer explained that Petitioner's original superior labral tear extended into the actual long head of the biceps root and that particular tendon was at increased risk of having ongoing damage and problems for Petitioner given the high demands placed on his arm at work.

Based on Petitioner's credible testimony, the persuasive testimony and opinion of Dr. Obermeyer and on the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left arm is causally related to the undisputed accident of October 21, 2014. Accordingly, the Arbitrator further finds that the need for the currently recommended surgery is also reasonable, necessary and causally related to the injury of October 21, 2014 and that Respondent shall authorize and pay for the surgery and its attendant care recommended by Dr. Obermeyer 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 Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with his left shoulder injury pursuant to Sections 8 and 8.2 of the Act. 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 WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Absher,

Petitioner,

vs. NO. 15WC 03915

Karpet Korner, Inc,

17IWCC0479

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 disability, causal connection, medical expenses, 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 January 17, 2017 is hereby affirmed and adopted.

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

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

DATED: JUL 31 2017
SJM/sj
o-7/13/17
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ABSHER, MARK
Employee/Petitioner

Case# **15WC003915**

KARPET KORNER INC
Employer/Respondent

17IWCC0479

On 1/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
HERRIN, IL 62948

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

17IWCC0479

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

Mark Absher
Employee/Petitioner

v.

Karpet Korner, Inc.
Employer/Respondent

Case # 15 WC 3915

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **November 15, 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 **September 23, 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.

In the year preceding the injury, Petitioner earned **$39,000.00**; the average weekly wage was **$750.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **1** dependent child.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his 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.

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

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

1/11/17
Date

JAN 17 2017

17IWCC0479

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mark Absher
Employee/Petitioner

Case # 15 WC 3915

v.

Consolidated cases: N/A

Karpet Korner, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he sustained an accident on September 23, 2014. He testified that at Respondent's facility, they have vinyl racks that are stacked, that they get heavy and that you reach down low by the wheels in order to pull them out. He testified that he was pulling out one of the vinyl racks when his back started burning. He testified that the racks were 4½-5 feet tall, that they were close to 14 feet long and that they were on wheels. He testified that everything was working on the rack and that it was able to be pulled out, but that it was heavy. He testified that his low back was burning and that he had problems with his right leg as well, as he had pain shooting down his leg to the foot. He testified that on the date of accident after he was done, he called Stuart Martin. He testified that a co-worker by the name of Trevor Lind was there on the day of the accident. He testified that he did not fill out any paperwork.

Petitioner testified that he was the sales manager for Respondent, and that he worked there for almost 18 years. He testified that he continued to work after the accident and that he was not sure how long he worked before he sought medical attention, but agreed that he first sought treatment in December. He testified that between the time of the accident and when he was seen in December, the problems with his back and leg got worse. He testified that he eventually sought treatment and was referred to Dr. Koth. He testified that he saw Dr. Koth in January, at which time he was recommended to undergo surgery. He testified that after the surgical recommendation was made, he continued to work. He testified that before he had surgery, he was laid off on May 30th. He testified that after he was laid off, he had surgery by Dr. Koth on July 2, 2015. He testified that the surgery took the pain away and that he did not have problems after it. He testified that he had a very quick recovery and ended up going back to work at a different job on August 3, 2015. He testified that he has no residual issues.

Petitioner testified that when he first saw Dr. Koth in January, he was given restrictions and that he worked within those restrictions until he was laid off.

On cross examination, Petitioner admitted that while he worked for Respondent, every once in a while he worked other jobs and laid carpet. He testified that he was not sure how often he would lay carpet. He testified that he was not sure if he laid any carpet around the time this incident occurred. He testified that he was not sure if he was laying carpet for Respondent at the time this incident occurred.

On cross examination, Petitioner denied having any other low back injuries other than this one. He testified that his current job involves driving a truck at the coal mines. He denied having any loading

or unloading duties. He testified that his current job was less strenuous than the job that he had with Respondent.

On cross examination, Petitioner testified that on the date of accident he spoke with Stuart Martin by telephone. He testified that he told Mr. Martin that he was pulling out a vinyl rack and that his back started burning.

Stuart Martin was called as a witness by Respondent at the time of arbitration. Mr. Martin testified that he lives in Dalton, Georgia and is the president and owner of Respondent. He testified that all Petitioner had to do was be a salesperson and sell carpet. He testified that he has known Petitioner all his life, and that he had worked for Respondent for almost 20 years.

Mr. Martin testified that he first became aware of Petitioner's alleged accident in January or February. He testified that Petitioner stated that he had some issues with his back and that he said he went to the doctor and needed surgery and could not afford the deductible, so he was going to try to run it through worker's compensation. Mr. Martin testified that he said he would not fight it, but that he would not lie. He testified that his best memory was that Petitioner said that he injured himself in September or possibly earlier, and that he had hurt himself laying hardwood for a customer but that he was not doing so as an employee of Respondent. He denied receiving a phone call from Petitioner on September 23rd. He denied having received a call any time around that point in time. He testified that while he was at the store approximately four days per week, he was in town every week.

Mr. Martin testified that he after the discussion about trying to run the claim through worker's compensation, he had no further discussions about Petitioner's claim.

On cross examination, Mr. Martin testified that he was contacted by State Farm about 10 days after the claim was filed.

On rebuttal, Petitioner testified that after he was hurt he and Mr. Martin talked about what had happened and how his back hurt. He testified that Mr. Martin wanted him to run it through group insurance. He testified that the conversations took place shortly after the accident, not in January or February.

On cross examination, Petitioner testified that he talked with Mr. Martin about using group insurance after he had gone to the doctor. He agreed that he did not go to the doctor until December. When asked if the discussion occurred at the earliest in mid-December, Petitioner responded that he was not sure but agreed that it had to have been after December 15, 2014.

On redirect, Petitioner confirmed that he was still claiming that he called Mr. Martin on the day of the accident.

On further cross examination, Petitioner testified that when he called Mr. Stuart's cell phone, he had no idea where he was.

Mr. Martin was recalled as a witness by Respondent. He denied receiving any calls from Petitioner on September 23rd. He testified that the conversation they had was face-to-face. He agreed that he heard Petitioner testify that he encouraged him to use his group health insurance, but testified that it did not matter to him who processed the payments. He testified that he was encouraging Petitioner to get help because he looked hurt. He denied ever encouraging Petitioner to use his health insurance as opposed to worker's compensation insurance.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The exhibit is duplicative of that as contained in Arbitrator's Exhibit 2. (PX1; AX2).

The medical records of SIH/Primary Care Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on April 20, 2015 for issues with his left shoulder. It was noted that Petitioner was waiting to have surgery on L4 and L5, and that he was not sure if it was work-related as he was on light duty from a low back disc injury. The assessment was that of low back pain, cervical radiculopathy and history of fusion of cervical spine. Petitioner was prescribed medications and ordered to undergo x-rays of the cervical spine. The records reflect that Petitioner was ordered to undergo an MRI of the cervical spine on April 22, 2015. (PX2).

The records of SIH/Primary Care Group reflect that Petitioner was issued a work slip allowing him to return to work modified duty beginning January 13, 2015. It was noted that Petitioner was recommended to undergo a microdiscectomy and laminectomy. At the time of the January 12, 2015 consultation, it was noted that Petitioner's chief complaint was that of back and right hip pain. It was noted that Petitioner injured his back at work in September 2014 when he was "lifting a vinyl rack, pushing and pulling a vinyl rack." It was noted that the wheel was broken and made it very difficult to pull the device. It was noted that Petitioner developed a burning sensation in his back and had not gotten any better. It was noted that Petitioner had had a previous spine fusion and that the bottom of his foot was numb on the right side. The assessment was that of (1) HNP L4/5; (2) radiculopathy; (3) low back pain; (4) neurogenic claudication. It was noted that Petitioner was recommended to undergo a microdiscectomy and laminectomy L4/5 on the right by Dr. Koth. (PX2).

Included within the records of SIH/Primary Care Group was the interpretive report for an MRI of the lumbar spine performed on January 2, 2015, which was interpreted as revealing degenerative disc disease at L4-5 with dessication and predominantly right-sided disc protrusion, resulting in extrinsic compression upon the right L5 nerve root within the lateral recess and abutment of the right L4 nerve root within the foramina. Also included within the records was an interpretive report for x-rays of the lumbar spine performed on December 15, 2014, which were interpreted as revealing (1) no acute bone abnormality; (2) mild dextroconvex thoracolumbar scoliosis; (3) mild disc space narrowing L4-5. (PX2).

The records of SIH/Primary Care Group reflect that Petitioner was seen on December 15, 2014, at which time it was noted that he presented with acute lumbar back pain. It was noted that the condition occurred without any known injury, that the symptoms included paresthesias (right leg numb) and that the symptoms were located in the right lumbosacral area and radiated to the right posterior thigh, right lateral thigh and right foot. It was noted that the onset was two months ago and that Petitioner denied any injury. The assessment was that of low back pain and paresthesia. Petitioner was given medications and an injection of Kenalog, and was recommended to undergo an MRI of the lumbar spine. (PX2).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on July 17, 2015 for a post-operative visit. It was noted that Petitioner stated he was doing great from his surgery and that he walked two miles that morning before his appointment. It was noted that Petitioner was wearing his brace and was also doing better from his superficial DVT on the right lower extremity from July 13, 2015. Petitioner was recommended to continue icing as needed and to wear his back brace for one more month. It was noted that Petitioner would continue with the same restrictions, that he could go into the water in one more week and that he could start driving as long as he was not on pain medication. (PX3).

Included within the records of Orthopaedic Institute of Southern Illinois was the interpretive report for a right lower extremity venous Doppler performed on July 10, 2015 for a history of pain in the

right calf. The impression was noted to be that of no sonographic evidence of deep venous thrombosis right lower extremity; superficial thrombophlebitis posterior right calf. (PX3).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on July 10, 2015, at which time he presented with pain and it was noted that the symptoms occurred rarely and that the problem was better. It was noted that Petitioner had calf pain and was recommended to undergo a stat ultrasound to rule out a DVT. The Operative Report dated July 2, 2015 noted that the following procedures were performed on that date: (1) minimally invasive microdiskectomy and hemilaminectomy at L4-5 on the right side; (2) facetectomy at that level; (3) operative microscope; (4) C-arm control and interpretation. The pre- and post-operative diagnoses were noted to be that of (1) herniated disk at L4-5 on the right side; (2) radiculopathy; (3) neurogenic claudication. (PX3).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on June 24, 2015 for a consultation, at which time it was noted that he presented with numbness and tingling into the left thumb, index and long fingers. It was noted that Petitioner's symptoms had been chronic and non-traumatic, and that the symptoms occurred constantly. A nerve conduction study of the bilateral upper extremities was recommended. At the time of the July 30, 2015 visit, it was noted that on July 27th, a knot came up on Petitioner's back around his incision site. It was noted that he was not having any numbness or tingling or pain in his legs, and that he was getting ready to start a new job on August 3, 2015. Petitioner was recommended to see Dr. Balmforth for a CT-guided aspiration. (PX3).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

The IME Report of Dr. Petkovich was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Petitioner was seen on September 17, 2015, at which time it was noted that he stated that he sustained an injury while at work on September 23, 2014. It was noted that Petitioner reported that he was pulling on some racks with rolls of vinyl and that as he did this, he developed sudden pain in his lower back. It was noted that Petitioner indicated that he initially tried to ignore it and continued working, that he mentioned it to his boss, and that he continued working at his regular job for the next several weeks but had some persistent aching pain in his lower back with some pain developing into his right lower extremity. It was noted that Petitioner reported that the pain became more severe and that he was seen by his primary care physician, Kelly Phelps, physician's assistant, on December 15, 2014, and that Petitioner indicated that he did not know at that time that his pain was related to the incident that he described as occurring while at work on September 23, 2014. It was noted that Petitioner reported that he continued working at his regular job after he was initially seen by Ms. Phelps on December 15, 2014, and that he delayed follow-up with Dr. Koth because he was unable to get authorization through his employer's insurance. It was also noted that Petitioner indicated that he was laid off from his job at Karpet Korner in June of 2015. (RX1).

The report noted that Petitioner's diagnosis was a lumbar disc herniation right L4-L5, and that he was status post surgery for right L4-L5 lumbar laminotomy and microdiscectomy. It was noted that Dr. Petkovich believed that Petitioner's disc herniation occurred at the time of the incident that he described while working on September 23, 2014, and that Petitioner appeared to be a "very stoic" man. Dr. Petkovich opined that he believed that all of the medical care and treatment that Petitioner had after the incident was reasonable and necessary as a result of the incident on September 23, 2014, but that the cervical spine condition was totally unrelated to his employment and the accident of September 23, 2014. It was noted that Dr. Petkovich opined that Petitioner had 7% whole person impairment as a result of the lumbar disc herniation at the L4-L5 level and the subsequent surgical procedure in conjunction with the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on September 23, 2014 that arose out of and in the course of his employment with Respondent.

In Illinois, it is well-settled that a party seeking an award under the Workers' Compensation Act must prove by direct and positive evidence, or by evidence from which the inference can be fairly and reasonably drawn, that the accidental injury arose out of and in the course of his employment. *Corn Products Refining Co. v. Industrial Commission*, 6 Ill. 2d 439, 442-443 (1955). The burden is upon the applicant to establish by a preponderance of competent evidence all of the essential elements of his right to compensation. *Id.* at 443.

In the present case, the Arbitrator finds that Petitioner failed to prove by a preponderance of evidence that he sustained an accident on September 23, 2014 that arose out of and in the course of his employment, as Petitioner's testimony regarding the history of accident is not supported by the record and is fatally undermined by his lack of credibility.

The Arbitrator finds that Petitioner's testimony at arbitration that on September 23, 2014 he injured his lower while pulling a vinyl rack is undermined by the medical records in this matter. While the January 12, 2015 visit with Dr. Koth noted a history that Petitioner injured his back at work in September 2014 when he was "lifting a vinyl rack, pushing and pulling a vinyl rack" and it was noted that the wheel was broken and made it very difficult to pull the device, the first record of any post-accident medical treatment was that with Kelly Phelps, physician's assistant, on December 15, 2015, at which time it was noted that the condition occurred without any known injury, that the symptoms included paresthesias (right leg numb), that the symptoms were located in the right lumbosacral area and radiated to the right posterior thigh, right lateral thigh and right foot, that the onset was two months ago and that Petitioner denied any injury. (PX2). Significantly, the first post-accident note makes no reference whatsoever to the alleged accident of September 23, 2014 involving a vinyl rack as described by Petitioner at the time of arbitration, let alone did it make mention of any issues with the wheels on the rack which, incidentally, was not described by Petitioner at the time of arbitration. As a result thereof, the Arbitrator finds that Petitioner failed to prove that he sustained an accident on September 23, 2014 that arose out of and in the course of his employment with Respondent.

The Arbitrator finds Petitioner to be an incredulous witness and places no evidentiary weight on his testimony. The Arbitrator notes that Petitioner's testimony in this case was overwhelmingly contradicted not only by the testimony proffered by Stuart Martin who testified on behalf of Respondent, but also the objective medical records that were entered into evidence at the time of arbitration as well. The Arbitrator notes that Petitioner appeared to be somewhat elusive when questioned on cross examination at the time of arbitration, as he responded several times to several questions by answering that he was "not sure." As a result of the multitude of discrepancies between Petitioner's testimony and the objective medical records in this matter, the Arbitrator finds that Petitioner's testimony at the time of arbitration was incredulous and places no evidentiary weight on his testimony.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (E), (F), (J), (K) and (L), as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cheryl Hildebrand,
Petitioner,
vs.

NO: 15 WC 09754

Heyl, Royster, Voelker & Allen,
Respondent,

17IWCC0432

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 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 $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: JUL 7 - 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

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CJD/rlc
049

17IWCC0432

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove accident. I would instead reverse the findings of Arbitrator Dollison and find that Petitioner did prove she suffered from bilateral repetitive trauma carpal tunnel syndrome as a result of her work related activities, and is entitled to reasonable medical expenses, temporary total disability, and permanency benefits.

The Petitioner was employed by Respondent doing data entry, and has worked for Respondent for 7 years. For the first 3 years, she transcribed dictation and did keyboard work for 7 hours per day. The past 4 years, she has worked as a "new files entry operator" initially doing keyboard work for 6 hours per day under the "ProLaw" system, and then when Respondent switched systems to "Acumen", for 4 hours per day. The ProLaw system required more typing and repetitive strokes. Petitioner noticed numbness, weakness, and tightness in her palms while working under the ProLaw system, and reported same to Respondent in August, 2014. An EMG in November, 2014, revealed bilateral carpal tunnel syndrome.

The Arbitrator should be reversed for the following reasons:

1) Petitioner's condition manifested while working with ProLaw system – a data entry system that involved significantly more repetitive typing than the Acumen system later implemented by Respondent;

2) The video on which Respondent's expert, as well as the Arbitrator relied, was flawed as it was not an accurate depiction of how Petitioner performed her job under the ProLaw system; and

3) Both Petitioner's treating physician and IME doctor found causal connection of Petitioner's work-related activities to the diagnoses of bilateral carpal tunnel syndrome due to repetitive trauma, and recommended surgical release.

Petitioner testified consistent with the records, job description and taped statement. Petitioner typed at least 2/3 of the work day from the start of her legal career, approximately 20 years ago, until the development of her symptoms in the spring of 2014. At the time her symptoms developed, she had been working for Respondent for 7 years, during which time she either performed straight dictation/transcription or entry of new files on the ProLaw system, which accounted for 6-7 hours of her day. Petitioner testified that her hand symptoms significantly increased when typing.

Respondent's IME physician, Dr. Vender, based his causation opinion on an inaccurate and short 5 minute job video. Petitioner testified that the video was not accurate because it showed her working on an existing file rather than a new file, and that she was typing a lot slower because she was "extremely nervous." Additionally, the job video is of the Acumen data entry system which was not put into place until nearly a year after Petitioner developed her symptoms. At the time Petitioner's symptoms developed and she was diagnosed with carpal tunnel syndrome, she was using the ProLaw system. Even Dr. Vender agreed Petitioner suffered from bilateral carpal tunnel syndrome and would benefit from carpal tunnel releases.

17IWCC0432

Petitioner's treating physician, Dr. Williams, diagnosed Petitioner with bilateral carpal tunnel syndrome and recommended surgical release. Dr. Williams' records show that Petitioner's symptoms worsened with work and were better when she was not working. In Dr. Williams' medical questionnaire, Petitioner identified her symptoms as 9 out of 10 during work and the activity that made the pain better or worse was work and typing. Her symptoms went down to 5 when not working. Dr. Williams' records reflect that the EMG results showing bilateral carpal tunnel syndrome was consistent with Petitioner's complaints.

Petitioner's IME physician, Dr. Seidl, diagnosed bilateral carpal tunnel syndrome. Dr. Seidl opined that Petitioner's carpal tunnel was causally connected to Petitioner's work activities and based on that connection, Petitioner's carpal tunnel release surgeries were also causally connected to her work injury. He based his opinion on the fact that Petitioner's symptoms increased at work and showed improvement when she was not at work or performing the repetitive typing activities.

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 in the amount of $5,683.00, temporary total disability from June 17, 2015 through August 31, 2015, and permanency benefits of 10% for each hand.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HILDEBRAND, CHERYL
Employee/Petitioner

Case# **15WC009754**

17IWCC0432

HEYL, ROYSTER, VOELKER & ALLEN
Employer/Respondent

On 2/10/2016, 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2593 GANAN & SHAPIRO PC
TIMOTHY STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

17IWCC0432

☐ 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

Cheryl Hildebrand
Employee/Petitioner

v.

Heyl, Royster, Voelker & Allen
Employer/Respondent

Case # **15 WC 09754**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on **December 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On 8/14/2014, 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 $**38,937.60**; the average weekly wage was $**748.80**.

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

Respondent shall be given a credit for payments made by group health in the amount of $**35,381.19** pursuant to Section 8(j) of the Act.

ORDER

Having found that Petitioner failed to prove she sustained an accident that arose out of and in the course of her employment with Respondent and furthermore that her condition is causally related to her employment, her request for compensation is hereby denied.

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

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

Signature of Arbitrator

2/8/16
Date

FEB 10 2016

FINDING OF FACTS:

Petitioner testified she has been employed for Respondent for seven years and was employed as a new file entry operator for the past four years. Petitioner testified she primarily enters new asbestos cases. Petitioner testified she has a history of hypertension and takes medication for this condition. Petitioner testified she was approximately 5 foot tall and weighed approximately 230 pounds. Petitioner testified she did not have a history of diabetes, hypothyroidism or rheumatoid arthritis.

Petitioner testified she first reported problems with her hands to Respondent on August 14, 2014. Petitioner testified she noticed numbness, weakness and tightness in her palms which were waking her up at night. Petitioner testified her symptoms began approximately April or May 2014. Petitioner testified her initial complaints were worse on the left side then on the right side.

Petitioner testified that prior to working for Respondent, she was employed as a paralegal with a different law firm and she has worked in the legal field for 20 years.

Petitioner testified that as a new file clerk, she seldom answered phones. Petitioner testified her job involved mainly data entry wherein she would enter new files obtained by Respondent into the system or add additional information to existing cases. Petitioner testified she had a pad in front of her keyboard which she would rest her wrists on. Petitioner demonstrated the position of her hands which were extended approximately 30 degrees from her neutral position. Petitioner testified the keyboard was movable, indicating she could move the keyboard up or down.

Petitioner testified when she got a new file, she would normally print same so that she could check the paperwork herself. Petitioner testified she would have pre-populated information from clients but would have to enter the plaintiff information including case number and caption. Petitioner testified she would have to type sentences when she prepared the synopses which would be dependent on who was the plaintiff's attorney. Petitioner testified she would have to run conflicts on all the parties and then she would take a sheet of paper, review it, and then take the information to determine what relevant field to input that information. Petitioner would also have to enter each of the defendants in their own separate fields. Petitioner testified there would be a stack of papers she would go through when she entered the information. Petitioner testified she would need to find out the plaintiff's diagnosis, when the diagnosis was made, determine if the plaintiff was deceased and enter the date of death when appropriate.

Petitioner initially treated with Dr. James Williams on September 25, 2014 wherein she reported pain, numbness and tingling in her bilateral hands. By medical history, it was noted Petitioner was 61 inches tall, weighed 230 pounds and had a BMI of 43.5. Petitioner reported she worked for Respondent and "…typed all day." Petitioner reported having these symptoms for approximately six to eight months. Dr. Williams assessed bilateral carpal tunnel syndrome and ordered an EMG. (Px-5)

Respondent obtained a recorded statement from Petitioner on October 31, 2014. (Rx-2) Petitioner reported she was 5'2" and weighed 180 pounds. Petitioner reported she entered in new files and she typed eight hours a day. Petitioner reported the palm of her right hand hurts while holding a mouse and stated she noticed tingling and numbness in her hands in April/May 2014. Petitioner stated she reported her symptoms to her doctor for a routine exam and she was referred to orthopedics where she saw Dr. Williams. Petitioner reported

she had a prior workers' compensation claim in 1991 when she fell off a ladder causing impingement syndrome in her right shoulder.

The prescribed EMG/NCV was completed on November 18, 2014, demonstrating evidence of bilateral carpal tunnel syndrome, mild on the left and moderate on the right. (Px-6) On December 1, 2014, Dr. Williams recommended bilateral carpal tunnel release. (Px-5)

Respondent introduced a job analysis report prepared on January 15, 2015. (Rx-3) The job description details Petitioner's position as a new files clerk for building new case files for asbestos claims. This requires the worker to take documents that are printed for her that has been provided by an attorney or supervisor and could be several pages long. The clerk accesses data base looking up the particular rules for that client and begins entering the written material. This information may also be pulled from e-mails. The majority of information is entered using templates and filling in the appropriate form and filling in the pre-populated fields. The new file clerk may need to add and subtract data from the template as required. If there are multiple clients for the same claim, the new file clerk will open a separate file for each new client and that will get attached to the original file. Once data has been entered from the written material, the papers will be scanned into an e-mail PDF and then saved to the file. The new file clerk worked with a keyboard and mouse located on an adjustable keyboard tray.

The job description details that handling/grasping was on an occasional basis which was from zero to two and a half hours involving handling and grasping of papers and using a mouse to point and click. (Rx-3) There was no forceful gripping. Fine motor manipulation would be on a frequent basis from two and half to five hours involving use of a keyboard for data entry where a worker can control a pace of typing but there would be some job place requirements to ensure work is completed in a timely fashion. There was no low or high impact tools.

On January 27, 2015, Petitioner presented to Dr. Michael Vender for an IME at Respondent's request. (Rx-1) Petitioner complained of tingling and pain along with cramping in both hands more so on the right than on the left. Petitioner described her work activities as typing and utilizing her right hand for a mouse. Petitioner stated she weighed approximately 180 pounds although the medical records reflected she weighed 230 pounds and her calculated BMI as 43.5. Dr. Vender diagnosed Petitioner with bilateral carpal tunnel syndrome.

Dr. Vender reviewed Petitioner's video job analysis dated January 15, 2015 which demonstrated a worker sitting at a work station and a keyboard on a keyboard tray in front of a desk. (Rx-1) Petitioner was seen initially utilizing her left hand to perform limited data entry utilizing mostly the index finger. After over 30 seconds, Petitioner would then start performing data entry with both hands. This continued for several seconds and then Petitioner handled a piece of paper. While holding the paper in the left hand, Petitioner would then do numerical entry with the right hand. Petitioner would also intermittently use the mouse. Petitioner would occasionally use a pen or pencil with her left hand. Petitioner would stop and frequently read pieces of paper. The video is approximately four minutes. Dr. Vender indicated the activities shown on the video were office based and sedentary with intermit use of the hands and upper extremities. There would be significant periods of time with essentially no use of the hands as Petitioner would be reading off of her computer screen. No forceful exertions were demonstrated.

Dr. Vender opined Petitioner's work activities would not be contributory to any conditions seen in the hand. (Rx-1) Dr. Vender stated Petitioner's age and gender as well as her BMI were risk factors for carpal tunnel syndrome. Dr. Vender stated there were no forceful activities regarding Petitioner's hands which would

be contributory to her development of carpal tunnel syndrome. Dr. Vender stated her work activities would not be considered forceful on a regular and persistent basis. Dr. Vender opined any treatment Petitioner received would not be related to the work activities demonstrated.

On April 24, 2015, Petitioner presented to Dr. Robert Seidl for an IME at her attorney's request. (Px-1) Petitioner reported she performed clerical work for Respondent. Petitioner stated her symptoms were increased with work activities which involve typing, paperwork and computer work. Petitioner reported her symptoms improved when her work activities decreased on weekends when she was away from work. Petitioner's medical history was significant for hypertension and she was a prior smoker who had quit ten years ago. Petitioner reported pain and difficulty with daily activities that included repetitive wrist motions as well as pain, increase in symptoms with clerical work activities. It was noted Petitioner was five foot and weighed 230 pounds. Dr. Seidl diagnosed Petitioner with bilateral carpal tunnel syndrome.

Dr. Seidl opined Petitioner's work activities worsened her symptoms based on Petitioner's history, specifically Petitioner's temporal association of symptoms increasing at work with her multiple work activities and improvement when she decreased these activities away from work. (Px-1) Dr. Seidl opined Petitioner's bilateral carpal tunnel syndrome, although possibly a pre-existing condition, was aggravated by Petitioner's work activities. The doctor indicated that the increase in Petitioner's symptoms with multiple work activities provided evidence that her symptoms of carpal tunnel syndrome on both hands were related and aggravated by her work activities.

Prior to Petitioner's examination with Dr. Seidl, presented to Dr. Andrew Tsung of Illinois Neurological Institute on March 17, 2015 for presentation of bilateral hand pain, numbness and paresthesia complaints. (Px-4) Dr. Tsung diagnosed Petitioner with bilateral carpal tunnel syndrome. Petitioner underwent a left carpal tunnel release on June 17, 2015 and a right carpal tunnel release on July 23, 2015. On August 18, 2015, Petitioner denied having any further hand pain, numbness/tingling or weakness. Petitioner expressed her desire to return to work. Petitioner returned to work without restrictions on September 1, 2015. On September 18, 2015, Petitioner followed up with Dr. Tsung's office and again reiterated she no longer had numbness, tingling or pain in her hands or fingers. Petitioner described she had no symptoms in her hands at all. (Px-4)

Petitioner testified the video exhibit as shown in Respondent's Exhibit 4 showed her keyboard, mouse and her work station she used when she first noticed her complaints back in April and May 2014. Petitioner estimated she performed data entry with keyboard and mouse use about six hours a day. Petitioner testified she was left hand dominant. Petitioner stated it was her who was depicted in the job video analysis and it accurately portrayed what she did at that time. Petitioner however provided that she was typing a lot slower and she was extremely nervous during the video.

Petitioner testified the video job analysis showed her performing data entry on an existing file. Petitioner testified her other activities included scanning documents and saving them on her e-mail, opening up the e-mail and then saving it to the intended file.

Petitioner testified she typically used both hands for data entry. Petitioner testified she would not normally hold a piece of paper with her left hand and perform data entry with her right hand.

Petitioner criticized the job description as shown in Respondent's Exhibit 3 and stated she worked from templates only as it pertained to client information and not to plaintiff information. Petitioner agreed she would use her hands for file manipulation for about 33% to 66% of the time frequently. Petitioner testified the longest

she would perform data entry on a continuous basis could vary and would depend on who was assigned to the new file and estimated it could be an hour and a half or could be shorter.

Petitioner testified she initially presented to Dr. Garst with her pain complaints and then to Dr. Williams and subsequently to Dr. Tsung. Petitioner testified that when she had her initial complaints, her pain was a 9 out of 10 and when she was not working her pain was lessened to approximately 5 out of 10. Petitioner testified typing was the main activity that aggravated her hand symptoms.

Petitioner testified she explained her job duties to both Dr. Seidl and to Dr. Vender. Petitioner testified she spoke to Dr. Seidl for approximately 20 minutes and with Dr. Vender for 10 minutes or less. Petitioner testified Dr. Seidl spent more time on her history than Dr. Vender. Petitioner testified she told Dr. Seidl her hands were worse when she was typing at work but she did not provide that information to Dr. Vender.

Petitioner testified she has been released to return to regular work. Petitioner testified the numbness and tingling in her fingers were gone. Petitioner testified she still has pain in her right palm. Petitioner testified she had pain in her palm the entire time her hand is on the mouse while she is working. Petitioner testified that her sleeping has become better. Petitioner testified that using a hand can opener is more difficult and she does not feel as strong lifting the coffee pot. Petitioner also testified that lifting a casserole dish from a cabinet seemed heavier.

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; and (F.) Is Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator finds as follows:

After review of Petitioner's job description as well as video job analysis, the Arbitrator finds there is no discernable evidence to support Petitioner's job as a new file entry clerk was sufficiently repetitive of forceful enough wherein an accident could be described to have caused her bilateral carpal tunnel syndrome. A review of the video job analysis as well as the job description documents Petitioner's work station was set up ergonomically and the position of Petitioner's wrists would not have contributed to Petitioner's bilateral carpal tunnel syndrome. There is no evidence to support a defect in the work station or Petitioner had to type in an awkward fashion. The evidence shows Petitioner would have to pause while typing when sorting through paperwork before entering information into templates on the computer. As such, the Arbitrator finds Petitioner failed to prove she suffered an accident that arose out of and in the course of her employment with Respondent.

The Arbitrator also finds Petitioner failed to prove her bilateral carpal tunnel condition was causally related to her work activities. The Arbitrator finds the opinions of Dr. Vender are more persuasive then Dr. Seidl. Dr. Vender's opinions were with the benefit of a video job analysis and took into account Petitioner's co-morbidities where are risk factors for the development of carpal tunnel syndrome. On the other hand, Dr. Seidl's report documents Petitioner provided a general history of her job duties but there is no evidence Dr. Seidl reviewed Petitioner's job description nor her video job analysis. Dr. Seidl's opinions were based on Petitioner's perceived temporal relationship of her symptoms and her job activities but there is no evidence Dr. Seidl based his opinions on an accurate understanding of Petitioner's job duties.

Petitioner testified Dr. Seidl reviewed her job duties and history more thoroughly in comparison to Dr. Vender. There is no evidence in Dr. Seidl's report to corroborate Petitioner's testimony. In fact, Dr. Vender's report concerning Petitioner's job duties are more detailed in comparison to Dr. Seidl's report. Dr. Seidl's report only references a generic description of Petitioner's multiple clerical duties that "include typing, paperwork, and computer work, etc." The only inference one can make is that Petitioner provided a history of

typing eight hours a day to Dr. Seidl per the histories she gave to both Dr. Williams and in her recorded statement to the insurance company. This history appears inaccurate based on Petitioner's own admission at trial that she typed six hours per day. Based on a comparison of the IME reports, it appears Dr. Vender had a more accurate understanding of Petitioner's job duties.

In reliance of Dr. Vender's opinions, job description and video job analysis, the Arbitrator finds Petitioner failed to prove she suffered an accident that arose out of and in the course of employment with Respondent and furthermore has failed to prove her bilateral carpal tunnel condition is causally related to an accident at work.

All remaining issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dedra Koehler,

Petitioner,

vs. NO: 15 WC 14071

17IWCC0472

Murray 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 all of the issues, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the addition of the following supplemental analysis on the issue of whether Petitioner's injury arose out of and in the course of her employment:

> "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that [she] has suffered a disabling injury which arose out of and in the course of [her] employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). " 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Id.* There is no dispute that the accident in this case occurred in the course of Petitioner's employment; the issue here is whether the accident also arose out of her employment.
>
> "The 'arising out of' component is primarily concerned with causal connection" and is satisfied where the claimant shows "that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* The Appellate Court has devised three categories of risks to which employees 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." *Noonan v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152300WC, ¶19 (internal quotations omitted). Employment risks are compensable, and personal risks are not compensable. *Id.* Injuries resulting from a neutral risk are compensable only where the employee was exposed to the risk to a greater degree than the general public. *Id.*

Petitioner first argues that her knee injury was incurred as the result of an employment-related risk. "Risks are distinctly associated with employment when, at the time of the injury, 'the employee was performing acts [she] was instructed to perform by [her] employer, acts which [she] had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to [her] assigned duties.' " *Steak 'N Shake v. Illinois Industrial Comm'n*, 2016 IL App (3d) 150500WC, ¶35 (quoting *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). "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." *Caterpillar Tractor Co*, 129 Ill. 2d at 58.

Applying this definition, Petitioner notes that, as a cook, she was expected, and even required by regulation (see 77 Ill. Adm. Code 750.512 (now repealed)) to wash her hands after engaging in any activity that could contaminate her hands. She further points out that she chose the location of neither the hand-washing sink nor the trash can, so that her injury was caused by her "doing a duty she was required to do, at a location she was required to do it at." In support of her position, Petitioner cites the Appellate Court's recent decision in *Steak 'N Shake*, 2016 IL App (3d) 150500WC. In *Steak 'N Shake*, a case in which the claimant suffered an injury as a result of wiping down restaurant tables, the Appellate Court rejected the Commission's application of a neutral-risk analysis and instead held the activity to constitute an employment-related risk. *Steak 'N Shake*, 2016 IL App (3d) 150500WC, ¶37. In so doing, the Appellate Court relied on the claimant's credible testimony that her normal job duties included the habitual cleaning and busing of tables and was therefore distinctly associated with her employment. *Id.* at ¶38.

The mode of injury in this case, however, differs qualitatively from that in *Steak 'N Shake*. The task the *Steak 'N Shake* claimant performed at the time of her injury was a distinctly job-related task: wiping down restaurant tables. Here, by contrast, Petitioner was injured while discarding a paper towel. In cases where the claimant's injury is triggered by an everyday task that cannot be said to be distinct to the claimant's job, the Appellate Court's most recent precedent dictates application of neutral-risk analysis.

For example, in *Adcock v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130884WC, the claimant was injured while turning in a chair. The Appellate

Court reasoned that the risk associated with turning in a chair "was not 'distinctly associated' with the claimant's employment; rather, it was a neutral risk of everyday living faced by all members of the general public." *Adcock*, 2015 IL App. (2d) 130884, ¶33. In a similar case, *Noonan*, 2016 IL App (1st) 152300WC, the claimant was injured after he fell from his chair trying to reach for a pen he had dropped. The Appellate Court rejected the claimant's argument that his reaching for the pen was an act in furtherance of his duties and thus led to an employment-related risk, because the act of "reaching for a dropped item while sitting in a chair" was not "distinctly associated" with his employment (*Noonan*, 2016 IL App (1st) 152300WC, ¶21) but instead was a risk that he "would have been equally exposed to apart from his work for the employer" (*Noonan*, 2016 IL App (1st) 152300WC, ¶27). Thus, the Appellate Court applied a neutral-risk analysis. *Id.* at ¶27. In so doing, the court distinguished prior employment-risk cases that presented risks more closely associated with and distinct to the claimants' jobs:

> "Further, the facts in [*Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC, *Autumn Accolade v. Illinois Workers' Compensation Comm'n*, 2013 IL App (3rd) 120588WC, and *O'Fallon School District No. 90 v. Industrial Comm'n*, 313 Ill App. 3d 413 (2000)] each show that the claimant was performing acts his or her employer might reasonably have expected the claimant to perform when fulfilling his or her job duties—a parts inspector reaching into a box to retrieve a part for inspection (*Young*), a caregiver reaching to remove a safety hazard while holding onto an individual in the shower (*Autumn Accolade*), and a hall monitor turning and twisting to pursue a running student (*O'Fallon*)." *Id.* ¶26.

Based on this precedent, the risk that led to Petitioner's injury in this case—her turning to discard a paper towel—was an everyday occurrence that cannot be considered distinct to her employment even if it was undertaken in furtherance of her employment duties. Thus, the Commission must reject Petitioner's argument that her injury be considered the result of an employment-related risk.

Petitioner also argues that, if her injury is not the result of an employment-related risk, it nevertheless arose out of her employment with Respondent because it was a neutral risk to which she faced greater exposure than the general public. " 'Injuries resulting from a neutral risk generally do not arise of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public.' " *Noonan*, 2016 IL App (1st)152300WC, ¶19 (quoting *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014 (2011)). " 'Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public.' " *Id.* (quoting *Metropolitan*, 407 Ill. App. 3d at 1014). For

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example, in *Adcock*, the Appellate Court found an increased risk where the claimant undertook the everyday action of maneuvering in his chair on a "non-stop" basis. *Adcock*, 2015 IL App (2d) 130884WC, ¶34.

In this case, Petitioner offered no evidence that her job exposed her to any quantitatively or qualitatively unusual risk of injury due to turning to discard a paper towel. Although she points out in her brief that she was required to wash her hands (and incidentally required to discard her paper towel), she offers no evidence to quantify her exposure to this risk. In fact, her testimony establishes that she mopped the kitchen floor—the act she says triggers her duty to wash her hands—only once per shift, at the end of her workday. As a result, Petitioner has not carried her burden to establish that her job somehow gave her quantifiably greater exposure to the hand-washing or paper-towel-discarding risk. Neither did Petitioner offer any evidence to establish that her workplace somehow added a qualitative dimension to the risk. For these reasons, the Commission must find that Petitioner failed to carry her burden to show that her injury arose out of and in the course of her employment.

Petitioner also argues that the arbitrator erred in finding that she did not suffer a repetitive trauma injury, with a later onset date, as a result of her work. However, as the arbitrator observed, Petitioner offered no evidence that her injury was the result of repetitive trauma. For that reason, Petitioner's argument must be rejected.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/13/2016 is modified as stated herein.

DATED: JUL 25 2017
o:6/26/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOEHLER, DEDRA
Employee/Petitioner

Case# **15WC014071**

14WC016584

MURRAY CENTER
Employer/Respondent

17IWCC0472

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1239 KOLKER LAW OFFICES PC
BILLY A HENDRICKSON
9423 W MAIN ST
BELLEVILLE, IL 62223

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 13 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0472

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEDRA KOEHLER
Employee/Petitioner

v.

MURRAY CENTER
Employer/Respondent

Case # **15** WC **14071**

Consolidated cases: **14 WC 16584**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nowak**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **11/5/2015**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **5/1/14**, 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 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 **$45,120.21**; the average weekly wage was **$867.70**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to establish that she sustained accidental injuries which arose out of and in the course of her employment on 5/1/14 benefits are denied.

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

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

Michael K. Arbitrator

9/2/16
Date

OCT 13 2016

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FINDINGS OF FACT

Petitioner has two cases pending against Respondent. 14 WC 16584 alleges a single traumatic accident of March 29, 2014. (AX. 1) 15 WC 14701 alleges repetitive trauma injuries with a manifestation date on May 1, 2014. On the date of hearing the cases were consolidated without objection. The issues at trial were accident, causal connection, liability for medical costs, TTD, and Nature and extent of the Injury in both cases. In addition, notice was in dispute in 15 WC 14071.

Petitioner testified that she works at the Warren G. Murray Center where she has been employed since May 1st of 2008. At the time of her injury Ms. Koehler was working as a cook, and had been working in that position for about a year.

Petitioner testified that the kitchen was about half the size of football field. (T. 16) The kitchen included several different locations where materials were stored including a walk in cooler, freezer, ovens, and dry storage. (T. 16-17) As part of her job Petitioner was required to move from spot to spot gathering all the materials that were needed to prepare food for that day. (T. 16-17) Petitioner testified it was a fast paced job that required her to be on her feet and move around a lot. (T. 18) Her position also required a lot of lifting and carrying. (T. 17) After serving meals, Petitioner was required to clean up; moving all the pans to the dish room, cleaning all the tables, prep tables, stoves, and steam kettles. (T. 18-19) Petitioner would then sweep and mop the kitchen floor. (T. 19) Petitioner testified that her duties required her to be on her feet six hours out of her seven and a half hour day. (T. 20) Petitioner spent two to two and a half hours out of her day bending and squatting. (T. 20) Petitioner only spent one hour to one and a half hours of her workday sitting down or resting. (T. 20) Petitioner testified that when she got home from work after a typical day her feet and legs would be "tired, achy, and hurt." (T. 20)

Prior to March 29, 2014, Petitioner had been treating with chiropractor Dr. Michael Bowman for adjustments to her back. (T. 22) On March 25, 2014, Petitioner attended a regularly scheduled appointment with Dr. Bowman. (T. 22) On that date, Petitioner reported to Dr. Bowman that she had been having pain in her right knee for a couple weeks. (PX. 3) Petitioner testified that she was experiencing an "aching, dull pain behind her right knee" at that time and rated the pain a 2 out of 10. (T. 22-23) The medical record from this visit indicates that being on her feet for long periods of time made the pain worse, while resting with her leg up made the pain better. (PX. 3) The record further indicates that Dr. Bowman discussed the possibility of a Baker's cyst or degenerative joint disease of the knee with Petitioner. Petitioner testified that she had no injuries or treatment to her right knee prior to the March 25, 2014 visit with Dr. Bowman. (T. 25)

Four days after this visit to Dr. Bowman, on March 29th, 2014, Petitioner was working her regular duties as cook at Murray Center. (T. 25) Petitioner testified she had been at work for six and a half hours before the injury occurred. (T. 25) Petitioner had been on her feet for a majority of this time. (T. 25-26) Petitioner testified she had just mopped the floor, changed the mop head, and washed her hands. (T. 26) Petitioner went to throw a paper towel away after washing her hands, turning to her left toward the trash can, when she heard her right knee pop and felt a "very sharp pain" in the knee. (T. 26-28) Petitioner testified that she almost fell over having to catch herself on the sink because she could not put any weight on the knee. (T. 27) She testified that the pain was located behind and on the inside of her right knee, facing the interior. (T. 27) Petitioner rated the pain 10 out of 10, and stated it was a different pain than she had experienced prior to the accident. (T. 28)

A co-worker, Melodie Hall, witnessed the accident and reported it to their supervisor. The supervisor called a nurse on staff and Petitioner was directed to go to the emergency room at St. Mary's Hospital. Petitioner was rolled out of the facility in an office chair to a vehicle where co-worker Melodie Hall took her to the emergency room. (T. 30)

X-rays were performed at the emergency room at St. Mary's and Petitioner was diagnosed with a ruptured Baker's cyst. (PX. 2) Petitioner's leg was wrapped in ace bandages and she was given crutches. (PX 2) Petitioner was taken off work for three days. (PX. 6) Petitioner testified after leaving the hospital she could not put any weight on the knee and was directed to stay off it. (Tr. 30-31)

A Notice of Injury was filled out by Petitioner on March 29, 2014, and was received by Murray Center on April 3, 2014. (PX. 1)

On March 31, 2014, Petitioner returned to Dr. Bowman to have her knee evaluated. The record from this date indicates that Petitioner presented on crutches with swelling to both the anteromedial aspect and posteromedial aspect of the right knee. (PX. 3) She was diagnosed with internal derangement of right knee and a referred for an MRI. (PX. 3). She was taken off work until April 7, 2014. (PX. 6)

On April 4, 2014, Petitioner followed up with Dr. Bowman. (PX. 3) The record on this date indicates that Petitioner was off of crutches but notes swelling in the right knee and pain rated 6 out of 10. (PX. 3) This record indicates that Petitioner "still awaits the MRI – contingent on W/C." (PX. 3) Petitioner was taken off work until April 14, 2014. (PX. 6) Petitioner testified that she returned to Dr. Bowman for physical therapy for the right knee a few times before the MRI was taken. (T. 32-33) Petitioner was issued off work notes extending through this time. (PX. 6)

On April 4, 2014, Petitioner underwent an MRI of the right knee at InMed Diagnostic Services. (PX. 4) The MRI revealed fluid interspersed along the anterior aspect of the anterior cruciate ligament and "is noted suspicious for a partial tear…" (PX. 4) There was an increased signal in the posterior cruciate ligament and notes "It could represent a strain of that structure." (PX. 4) The MRI also indicates a slight elevation of the meniscus off of the anterior aspect of the tibia along the lateral aspect of the knee joint, and a possible contusion in the anterior aspect of the tibia. (PX. 4)

On April 21, 2014, Dr. Bowman referred Petitioner to Bonutti Clinic for evaluation and treatment. (PX. 3) Petitioner's first of two visits at Bonutti Clinic occurred on May 1, 2014. (PX. 5) Petitioner treated with physician's assistant Nickolas Williams. Upon reviewing the MRI, Mr. Williams noted edema in the intercondylar notch where the ACL attachment suggesting a grade I ACL sprain and questionable medial meniscus tear. (PX. 5) This record states "…this very likely is indeed a work related injury because of the new fluid collection around her ACL in ACL attachment site and intercondylar notch. In addition to this, there is a questionable medial meniscal tear." (PX. 5) Mr. Williams noted tenderness with Clarke compression. (PX. 5) The Arbitrator notes that this entry does not discuss repetitive stress to the knee, but instead indicates the condition is related to the incident on March 29, 2014. Further, even assuming Mr. Williams was referring to repetitive job duties as the source of Petitioner's condition, there is no description of Petitioner's job duties contained in the medical record. Mr. Williams simply states she worked as a cook. Petitioner was ordered to do physical therapy and was taken off work another 2-3 weeks, with a potential recommendation for injection or

arthroscopy if she failed to improve. (PX. 5) Petitioner continued physical therapy with Dr. Bowman through May 16, 2014. (PX. 3) Records through this period indicate that Petioner's condition was improving. (PX. 3).

On May 16, 2014, Petitioner phoned Bonutti Clinic and reported that she felt 80% better. (PX. 5) Physician's assistant, Nick Williams, extended her physical therapy and gave a return to work date for June 5, 2014. (PX. 5; PX 6) Petitioner testified she returned to work on this date. (T. 36) This is first date Petitioner had worked since the date of injury. (T. 36)

Petitioner continued her physical therapy with Dr. Bowman, and on June 12, 2014, Dr. Bowman ordered her to return as needed. (PX. 3) Petitioner returned to Dr. Bowman one final time on November 7, 2014. (PX. 3) The record on this date indicates that Petitioner was returning for a re-evaluation of her knee due to a mild exacerbation from work activities. (PX. 3) She was referred to Bonutti Clinic. (PX. 3)

Petitioner's second and final visit to Bonutti Clinic occurred on January 27, 2015. (PX. 5) These records note that Petitioner was still experiencing some slight instability in her right knee from time to time, "but it is very well tolerable." Petitioner was placed at maximum medical improvement. (PX. 5)

Petitioner testified that after returning to work she bid on and was transferred to a new position, property and supply clerk. Petitioner testified the main reason she wanted to transfer to this position was because of the injury to her knee and to avoid being on her feet so much. She stated, "It is a less paying job, but it is also less time on my feet." (T. 40) She testified that in her new position she is on her feet about half the time she was when she was a cook. (T. 40)

CONCLUSIONS

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of her employment. At the time of her injury, Petitioner was working in the kitchen on Respondent's premises. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of his employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. 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. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute,* 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

In this case, the Petitioner had finished washing her hands and simply turned to discard the paper towels into a trash container. There is evidence in the record tending to show that the she suffered from a physical condition prior to the accident. On March 25, 2014, four days before the alleged accident of March 29, Dr. Bowman had discussed the possibility of a Baker's cyst. When she went to the emergency department on the day of the alleged accident she was diagnosed with a ruptured Baker's cyst. This would seem to be, at least arguably, a risk personal to the employee. The risk associated with turning to throw paper towels away is clearly not a risk distinctly associated with employment as a cook. More compelling is the conclusion that the risk associated with risk associated with discarding paper towels is neutral in nature. See *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Injuries resulting from a neutral risk do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

While Petitioner asserts that the amount of time she spent on her feet created a quantitatively greater risk than that faced by the general public, there is not medical evidence to suggest that Petitioner's right knee injury is any way related to the amount of time she spent on her feet. Although PA Williams wrote "...this very likely is indeed a work related injury because of the new fluid collection around her ACL in ACL attachment site and intercondylar notch. In addition to this, there is a questionable medial meniscal tear," this simply indicates his opinion that the condition he diagnosed was related to the incident which occurred on March 29. It is not dispositive in determining whether an "accident" occurred under the Act. There is no evidence in the record to indicate Petitioner was exposed to any risk greater than that faced by the public at large. Turning to discard paper towels after washing ones hands is a risk to which the general public is exposed daily.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent on March 29, 2014. Benefits in 14 WC 16584 are therefore denied.

Likewise the record is bereft of any evidence indicating that Petitioner's condition is a result of repetitive trauma in any form. The Arbitrator further finds Petitioner has failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent on May 1, 2014. Benefits in 15 WC 14071 are therefore denied.

Because Petitioner failed to sustain her burden of establishing that she sustained injuries which arouse out of and in the course of her employment with Respondent all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosanna Concepcion,
Petitioner,

17IWCC0441

vs.

NO: 15 WC 14999

Cavalier Logistics,
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, 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 September 22, 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.

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

DATED: JUL 14 2017
o6/29/17
KWL/rm
046

Kevin W. Lamborn

David L. Gore

Stephen J. Mathis

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

17IWCC0441

CONCEPCION, ROSANNA
Employee/Petitioner

Case# **15WC014999**

13WC038591

CAVALIER LOGISTICS
Employer/Respondent

On 9/22/2016, 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 0.50% 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:

2333 WOODRUFF JOHNSON & PALERMO
LEANDRO ALHAMBRA
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0507 RUSIN & MACIOROWSKI LTD
JEFFREY E RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

17IWCC0441

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)

Rosanna Concepcion
Employee/Petitioner

v.

Cavalier Logistics
Employer/Respondent

Case # **15** WC **14999**

Consolidated cases: **13 WC 38591**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **08/16/16**. 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. [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. [ ] 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, **04/07/15**, 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 in her lumbar back ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$42,349.84**; the average weekly wage was **$814.42**.

On the date of accident, Petitioner was **58** 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

- Petitioner failed to meet her burden of proof on the issue of causation with regard to her back or lumbar condition. Therefore the Petitioner's claim for benefits related to her back or lumbar condition 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

9/21/16
Date

SEP 22 2016

FINDINGS OF FACT

This claim involves a Petitioner who has filed for two dates of accident with both cases consolidated. The first date of accident is December 1, 2012 (see Arbitration decision 13 WC 38591). Petitioner's second date of accident alleged was on April 7, 2015 (15 WC 14999) – which is the subject of this decision. At trial the issues in dispute were: 1) accident, 2) causation and 3) medical expenses.

Petitioner testified that on April 7, 2015, she was warming up her lunch. The refrigerator and microwave were moved out to the warehouse because renovations were being done to the kitchen. On her way back to her desk, Petitioner's right foot hit a groove in the concrete. She fell forward onto her right knee and then onto her right side. Petitioner testified that she was wearing heels at the time of the accident and was holding her lunch. Her right knee and right elbow struck the floor. She noticed redness in the right knee immediately after this happened. She notified her supervisor, Flora Suner, about the accident that same day and showed both her knee and her scuffed shoe to Suner.

Petitioner took a picture of the floor where the fall had occurred. (PX 11). On this picture, Petitioner circled what she described as the divot on which her foot got caught.

Respondent called Petitioner's supervisor, Flora Suner, to testify. Suner testified that Petitioner reported the fall to her that same day. Suner also noticed redness on Petitioner's right knee and Petitioner showed her the scuffed up shoe. Suner confirmed that the microwave and refrigerator were moved to the warehouse due to renovations. Suner testified that Petitioner continued to work that day. According to Suner, employees are allowed to wear heels to work.

On April 10, 2015, Petitioner saw Dr. Paul Helman with initial complaints of dizziness and vertigo (Px. 2). The records from this provider document an alleged fall four days prior with a contusion to the right knee (Px. 2). On examination, Petitioner had mild tenderness to the right knee. The record from Dr. Helman does not indicate any injury to the right elbow, right shoulder, left shoulder, low back and/or neck (Px. 2).

On May 4, 2015, Petitioner next saw Dr. Charles Carroll (Px. 2). The Arbitrator notes that Petitioner had been seeing Dr. Carroll for a prior injury, from December 1, 2012 - which is subject of Petitioner's companion claim under 13 WC 38591. Dr. Carroll documented an exacerbation of symptoms after a slip and fall, landing on her right side. At this visit Petitioner presented with left shoulder complaints following an alleged slip and fall onto the right side. The records from this visit do not mention: any numbness or tingling; any new elbow or shoulder complaints; any injury or problems to the right elbow, or right knee; or any complaints of low back pain or injury as a result of the April 7, 2015 accident. Dr. Carroll noted that Petitioner was stable following the injury. He recommened subacromial injection to the left shoulder at that time and additional occupational therapy.

On May 9, 2015, Petitioner saw Dr. Jose Kogan. Dr. Kogan's notes indicate that she was referred by Dr. Paul Helman. At that time, she had complaints of severe lower lumbar pain and bilateral leg numbness. She also continued to complain of bilateral shoulder pain and shooting pain to her buttocks.

On May 28, 2015, Petitioner saw Dr. Srdjan Mirkovic. At that time, she continued to have complaint of lower back pain as a result of slipping and falling at work on April 7, 2015. Dr. Mirkovic diagnosed her

with a lumbar sprain and ordered an MRI of her lumbar spine to rule out disc herniation. Petitioner underwent an MRI on June 7, 2015, which revealed degenerative changes.

She followed up with Dr. Mirkovic on June 11, 15. At that time, she continued to have lower back pain radiating to the buttocks with numbness and tingling down her bilateral lower extremities. The records indicate that Petitioner claimed that she had low back pain rated at an 8/10 on the pain scale with numbness and tingling in both feet. The physical examination performed by Dr. Mirkovic did not reveal any abnormalities other than three out of five positive Waddell's Findings, including symptom magnification and exaggeration. X-rays were performed and were normal. According to Petitioner, injections were discussed, however she refused them. At that time, Petitioner continued to complain of significant pain, wherein Dr. Mirkovic specifically stated "I am at a loss to explain the severity and extent, as well as the nature of her lower extremity symptoms." Dr. Mirkovic opined that Petitioner was not a surgical candidate, and referred her to Dr. Matthew Co for physical therapy and pain management if her symptoms did not improve.

On June 29, 2015, Petitoner saw Dr. Co. Dr. Co reviewed the June 7, 2015 MRI. Dr. Co diagnosed Petitioner with lumbar disc disease, lumbar radicular pain, neuropathic pain, and lumbar strain. Dr. Co recommended physical therapy for Petitioner. Petitioner underwent an EMG on July 24, 2015. The EMG findings were normal. She was last seen by Dr. Co on August 24, 2015. At that time, Dr. Co discussed steroid injections. Petitioner refused the injections. Petitioner testified that she continues to get refill prescriptions from Dr. Co.

Petitioner underwent a course a physical therapy at Athletico from July 1, 2015 through September 9, 2015.

At the request of the Respondent, Petitioner was seen by Dr. Mark Levin for a Section 12 examination on May 2, 2016. Dr. Levin found no objective pathology requiring any medical treatment to the lumbar spine or lower extremities from an alleged work occurrence on April 7, 2015. Further, Dr. Levin noted that any use of medications, including Gabapentin, is for subjective complaints of pain and not substantiated by true objective orthopedic discology from an alleged occurrence on April 7, 2015. Dr. Levin opined that Petitioner's alleged symptoms were documented several weeks after the alleged injury and do not fit with any objective pathology occurring to the lumbar spine or lower extremities from an acute fall on April 7, 2015. Dr. Levin found petitioner at MMI and completed a PPI rating of 0% whole person impairment (Rx. 6).

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that Petitioner sustained an injury that arose out of and in the course of her employment on April 7, 2015. This finding is based on the medical records and Petitioner's credible testimony, which was corroborated by her supervisor, Flora Suner. Petitioner's testimony that on April 7, 2015, she tripped and fell while walking to her desk during her lunch break, landing on her right knee, right elbow and right side, was not rebutted by any of the evidence. There was also no evidence to rebut Petitioner's testimony that there was a groove/dent on the concrete floor that caused her to fall.

2. Regarding the issue of causation for Petitioner's lumbar condition, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. This finding is supported by the medical evidence, which fail to show a causal connection between the Petitioner's April 7, 2015 accident - in which she struck her right knee and fell on to her right side - and her alleged condition of ill-being in her back. The initial medical records from four days after the Petitioner's accident show Petitioner sustained a contusion to her right knee and do not mention any injury to her back. Her next visit to Dr. Carroll do not mention any injury to her back. And although Petitioner does not allege any symptoms to the lumbar spine until a follow up with Dr. Kogan, a month after the alleged accident, that fact is overshadowed by Petitioner's own treating physician, Dr. Mirkovic, who was "at a loss" to explain the severity and extent, as well as the nature of her lower extremity symptoms. Dr. Mirkovic's finding of three out of five positive Waddell's Findings, including symptom magnification and exaggeration, is a significant finding in this case and is supportive of the Respondent's IME, Dr. Levin's opinion that Petitioner's alleged symptoms were documented several weeks after the alleged injury and do not fit with any objective pathology occurring to the lumbar spine or lower extremities from an acute fall on April 7, 2015. Based on these facts, the Arbitrator concludes that the Petitioner's condition of ill-being relating to her back or lumbar condition is not causally related to her April 7, 2015 work accident.

3. Based on the Arbitrator's findings with regard to the issue of causation, Petitioner's claim for medical expenses related to her back or lumbar condition are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTOPHER CREECH,
Petitioner,
vs.

NO: 15WC 22288

PONTIAC CORRECTIONAL CENTER,
Respondent.

17IWCC0445

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 issue of nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

DATED: JUL 14 2017
MJB/bm
o-7/11/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CREECH, CHRISTOPHER
Employee/Petitioner

Case# **15WC022288**

PONTIAC CORRECTIONAL CENTER
Employer/Respondent

17IWCC0445

On 11/10/2016, 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 0.53% 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:

5709 STROW LAW LLC
THOMAS M STROW
628 COLUMBUS ST SUITE 501
OTTAWA, IL 61350

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

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
500 S SECOND ST
SPRINGFIELD, IL 62702

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

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

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

NOV 10 2016

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRISTOPHER CREECH,
Employee/Petitioner

v.

PONTIAC CORRECTIONAL CENTER,
Employer/Respondent

Case # 15 WC 22288

Consolidated cases: _____

17IWCC0445

An *Application for Adjustment 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 **Bloomington**, on **10/27/16**. 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. ☐ 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 _____

17IWCC0445

FINDINGS

On **4/17/15**, 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 **$73,380.83**; the average weekly wage was **$1,411.16**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$12,265.65** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$12,265.65**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 101.25 weeks, because the injuries sustained caused the 10% loss of the right hand, the 10% loss of the left hand, the 12.5% loss of the right arm, and the 12.5% loss of the left arm, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

11/7/16
Date

NOV 10 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 38 year old correctional lieutenant, sustained an accidental injury to his bilateral hands and elbows that arose out of and in the course of his employment by respondent on 4/17/15. The parties stipulate that petitioner sustained an accidental injury to his bilateral hands and elbows; that his current condition of ill-being as it relates to his bilateral hands and elbows are causally related to the injury on 4/17/15; that all reasonable and necessary medical bills related to his bilateral hands and elbows have or will be paid by respondent; and that all temporary total disability benefits have been paid. The sole issue in dispute is the nature and extent of petitioner's injury.

Following the injury on 4/17/15 petitioner was diagnosed with bilateral carpal tunnel syndrome and bilateral ulnar neuropathy at both elbows.

On 5/13/15 petitioner underwent a Section 12 examination performed by Dr. James Williams at Midwest Orthopedic Center, at the request of the respondent. Following an examination and record review, Dr. Williams was of the opinion that petitioner suffered from bilateral cubital tunnel syndrome, made worse by pulling and pushing on stuck doors, doing cuffing and uncuffing. He was of the opinion that petitioner's subjective complaints were supported by his objective findings of bilateral cubital tunnel syndrome. He opined that petitioner had bilateral elbow cubital tunnel syndrome, and that there exists a causal relationship between his job duties and his current symptoms. He further opined that petitioner's surgical intervention was necessary in order to get him to maximum medical improvement, which he believed was reached 3 months after the procedure. He was of the opinion that petitioner could work his regular duty job without restrictions. He reported that he himself had toured Pickneyville Correctional Center, which is a non-automated prison, and many of the doors stuck when he tried to open them himself. He noted that there is no automation at the prison and he felt the work duties performed there are at least aggravating to the condition of bilateral elbow cubital tunnel syndrome.

On 8/11/15, TriStar risk Management sent a letter to petitioner informing him that his claim for his repetitive injury on 2/6/15 was accepted.

On 8/25/15 petitioner underwent a left open carpal tunnel release and left intramuscular ulnar nerve transposition. This procedure was performed by Dr. Jerome Oakey. Petitioner's postoperative diagnosis was left carpal tunnel syndrome and left cubital tunnel syndrome. Petitioner followed-up post-operatively with Dr. Oakey. On 10/8/15 petitioner followed-up with Dr. Oakey. He was of the opinion that petitioner was doing well following his surgery on 8/25/15. Petitioner reported that he felt independent enough so that he could

proceed with surgery on his right upper extremity. Dr. Oakey released petitioner with no restrictions for his left upper extremity.

On 10/8/15 petitioner underwent a right intramuscular ulnar nerve transposition and right open carpal tunnel release. This procedure was performed by Dr. Jerome Oakey. His postoperative diagnosis was right cubital tunnel and right carpal tunnel syndrome. Petitioner followed up post-operatively with Dr. Oakey.

On 11/18/15 petitioner followed-up with Dr. Oakey. Dr. Oakey noted that petitioner was coming along more slowly after the right upper extremity surgery than the left side. He recommended that petitioner continue in therapy.

On 2/18/16 petitioner last presented to therapy and work conditioning. Petitioner reported that he felt ready to return to work with respect to both upper extremities. He reported that his elbows and wrists only bother him at significant weights. He noted that sometimes his shoulder bothers him when lifting weight repetitively overhead. The therapist was of the opinion that petitioner had done very well with work conditioning, and had progressed his activities well without complaints. She noted that petitioner had been compliant and worked consistently during his time. She recommended that petitioner return to work at the Heavy Physical Demand Level.

On 2/19/16 petitioner last followed-up with Dr. Oakey. He reported that he was doing well and had increased strength. He reported no associated numbness or tingling. He felt that work conditioning was very helpful in alleviating his symptoms. Dr. Oakey released petitioner to full duty work.

Petitioner retired from respondent on 10/27/16. Petitioner testified that he currently has some symptoms. He complained of bilateral tingling and numbness in his little and ring finger when writing and typing. He stated since his release from treatment on 2/19/16 and trial he experienced numbness and tingling in his little and ring fingers when manipulating locks, using handcuffs, and opening a lot of cell doors. Petitioner testified that his symptoms currently are better than they were before surgery. With respect to his bilateral elbows, petitioner reported difficulty performing full extension of his elbows the first time he tries to extend them. He also reported some pain bilaterally, but nothing like what it was before surgery. Petitioner denied any of these symptoms before he worked for respondent. Respondent worked for respondent for 20 years. Petitioner reported cramping, aching and pain intermittently in his elbows during the day. Petitioner testified that Dr. Oakey told him these were just things he would have to live with. With regard to activities of daily life and recreational activities, petitioner testified that he no longer feels comfortable pitching or catching from his

daughter who plays softball. He also testified that he no longer water skis or does knee boarding. Petitioner testified that he has no permanent restrictions.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the accident on 4/17/15 petitioner sustained bilateral carpal tunnel syndrome and bilateral ulnar neuropathy at both elbows. On 8/25/15 petitioner underwent a left open carpal tunnel release and left intramuscular ulnar nerve transposition. On 10/8/15 petitioner underwent a right intramuscular ulnar nerve transposition and right open carpal tunnel release. Petitioner underwent a course of therapy and work hardening. On 2/19/16 petitioner was released from care without restrictions by Dr. Jerome Oakey. He returned to his regular duty job and retired on 10/27/16.

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 a correctional lieutenant. On 2/19/16 he was released to full duty work. He performed full duty work until he retired on 10/27/16, after 20 years of service. Based on these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 38 years old at the time of the accident. Since the accident petitioner has been released to full duty work without restrictions. When petitioner last followed up with Dr. Oakey on 2/19/16 he reported that he was doing well and had increased strength. He reported no associated numbness or tingling. He felt that work conditioning was very helpful in alleviating his symptoms. Petitioner returned to work at that time and retired on 10/27/15. He testified that he was moving to Florida and would probably work for the Sheriff Department. Based on these findings, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that following his release to full duty work on 2/19/16 petitioner worked without incident until he retired on 10/27/16. Petitioner stated that he would be most likely looking for a job with the Sheriff Department when he moved to Florida. He did not provide any evidence to support a finding that his future earning capacity is impacted by this injury. Because of this the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator adopts the findings and opinions of Dr. Oakely. On 2/19/16 petitioner last followed-up

with Dr. Oakey. He reported that he was doing well and had increased strength. He reported no associated numbness or tingling. He felt that work conditioning was very helpful in alleviating his symptoms. Dr. Oakey released petitioner to full duty work.

However at trial, petitioner testified that he currently has some symptoms. He complained of bilateral tingling and numbness in his little and ring finger when writing and typing. He stated that since his release from treatment on 2/19/16 he has experienced numbness and tingling in his little and ring fingers when manipulating locks, using handcuffs, and opening a lot of cell doors. He further testified that his symptoms currently are better than they were before surgery. With respect to his bilateral elbows, petitioner reported difficulty performing full extension of his elbows the first time he tries to extend them. He also reported some pain bilaterally, but nothing like what it was before surgery. Petitioner reported cramping, aching and pain intermittently in his elbows during the day. Petitioner testified that Dr. Oakey told him these were just things he would have to live with. With regard to activities of daily life and recreational activities, petitioner testified that he no longer feels comfortable pitching or catching from his daughter who plays softball. He also testified that he no longer water skis or knee boarding. Petitioner testified that he has no permanent restrictions. These complaints of petitioner's are not corroborated by the credible medical records.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 10% loss of use of his right hand, 10% loss of use of his left hand, 12.5% loss of use of his right arm, and 12.5% loss of use of his left arm, pursuant to §8(e) of the Act.

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

Tina Haemker,

Petitioner,

vs. NO. 15WC 22326

Eastern Will County Communication Center,

17IWCC0452

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

DATED: JUL 18 2017

SJM/sj
o-6/29/17
44

Stephen J. Mathis

David L. Gore

Kevin L. Lamborn

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

HAEMKER, TINA
Employee/Petitioner

Case# **15WC022326**

17IWCC0452

EASTERN WILL COUNTY COMMUNICATION CENTER
Employer/Respondent

On 12/2/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

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

17IWCC0452

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Tina Haemker
Employee/Petitioner
v.
Eastern Will County Communication Center
Employer/Respondent

Case # 15 WC 22326

An *Application for Adjustment 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 **May 11, 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 **May 10, 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 **$50,627.20;** the average weekly wage was **$973.60.**

On the date of accident, Petitioner was **50** years of age, **married** with **0** dependent children.

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

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $9,001.73 in accordance with Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for all reasonable and necessary costs relative to the myelogram/CT Scan, as ordered by Dr. Sweeney, and the attendant care, as well as any follow treatment for the neck and right shoulder adhesive capsulitis, as prescribed by Dr. Sweeney in accordance with the provisions of §8 and §8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits at the rate of **$649.07** per week for **51-6/7 weeks**, commencing **05/15/2015 through 05/11/2016**.

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 AMOy

Signature of Arbitrator

12/01/2016

Date

IC ArbDec19(b) p. 2

DEC 2 - 2016

 17IWCC0452

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Haemker	)	
Petitioner,	)	
vs.	)	**No. 15 WC 22326**
Eastern Will County Communication Ctr.)		
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 May 11, 2016. The parties agree that on May 10, 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 Petitioner earned $50,627.20 in the year pre-dating the accident and the petitioner's average weekly wage calculated pursuant to §10 was $973.60.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental 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 injury.
3. Whether respondent is liable for the unpaid medical bills
4. Whether petitioner is entitled to payment for prospective medical treatment.
5. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner testified that on May 10, 2015, petitioner had been employed by respondent as a 911 telecommunicator for 16 years. On that day, petitioner arrived at 3:45 A.M. She worked from 4 A.M. to 8:00 A.M. at the call-takers position. She then moved to the fire console. As a 911 telecommunicator, petitioner dispatched police, fire and ambulances in response to emergency calls. The dispatcher has thirty seconds to dispatch a call from the time the nature of the call is known.

In her job, petitioner used a CAD computer and MABAS books. MABAS books are used to dispatch a box alarm in cases of escalated structure fires in order to bring in more towns and more equipment. MABAS books are three-ring binders. The books are kept on a counter.

On the morning of May 10, 2015, petitioner relieved her supervisor, Natalie Kapf at the fire console. Petitioner testified there was a purifier on the counter. The purifier was blocking her ability to open the MABAS books on the counter. Therefore, petitioner pulled the humidifier (sic) forward with both hands, and as she lifted it, she felt a pop in her neck. She slid the purifier down her leg to the floor. Petitioner estimated the purifier weighed between 20 to 25 pounds. Petitioner had severe pain down her neck, back, rear-end and into part of her legs.

Prior to May 10, 2015, petitioner denied havingproblems with her neck and cervical spine, but confirmed she previously underwent two [lumbar] spinal fusions. She was not under any work restrictions as of May 10, 2015.

Even though the pain became unbearable, petitioner finished her shift that day as she didn't want to lose her four hours of overtime. She told no one of the accident that day.

That night, she couldn't sleep. Her husband had to help her dress. The next morning she went into work and spoke with Pam Buzan in her office. She reported to Pam Buzan that she injured her neck the day before when she moved the purifier as it was in the way of the Mutual Aid Box Alarm System (MABAS) books.

She continued to work that week, although her pain increased. On May 15, 2015, petitioner was seen at Clinical Associates and Medicine and was advised to remain off work until the follow-up visit. She followed up on May 19, 2015 and June 2, 2015 at Clinical Associates.

On June 11, 2015, petitioner saw Dr. Patrick Sweeney at the referral of Dr. Singla of Clinical Associates. Petitioner had a CT scan and followed up with Dr. Sweeney on June 18, 2015. Dr. Sweeney diagnosed a herniated disc and ordered physical therapy. On August 13, 2015, Dr. Sweeney advised the physical therapy was not helpful. Dr. Sweeney's records also noted discomfort petitioner was having in her right shoulder and down in to her fingers. This problem came on within a week after the injury to her neck.

Petitioner remained under the care of Dr. Sweeney through 2015. Dr. Sweeney injected petitioner's shoulder. Through April, 2016, Dr. Sweeney continued to recommend a CT myelogram and kept petitioner off work.

Petitioner continued to have pain, stiffness and an inability to lay flat. She has spasms and pain in the arm and is unable to move her right shoulder. She denied any new injuries to her neck or shoulder since May 10, 2015.

Petitioner completed the accident form on May 30, 2015 as that was the first time she was able to get ahold of the form.

On cross examination, petitioner agreed she had a spinal cord stimulator implanted for her lower back problem. She was also on pain meds and had to undergo periodic blood tests due to the pain meds.

Petitioner denied complaining of prior neck problems to supervisor, Natalie Krapf, or to Cindy Sepula.

Petitioner agreed she was working with supervisors Natalie Krapf and Cindy Sepula, and also Emily Seneke, on May 10, 2015.

Petitioner identified Respondent's Exhibit 1H as a photograph of the fire console where the MABAS are located. Petitioner put a 1 on the photograph (RX. 1H) to depict where the MABAS books were located on May 10, 2015. Petitioner placed a 2 on the photograph to depict where the purifier was located on May 10, 2015 (RX.1H). Petitioner testified the purifier was blocking her ability to use the MABAS books, which she would have to open on the counter. Petitioner agreed the purifier was not blocking access to the Mabas books, only blocking the ability to open the books to review.

Petitioner had applied and received FMLA twice due to her lower back and was denied a third time. Therefore, she applied for Social Security.

Respondent called Cynthia Sepula to testify. Sepula has been employed by respondent as a supervisor and dispatcher for seven and a half years. Sepula worked with petitioner on May 10, 2015. Sepula did not see the purifier on the counter that day. Sepula did not see petitioner move the purifier. Sepula did not remember hearing petitioner tell her that her neck was hurting.

Sepula was petitioner supervisor on May 10, 2015. Petitioner did not report any injury to her on May 10, 2015.

On cross examination Sepula testified to the best of her recollection the purifier was not on the counter on May 10, 2015. Sepula agreed she discussed with co-workers and boss where the purifier was located on May 10, 2015 before she testified.

Natalie Krapf, who been employed since 1998 as a supervisor for respondent, testified in behalf of respondent. Krapf agreed the MABAS books were always kept on the counter but the purifier was moved around. Krapf testified the purifier was located on the counter on May 10, 2015. Krapf agreed that if the purifier was on the cabinet there would not be enough room to open the MABAS books.

Krapf testified petitioner complained of neck problems more than once, but she could not verify when petitioner had complained.

Pamela Buzan testified in behalf of respondent. She identified photos taken of the area. She is respondent's director and was respondent's director on May 10, 2015. Respondent is a public service answering point (911 PSAP). Buzan's duties as director were to oversee the operations of the center. Dispatcher's job was to answer 911 and non-emergency calls and dispatch police, fire and EMS appropriately.

Buzan testified she had never seen the purifier on the counter in the spot petitioner marked as 2 on Respondent's Exhibit 1H. Buzan learned that petitioner was hurting when Buzan saw petitioner hunched over. Petitioner then pointed to the console [where the purifier had been] and told Buzan that she lifted something she shouldn't have. Petitioner told Buzan that she couldn't reach the MABAS books as the purifier was in the way.

Buzan asked Cindy if petitioner had told her she was injured the day before and Cindy told her no. Buzan later testified the purifier was on the counter on May 11, 2015.

On May 10, 2015, petitioner was out of vacation and sick time and was on restricted sick leave. Buzan could not confirm petitioner's time off was due specifically for neck or back problems.

Accident Illness Report Dated May 30, 2015 (PX. 1)

Petitioner completed the form indicating that she injured her back when she lifted a black purifier to move it form the counter as it was blocking the counter where the MABAS books were kept.

Dr. Singla Records (PX. 2)

These records reflect that petitioner was seen on May 15, 2015 with a history of hurting her back after lifting something at work on Sunday. Petitioner was kept off work due to a back injury. The records also reflect petitioner returned on May 19, 2015 and reported pain remained from left side of back from neck to toes. Petitioner was released to return to work on June 1, 2015. Petitioner returned on June 2, 2015 with pain getting worse and barely able to walk. She was directed to go to the emergency room and report back to Dr. Singla after she was released [from the hospital].

Tinley Park Open MRI & Imaging Center Records (PX.3)

The June 18, 2016 CT scan showed multilevel spondylosis and facet and foraminal stenosis at several levels most prominent on the left at C5-6.

ATI Records (PX.4)

Petitioner received physical therapy to her cervical region from June 23, 2015 through July 27, 2015.

Minimally Invasive Spine Specialists/Dr. Patrick Sweeney Records (PX.5)

According to these records, petitioner was first seen by Dr. Sweeney on June 11, 2015. Petitioner's history was consistent with petitioner's testimony as to the work accident of May 10, 2015. Dr. Sweeney diagnosis was likely cervical herniated disc. Dr. Sweeney ordered petitioner off work.

Petitioner returned to Dr. Sweeney on June 18, 2015 with the CT scan disc. Dr. Sweeney could not rule out a herniated disc based on his review of the June 18, 2015 CT scan. Dr. Sweeney ordered physical therapy and if no benefit then a CT scan/myelogram. Dr. Sweeney again ordered petitioner off work.

Petitioner returned to Dr. Sweeney's office on July 23, 2015. Petitioner noted improvement to her shoulder and arm with therapy but the neck pain remained. Myelogram/post myelogram CT scan was ordered. Petitioner was to remain off work.

Petitioner returned to Dr. Sweeney on August 13, 2015. Again the myelogram/post myelogram CT Scan was ordered and petitioner was ordered off work.

On September 17, 2015, petitioner returned to Dr. Sweeney who stated: "It's obvious that this injury occurred at work and her conditions (sic) is a result of that work injury." He reiterated the order for the myelogram/CT scan and ordered petitioner continue off work.

Petitioner followed up with Dr. Sweeney on October 22, 2015, November 19, 2015, January 7, 2016, February 4, 2016 and March 10, 2016 who had the same findings and recommendations; to remain off work and a myelogram/CT scan. As of April 7, 2016 Dr. Sweeney reported petitioner had developed adhesive capsulitis of the right shoulder and needs approval of care.

Medical Bills (PX.8)

ATI Bills $5,216.73
Clinical Associates (Dr. Singla) $370.00
Minimally Invasive Spine (Dr. Sweeney) $1,915.00
Tinley Park MRI & Imaging $1,500.00

Photos of Area and Purifier (RX 1)

MABAS Division #27 Box Alarm Log sheet 2015 (RX.2)

Clinic Associates in Medicine Records (RX.3)

These records indicate petitioner saw Dr. Singla's PA on February 10, 2015 with complaints of pain worse in the morning and hands always hurting and wanted to be tested for RA (rheumatoid arthritis).

Petitioner was seen on November 24, 2014 for chronic pain. She was also seen on June 9, 2014. February 13, 2014.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator had the opportunity to view the mannerisms and the petitioner's presentation and found petitioner to be credible. The Arbitrator questions the credibility of respondent's witnesses as there were, admittedly, discussions between the witnesses before testifying and inconsistencies in their testimony. Specifically, Pamela Buzan testified she never had seen the purifier on the counter in the spot indicated by petitioner on the counter and then later said the purifier was still on the counter on May 11, 2015.

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:

Although not witnessed, petitioner testified credibly that she injured her neck when she lifted the purifier in anticipation she would need easy access to MABAS books if required on May 10, 2015. Although she did not tell the two supervisors that she was hurting on the day of the occurrence, she reported the injury to respondent's director, Pam Buzan, the next day.

The preponderance of the evidence supports petitioner's claim that she suffered accidental injuries in an accident at work on May 10, 2015 when she lifted a purifier off a counter in order to access the use MABAS books when needed.

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:

There is no medical evidence to support petitioner had any prior cervical or neck problems before the work incident of May 10, 2015. Dr. Sweeney's records support petitioner's claim that the neck injury diagnosed as cervical herniated discs at C2-3, C3-4 with stenosis at C5-6, for which Dr. Sweeney ordered cervical myelogram/CT scan, resulted from the work accident. As of April 7, 2016, Dr. Sweeney also determined petitioner had developed adhesive capsulitis secondary to pin with movement of the right shoulder as a result of the work accident. Respondent offered no medical evidence to refute Dr. Sweeney's causation opinion.

Based upon the foregoing, the Arbitrator finds petitioner sustained herniated discs at C2-3, C3-4 and stenosis at C5-6, as well as adhesive capsulitis of the right shoulder as a result of the work accident of May 10, 2015.

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's cervical injury and shoulder adhesive capsulitis were caused by the work accident of May 10, 2015, awards the medical bills pursuant to the provisions of §8 and §8.2 of the Act:

$5,216.73 - ATI
$370.00 - Clinical Associates (Dr. Singla)
$1,915.00 - Minimally Invasive Spine (Dr. Sweeney)
$1,500.00 – Tinley Park MRI & Imaging

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

The Arbitrator, having determined petitioner's injuries to her neck and right shoulder were caused by a work accident arose out of and in the course of his employment with respondent on May 10, 2015, awards the costs for the treatment prescribed by Dr. Sweeney which includes a myelogram/CT scan and treatment for the developed adhesive capsulitis in accordance with the provisions of §8 and §8.2 of the Act.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

Petitioner was under the care of Dr. Singla, who kept her off work as of May 15, 2015 Petitioner was then under the care of Dr. Sweeney who kept her off work to the date of hearing. Respondent did not provide contrary medical evidence to refute petitioner's disability. The Arbitrator therefore finds petitioner is entitled to temporary total disability as of May 15, 2015 through May 11, 2016, which is 51-6/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Fortney,

Petitioner,

17IWCC0458

vs.

NO: 15 WC 23156

Performance Food Service,

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

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

17IWCC0458

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 $11,400.00. 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: JUL 19 2017
o7/13/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0458

FORTNEY, LARRY
Employee/Petitioner

Case# **15WC023156**

PERFORMANCE FOOD SERVICE
Employer/Respondent

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5341 BROWN & BROWN
DAVID J JEROME
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HEIGHT, IL 62208

2542 BRYCE DOWNEY & LENKOV LLC
EDWARD JORDAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

17IWCC0458

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
19(b)

Larry Fortney
Employee/Petitioner

v.

Performance Food Service
Employer/Respondent

Case # 15 WC 023156

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **9/7/16**. 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] Were the 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 [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **1/8/15**, 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 **$14,545.10 over 13-5/7**; the average weekly wage was **$1,060.60**.

On the date of accident, Petitioner was **48** 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 **$25,743.81** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,049.98** for other benefits, for a total credit of **$31,793.79**.

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 $707.06 for 43-6/7 weeks, commencing 11/5/15 through 9/7/16, as provided in Section 8(b) of the Act. It is agreed by the parties that Petitioner was appropriately paid lost time benefits from 1/9/15 to 8/24/15 and 8/26/15 to 11/4/15. These benefits were paid at an incorrect rate and Respondent agrees to apply a previous $2,000.00 advance to the underpayment of temporary total disability and will pay an additional $2,371.38 to bring lost time benefits current up to 11/4/15.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $11,922.06; Respondent shall also reimburse Petitioner out-of-pocket expenses of $209.49.

Respondent shall authorize medical treatment currently being prescribed by Dr. Matthew Gornet.

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. Glenn McCarty

10/06/2016

Signature of Arbitrator

Date

ICArbDec19(b)

OCT 13 2016

Larry Fortney v. Performance Food Service
IWCC# 15 WC 023156

STATEMENT OF FACTS

Petitioner Larry Fortney filed an Application for Adjustment of Claim at the Illinois Workers' Compensation Commission alleging that he slipped on frozen items and sustained injury to his right knee, low back, and bilateral lower extremities. On that date, Petitioner was employed by Performance Food Service as a delivery driver. (Tr.14-15). Petitioner began working at this position in September of 2014. (Tr.15). Petitioner testified that his job required delivering food products to grocery stores, nursing homes, and schools. He was physically required to load food items onto a dolly and take them into the customer. (Tr.15). Petitioner testified that he was working this position on a full-time status leading up to the work accident. (Tr.15).

On January 8, 2015, Petitioner was delivering food to a restaurant. While unloading the truck, he slipped on what he believed to be pickle juice as he testified that he smelled like pickles all day following the fall. (Tr.16). Petitioner testified that when he landed, his right leg went outward and twisted and his feet flew out from under him. Petitioner testified that his first instinct was to put his arm back to prevent him from hitting his head but he ended up landing hard on his tailbone. (Tr.16-17). Petitioner testified that when he initially got up, he primarily noticed extreme throbbing and a stinging sensation in his right knee. (Tr.17-18).

Petitioner testified that when this accident occurred, there was no one to come to his aid as it was early in the morning and he was the only one at the back of this truck. (Tr.18). Petitioner testified that he hobbled through the rest of that load and believed that it was the last dolly full of food that needed to be delivered. (Tr.18).

Petitioner testified that after he finished this job, he contacted Phil, the lead driver and advised him that he had fallen and was having severe problems with his knee. (Tr.19). Petitioner testified that at that time, he was not having any low back problems. (Tr.20). Petitioner testified that he also talked with his supervisor, Joe, and advised him of the work accident. He advised Joe that he was in extreme pain but that he would do his best to finish his workday, which he did. (Tr.20-22). Petitioner testified that when he talked with Phil and Joe, his main concern was his knee because that was where he was having the significant portion of his symptoms. (Tr.22).

Petitioner testified that the next day he completed an Employee Statement of Injury and Illness. (Px.3). Petitioner testified that when he completed this report, he described how his feet went out from under him and that he twisted his knee causing sharp pain in the right knee. Petitioner testified that at that time, he was not having low back symptoms but was having severe pain in his knee. (Tr.23-24). He described the pain to the front of the knee but also having numbness to the back of the leg. (Tr.24). Petitioner noted that at that time, he was not able to put any more pressure on his knee because of the sharp acute pain in the front of the knee. (Tr.24-25).

After talking with Joe, Petitioner was sent to a telephonic nurse who advised him to either go to the emergency room or go to a doctor of his choosing. This nurse did not examine him but simply talked to him over the phone. (Tr.24-25). Petitioner advised the nurse that he was having extreme pain in his knee.

Petitioner's first medical care provider was a nurse practitioner at his doctor's office. Medical records from this facility confirm Petitioner's history of having slipped and injured his knee. Petitioner confirmed that at that time, he was not having specific low back symptoms but was continuing to have numbness in the back of the leg. (Tr.26-27). Petitioner was sent for physical therapy, provided medications and told to rest his leg for a few days. Petitioner was not able to walk following this time period as he remained in excruciating pain. (Tr.27). As a result, Petitioner was referred to an orthopedist. (Px1).

Petitioner testified that his family doctor wanted him to be seen by Dr. Luetz but that he was not seen by this doctor as the appointment was cancelled by the Nurse Case Manager. Instead, the Nurse Case Manager scheduled him an appointment with Dr. Werries. (Tr.28-29).

Petitioner was first examined by Dr. Werries on March 18, 2015. (Tr.31). Petitioner completed a questionnaire on that date describing the accident as well as the symptoms. The Patient Questionnaire has additional writing that the Petitioner acknowledged was not his but that of the doctor which indicated that Petitioner was also having posterior knee numbness and tingling. (Tr.32). Petitioner testified that at that time, in addition to the pain in the front of the knee, he was having numbness on the backside of the knee that began immediately following the work injury. Petitioner testified that he had never had these symptoms at any point prior to this work accident. (Tr.34).

Dr. Werries' medical records confirm that on March 18, 2015, Petitioner was seen for problems with his right knee. The doctor noted that on January 8, 2015, Petitioner had stepped out of the back of the truck and slipped on a metal bar that was covered in frost and fell to his right knee. Petitioner rated his pain as an 8 out of 10 and noted that walking and going up stairs exacerbated his symptoms. Dr. Werries also noted that Petitioner was having numbness and tingling to the posterior knee. Following examination, Dr. Werries diagnosed Petitioner with having a medial meniscal tear and chondrolmalacia of the patella. Dr. Werries testified that although he had identified the medial meniscal tear, there were a couple of things that concerned him. The first was the fact that he was having numbness and tingling at the posterior aspect of his knee that was inconsistent with a meniscus tear. (Px1:13). Dr. Werries was also concerned that Petitioner had a pain level that was 8 out of 10 that was much higher than someone would have with a simple meniscus tear. (Px1:13)

Following testing, Dr. Werries took Petitioner to surgery on April 22, 2015 at Passavant Area Hospital. Dr. Werries diagnosed and corrected a right medial meniscus tear by way of a right knee arthroscopy and arthroscopic partial medial meniscetomy and limited debridement. Post-operatively, Petitioner underwent physical therapy at Passavant Area Hospital. In the initial assessment of May 5, 2015, Petitioner was noted to be ambulating with one crutch but still having a mildly antalgic gait. (Px4).

Petitioner testified that following the surgery, he was still sore in the knee area but he was primarily having a lot of problems with the back of his knee. Petitioner testified that when he tried to walk, his knee would want to buckle on him. Further, he continued to have a lot of pain in the back of his knee. (Tr.35-36). Petitioner confirmed that he had never had any problems with his knee buckling or wanting to buckle prior to this accident. (Tr.36).

Dr. Werries noted that on the follow up of May 20, 2015, Petitioner was still using his crutches. (Px2:17-18). Dr. Werries testified that at that stage of post-operative care, he was not expecting Petitioner to continue to use crutches. He noted that Petitioner was continuing to have significant symptoms and had suggested the possibility of complex regional pain syndrome. (Px1:18-19). As a result, Dr. Werries recommended a venous Doppler to rule out the DVT. This was completed and found to be negative for a blood clot. (Px1:19-20).

Dr. Werries testified that by June 10, 2015, Petitioner's knee was improving but that he was noticing significant pain when he would attempt to straighten his leg out. Dr. Werries noted that this was consistent with an ongoing lumbar radiculopathy. Dr. Werries noted that previously, he was focusing on Petitioner's knee but then began to feel that there was some possible issues associated with his low back and recommended a nerve conduction study and an MRI of the lumbar spine. (Px1; Tr.20-21).

Medical records from Passavant Rehabilitation Services noted that by June 18, 2015, Petitioner continued to have right knee pain that was worse with walking, especially going down steps or on uneven ground. Petitioner was noted to have sharp shooting pain to the medial side of the knee when going down stairs. He was also noted to have a numb/dead feeling from the back of the knee and down into the entire leg.

Dr. Werries testified that by July 8, 2015, Petitioner's knee condition was progressing and that he was obtaining full extension and flexion. However, Petitioner was continuing to have problems progressing in physical therapy to get back his strength and reduce his pain levels. Dr. Werries testified that these symptoms and problems could be explained by a lumbar radiculopathy. As of that date, Dr. Werries recommended an MRI that confirmed a disc bulge and some foraminal narrowing that appeared to be putting pressure on the nerve in the lumbar spine. (Px1; Tr.23-24).

Dr. Werries testified that on August 10, 2015, he reviewed the MRI results and recommended Petitioner be seen by a spine specialist. Dr. Werries advised that he placed work restrictions of no pushing or pulling greater than 100 pounds until seen by the spine specialist. Dr. Werries testified that the symptoms associated with the low back and knee can sometimes overlap and that it is not unusual for a patient to have two problems that are going on concurrently. (Px1:26). Dr. Werries testified that the problems with the knee as well as the symptoms down the back of the leg began following this work injury, as per Petitioner's history to him. Dr. Werries testified that Petitioner did not tell him of any subsequent accidents, injuries, or events that occurred from March until August of 2015.

Petitioner testified that following physical therapy, he was sent for work hardening. In completing work hardening, he was asked to pull 125 pounds in a dolly around the building or up and down stairs. (Tr.38-39). His other activities included placing weights into milk crates and moving them from one shelf to another. Petitioner testified that there were days that were good days but other days when he would be in a lot of pain and his leg would stiffen up and cause problems with buckling. (Tr.39-40). Petitioner testified that his symptoms worsened while undergoing work hardening. (Tr.40).

Petitioner testified that when he last saw Dr. Werries, he was referred over to a back specialist. At that time, Petitioner went on his own to Dr. Matthew Gornet. However, shortly before seeing Dr. Gornet, Petitioner attempted to return to work on August 24, 2015. At that time, he had a 120 pound lifting limit when he attempted to complete his work activities. (Tr.43). Petitioner testified that by the end of the day, he was in extreme pain. The following day, he did not go into work as he was scheduled for an MRI. However, he did return to work on August 26, 2015 and described having significant low back pain. (Tr.44). Petitioner testified that his leg tightened up and began to have a dead feeling. (Tr.44). Petitioner described having numbness in the back of the knee that spread to his foot the longer he was on his leg. (Tr.45).

On August 26, 2015, Petitioner was seen by Dr. Matthew Gornet. Dr. Gornet recorded that Petitioner had sustained an injury on January 8, 2015 when he slipped causing his feet to go out from under him and twisting his knee. Petitioner had advised the doctor when he tried to catch himself, he landed on his left buttock. Dr. Gornet reviewed the medical notes from Dr. Werries from March 18, 2015 documenting the reports of numbness and tingling in the posterior knee. Dr. Gornet testified as follows:

> "The gentleman had a fall which is known to be consistent as far as causing a structural problem in the spine. And he had knee pain and he had knee pathology. But yet after a reasonable surgery which has a high degree of success, he had continued symptoms. His symptoms, as I can see from the reports, were predominantly around the knee from the very beginning. A disc herniation at L3-4 could easily cause knee pain and easily be encompassed in this overlying diagnosis of a knee problem, and, therefore, be masked. And a physician who sees obvious pathology in the knee would more likely than not never even look for anything else until the patient failed appropriate treatment. So in this situation, his knee symptoms easily could have been coming from his back from the very beginning, and they are called radicular symptoms or referred. And the fact that he had tingling in the back of his knee is also consistent with that. That's not consistent with a knee injury. So all of the things, again, looking at it retrospectively are consistent with a spinal problem in addition to his knee problem." (Px2; Tr.12-13).

Further, Dr. Gornet testified that when he examined Petitioner on August 26, 2015, Petitioner had decreased quad strength on the right; decreased EHL and ankle dorsal flexion on the right at 4 over 5; decreased sensation in the L3 and L4 dermatones which essentially encompassed the knee region. (Px2:16). Dr. Gornet noted that these symptoms correlated with the radiographic findings that showed a fairly massive disc herniation

causing near complete or obliteration of the spinal canal at L3-4 resulting in severe spinal stenosis. Dr. Gornet also noted that Petitioner has a central disc protrusion annular tear at L4-5 with a foraminal herniation and foraminal stenosis on the right at L4-5. (Px2:17). Dr. Gornet concluded that these symptoms were consistent with the type of accident that Petitioner had described to him as well as the nature of this work injury. (Px2:18).

Dr. Gornet testified that he had no problem with the treatment provided by Dr. Werries as the torn medial meniscus would have needed to have been treated anyway. (Px2:19). The doctor went on to indicate that when an individual has problems that overlap, that patient is often sent back and forth between the spine surgeon and sports medicine doctor to try to figure out the true mechanism of symptoms. (Px2:19).

As of August 26, 2015, Dr. Gornet recommended conservative care with medications as well as a repeat MRI because the previous scan was of poor quality. Dr. Gornet also recommended injections at L3-4 and L4-5 with consideration of surgery if his symptoms did not improve. (Px2:20).

By August 29, 2015, Dr. Gornet noted that the injections had helped Petitioner temporarily but that the symptoms had returned. As a result, Dr. Gornet recommended a two-level spinal fusion at L3-4 and L4-5. (Px2). In confirmation of this surgery, Dr. Gornet completed a myelogram on January 11, 2016. (Px2:22). The myelogram findings were consistent with the same impressions that he had obtained from the MRI which confirmed his recommendations for surgery. (Px2:23). Dr. Gornet testified that he continues to have Petitioner off of work until the surgery can be approved.

Dr. Gornet testified that Petitioner may have had pre-existing disc degeneration and pre-existing facet arthropathy. However, Dr. Gornet believed that the injuries from his accident pushed him over the edge, leading to the recommendation for surgery. The doctor went on to conclude that the severe compression seen at the level of L3-4 is not consistent with a long-standing process. (Px2:35-36).

Dr. Gornet testified that if an individual has radiculopathy, they may not notice any low back pain whatsoever because of having significant knee pain. The doctor testified that a patient may find that due to significant pain in an isolated extremity it is not unusual for them to not also have low back symptoms. (Px2:36). Dr. Gornet indicated that a patient can have a disc herniation with severe radicular pain and have no back pain. He noted that he sees that commonly. (Px2:39). Dr. Gornet noted that as an example, he can stick a knife into a patient's L3-4 nerve and that individual may not have much in the way of back pain but would have pain in their knee. (Px2:41).

Petitioner testified that he wants to proceed forward with the treatment recommended by Dr. Gornet. Petitioner testified that right now his life is miserable as he cannot do anything. (Tr.47-48). Petitioner testified that if he tries to go shopping, his leg goes numb. Petitioner also described being in fear of his knee buckling because it does so regularly. (Tr.48). Petitioner testified that the knee buckling began right after the accident. (Tr.48). Petitioner testified that he continued to receive lost time benefits up until November of 2015. Petitioner testified that at that time, he had not been released to go

back to work in any capacity by Dr. Gornet. (Tr.50). Additionally, Petitioner testified that he remains employed by Performance Food Service and has not been told that he has been terminated. (Tr.50). However, he has not received any lost time benefits but did receive short-term disability benefits for a duration.

Petitioner testified that prior to the work injury in 2000, he was working for Capital EMI Records. While picking up a skid, he pulled a muscle in his low back. He was seen by his regular doctor, Dr. Henschen and was referred over to Dr. Van Fleet for a single visit. During his treatment following this injury, he was never sent for an MRI nor was he recommended for any type of surgery. (Tr.52-53). Petitioner testified that while undergoing this treatment for his low back, he had no numbness in the back of his knee. (Tr.53).

Petitioner testified that prior to the injury, there were times when he would have low back symptoms but that he was never referred for any orthopedic or neurosurgical consult except for the one visit by Dr. Van Fleet in 2000.

Petitioner testified that on July 25, 2012, he was working for Lincare and delivering home oxygen to people when he strained a muscle in his low back lifting a heavy object. At that time, he was having right upper back pain as well as low back pain with numbness down his left leg. He was not referred for any MRIs but was simply given light duty for two weeks. Following that two week off work time, he had no ongoing problems with his back.

In June of 2014, Petitioner had a couple of visits with the doctor talking about right back pain on and off as well as pain shooting down his right leg. Petitioner testified that during that time period, he underwent gallbladder surgery in August of 2014 that relieved the symptoms with his low back. (Tr.56-57).

Petitioner testified that his job required that he load and unload the food on a daily basis. He described the job as being very physically demanding. (Tr.57). Petitioner testified that there were times when he would have aches and pains associated with his lifting activities at work but that he had never had numbness in the back of his leg until this work injury. (Tr.58). Petitioner testified that as part of beginning his work activities for Respondent, Petitioner had to do a Work Step Physical Examination. As part of a Work Step Physical Examination, he had to complete a job simulation and complete the physical activities performed by policeman and fireman. Petitioner testified that he had no problems completing this test and had no problems associated with his low back. (Tr.61-62). Similarly, in November of 2014, Petitioner completed a DOT physical examination and was having no problems at all associated with his low back.

As part of Respondent's defense of this matter, it had Petitioner examined by Dr. Craig Beyer on October 20, 2015. Petitioner testified that Dr. Beyer spent 10 to 15 minutes with him. (Tr.64). Petitioner testified that when Dr. Beyer first came into the room, he had a big stack of papers in a folder that he threw down, shook his head, and said that he had been going over the reports. Petitioner stated that Dr. Beyer advised him that he was obese and did not believe that his back problems were due to his falling. (Tr.64). Further,

Petitioner testified that Dr. Beyer spent most of the examination time telling Petitioner that he thought he was obese and had degenerative problems. (Tr.66). Petitioner testified that the examination only included the doctor checking his heart and having Petitioner stand up and try to touch his toes. (Tr.66). Petitioner testified that Dr. Beyer did not have him take his shirt off; did not touch his back; did not weigh him; and did not run a pinwheel along his back of the back of his leg. (Tr.66-67). Dr. Beyer did not even touch the area that Petitioner described as being numb. Petitioner also testified that Dr. Beyer describes as having reviewed medical records from a Dr. Carragee that were MRI findings of the MRI spine that had predated the work injury. Petitioner testified that he does not know who Dr. Carragee is nor did he see a Dr. Carragee. Moreover, Petitioner testified that he had never had any MRIs of his low back until this work injury. (Tr.67-68).

Dr. Beyer testified by way of deposition. He said that he does not have an active medical practice and last saw patients in July of 2015. Dr. Beyer testified that he was only doing medical/legal work. (Rx1:43). Further, Dr. Beyer testified that he does not do back surgeries and that the last time that he had done any spinal surgery was back in 1992. (Rx1:45). Dr. Beyer testified that 80% to 90% of his referrals for his medical/legal only practice come from the defense side. (Rx1).

Dr. Beyer testified that although he reviewed a report indicating that Petitioner's feet went out from under him, he did not believe that he landed onto his low back. (Rx1:58). Dr. Beyer testified that he did not believe that the low back condition was related to the original injury as he believed there was a two and half month delay between the injury events and the signs, symptoms, or complaints that maybe a radicular problem or low back pathology. (Rx1:50). As a result, Dr. Beyer concluded that Petitioner was at maximum medical improvement relative to his knee arthroscopy and was capable of returning to work. (Rx1:39-41). Dr. Beyer based his conclusions on his review of the medical records and physical therapist evaluations. (Rx1:50-51). Dr. Beyer responded regarding Dr. Werries' conclusions in this regard in the following manner:

> "Q: And if Dr. Werries would suggest that when I first saw him, although I didn't put it in my report, I thought there may have been something associated with the low back. That's certainly something that since you didn't examine him, didn't know anything, you are having to rely on what Dr. Werries first saw when he evaluated Larry back in March of 2015; correct?
> A: I am looking at what Dr. Werries said, and he didn't report any of that information. So all I can say it what's in the records." (Rx1:50-51).

Dr. Beyer testified that if an individual sustained a disc herniation or other disc injury relating to a fall, he expected the patient to complain of symptoms immediately after the incident. (Rx1:66). Dr. Beyer testified that if there is a disc herniation, it would cause nerve irritation, extremity pain, or numbness and tingling. Dr. Beyer testified that these symptoms do not appear in the record until June 18, 2015, a full five months after the injury. As a result, Dr. Beyer testified that this delay in the onset of numbness in the lower extremity precluded a cause and effect relationship. (Rx1:66).

Dr. Beyer testified that in reviewing the medical notes from Dr. Werries, he did not believe that Dr. Werries had any concerns for lumbar radicular pain. (Rx1:16) Dr. Beyer felt that Dr. Werries had concluded that the posterior knee symptoms were actually related to a patellofemoral maltracking which he indicated to be chondromalacia patella. (Rx1: 16). Dr. Beyer admitted that in determining Dr. Werries' conclusions, he had not talked with the doctor but had to rely exclusively on the medical records and the terms used therein. (Rx1:51). Dr. Beyer was not aware that Dr. Werries had recommended or completed an MRI. (Rx1:51). Dr. Beyer was also not aware that Dr. Werries had referred Petitioner to a neurosurgeon and taken him off work due to low back issues. (Rx1:51-52). At the time of Dr. Beyers' deposition, Dr. Werries had not yet been deposed.

Dr. Beyer testified in reviewing the medical records between June 2, 2015 and June 18, 2015, he felt that Petitioner's condition had changed considerably. (Rx1:20). Dr. Beyer noted that Petitioner's pain symptoms were worse and that his activities were causing sharp numbness as well as a dead achy feeling. (Rx1:20-21). Dr. Beyer concluded that this was a completely new finding which he believed to be an abrupt onset of lumbar radiculopathy. (Rx1:20-21). Dr. Beyer noted that in reviewing the physical therapy notes from Passavant Area Hospital, it showed co-existing new back problems interfering with Petitioner's progress in terms of his ability to return to work. (Rx1:22). Dr. Beyer concluded that Petitioner's back problems that were noted in the work hardening records were impairing his recovery from his knee arthroscopy. (Rx1:22-23). Dr. Beyer concluded that work hardening is typically not necessary for knee arthroscopies as there is not time for someone to have considerable muscle loss. As a result, Dr. Beyer did not believe that work conditioning was a reasonable treatment in this case even though it was completed at the request of Dr. Werries. (Rx1:23).

Dr. Beyer admitted that he did not review any medical records for treatment that existed prior to the work injury. He was not aware of any MRIs or testing that had been completed to the low back prior to the work injury. (Rx1:51-52). Dr. Beyer was not provided any pre-employment physical examinations or pre-employment functional capacity evaluations that had been completed. (Rx1:52). Dr. Beyer did admit that when he examined Petitioner, he advised him that he was working full duty without restrictions leading up to the date of the accident. (Rx1:53).

Dr. Beyer testified that when he examined Petitioner, he believed that there was a protrusion and an annular tear at L4-5. He did not recall seeing a large herniated disc at L3-4 but admitted that he did not have the films with him at the time of the deposition. (Rx1:54). Dr. Beyer admitted that he was not provided any of the medical records from Dr. Gornet or any of the new MRIs completed by Dr. Gornet's office. (Rx1:55).

Petitioner testified at trial that he continues to have numbness down his right leg that is constant. (Tr.69). Petitioner testified that if he walks too much, he begins to develop back pain and his leg goes completely numb with a dead feeling. (Tr.69-70). Petitioner testified that he can walk for a couple of minutes before it starts to tighten up. Thereafter, it starts to go numb all the way down into his foot. (Tr.69-71). Petitioner testified that when this occurs, he becomes frightened that he is going to fall because of his leg giving way. (Tr.71). Petitioner testified that his leg gives way all the time since

this work injury. He does not relate it to any type of specific activity and notes that he could just be sitting down and when he tries to get up, the leg will buckle. (Tr.73-74).

Petitioner testified on cross-examination that after reviewing the report of injury, he would agree that it does not indicate that he was having any back pain. Petitioner went on to indicate that when he landed on his tailbone, the excruciating pain was in his knee and not his tailbone. Further, Petitioner testified that even as of the trial date, he does not have a lot of back pain. It is only when he is out walking that he develops symptoms going up into his back. (Tr.85-86). Similarly, Petitioner stated that whenever he completed the paperwork for Dr. Werries, he did not advise of having any back pain. (Tr.96). However, he does note that there was recorded by Dr. Werries that he was having posterior knee numbness and tingling. (Tr.95).

Petitioner testified that in June of 2014, he was seen by Dr. Griffin as well as Ms. Lansaw with problems associated with his gallbladder. He does not specifically recall telling the physician that he had back pain off and on for two years as well as pain down his right leg. (Tr.107).

Petitioner testified that after his knee surgery, he was encouraged by Dr. Werries to get out and become active to help him build up his strength. (Tr.112-113). As a result, he took a one day trip to Cleveland, Ohio with his wife. (Tr.113). Petitioner testified that his wife drove the whole way although he did help to drive in some of the heavy traffic because she did not like driving in traffic. (Tr.113). Petitioner testified that the drive was six or seven hours and he went to the Rock and Roll Hall of Fame. (Tr.114-115). Petitioner testified that he was at the Rock and Roll Hall of Fame for an hour to an hour and a half but testified that there was a lot of sitting involved. (Tr.116). Petitioner testified that at that time, he had a knee brace but was not using crutches.

Additionally, Petitioner testified that between January 8, 2015 and August of 2015, he went to one baseball game. Petitioner testified that his wife drove to St. Louis for this event. (Tr.116-117).

Petitioner testified that in August of 2015, he went to the State Fair in Illinois to attend a concert. Petitioner testified that he paid extra to get VIP seats so that he could be off to the side so that he could sit. (Tr.117-118). Petitioner testified that the concert was an hour and a half to two hours and that he spent most of the time off to the side.

Petitioner testified that following the accident in January of 2015, he had constant issues with his knee buckling. Petitioner testified that he advised Dr. Werries of this problem several times. (Tr.119-120). Petitioner testified that he believed that the knee was giving out because of the torn meniscus in his knee. (Tr.120).

Petitioner testified that when he talked with Phil and Joe immediately following this injury, he was not having any symptoms in his low back so he did not talk with them about having any low back problems. (Tr.120-121). Similarly, when Petitioner talked with the nurse practitioner, he was not having any specific symptoms in his low back as all of the symptoms were in his knee and to the back of his leg. Petitioner testified that when he

was receiving treatment for his knee, he thought that the numbness and pain in the back of his leg was all combined together. (Tr.122-123). After the surgery, Dr. Werries is the one who identified the potential issue with the pain going down from his low back into his leg. (Tr.124). Petitioner testified that he did not come to the doctor asking for treatment on his back but it was Dr. Werries who advised him that he thought that there was something further going on besides the meniscal tear and later diagnosed the problems in the low back. (Tr.124-125).

Sean McGrath testified on behalf of Respondent. McGrath testified that he was a driver at Performance Food Groups Fox River. He noted that his job was to unload trucks; check items; deal with customers; get signatures; move onto the next customer to do the same thing. McGrath testified that he worked with Petitioner on August 26, 2015. (Tr.132). McGrath testified that on that date, they began working together at 5:00 a.m. and continued working until around 12:00 p.m. or 1:00 p.m. McGrath testified that he drove the truck to the various sites while Petitioner sat in the passenger seat. On that date, McGrath stated that Petitioner did not do much work in the trailer and only took a few loads. McGrath noted that Petitioner was on a weight restriction so he did not put much weight on the dolly and only ran a few of them in. McGrath testified that he did most of the work that date. (Tr.135).

McGrath testified that in talking with Petitioner, Petitioner had asked if he had ever had a slipped disc. (Tr.135-136). McGrath noted that Petitioner did not seem any different regarding his ability to walk. (Tr.136). McGrath testified that Petitioner had advised him about going to a concert; going to a baseball game; and going to a building that was diamond shaped or triangle shape with a bunch of glass. (Tr.136-137). McGrath was not aware of the dates when Petitioner went but just simply talked about having gone since he was off work.

McGrath admitted that in previous times when he had worked with Petitioner, Petitioner was able to do his full work and was able to load and unload the trucks with him. This was different from when he worked with Petitioner on August 26, 2015. (Tr.138). On August 26, 2015, McGrath testified that Petitioner did not do much work and McGrath had to do most of the loading and unloading. (Tr.138-139). McGrath did not ask Petitioner why he was unable to do more as he knew that Petitioner was on a weight restriction.

McGrath testified that Petitioner had asked him about a slipped disc but that McGrath did not remember the exact context of the conversation but simply remembered Petitioner asking him something about back pain. McGrath testified that it appeared to be that Petitioner was explaining to him the pain that he had coming from what he perceived to be a slipped disc. (Tr.140).

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

Petitioner sustained an accidental injury on January 8, 2015 when he slipped on a liquid twisting his right leg and landing on his low back. The Petitioner admitted, and the

medical records clearly established, that he had a history of prior lower back symptoms with radiation into the right leg, described in those records as sciatica. (PX 5) In 2000, the Petitioner had numbness in the right leg. He was seen by a spinal surgeon, Dr. Van Fleet, on referral from his family physician, Dr. Hinchen. Dr. Hinchen noted on July 18, 2000 that the Petitioner did not have sufficient disc pathology to warrant surgery. (PX 5) He was seen again in August of 2001 with an acute strain of the right lumbar spine. From August through November of 2002, he received treatment for right lumbar pain. No record of any back pain was entered into evidence from then until July 2012, when he reported lower back pain occasionally going to the right. (PX 5) On June 11, 2014, he complained of radiating pain down the right thigh and physical therapy for sciatica was prescribed. (Id) As late as October 29, 2014, the Petitioner reported to his family physician that he was working a new job unloading trucks and needed a refill of his Naproxen which he took for right sciatica. (Id) However, as stated above, he passed an employment physical in September when he was hired by the Respondent and passed his DOT physical on November 26, 2014. The issue is whether the accident aggravated the condition or conditions which were causing the sciatica, bringing about the need for Dr. Gornet's proposed surgery.

Dr. Gornet, a spinal surgeon, testified persuasively that such an aggregation had occurred. He said that the numbness and tingling the Petitioner experienced in the back of his right knee, symptoms noted by Dr. Werries when he first saw the Petitioner on March 18, 2015, were consistent with lumbar radiculopathy and not a torn meniscus. (PX 2 at 15) He said that the accident, whether it involved the Petitioner falling on his buttocks or just twisting, could have caused a herniation of the L3-4 disc, bringing about the symptoms. (Id at 42)

The main issue for the Arbitrator to resolve is how could there have been such an aggravation, described by Dr. Gornet as producing a massive ruptured disc, without it bringing on immediate symptoms of severe lower back pain and radiation not just behind the knee, but down the entire right leg. Dr. Gornet dealt with the issue. As his testimony, quoted above in the finding of facts, points out, he felt the knee injury symptoms could have masked the spine related symptoms. He said that the Petitioner may not have immediately noticed back symptoms because the knee pain he had was so significant. (Id at 36) Once the knee injury was treated and he experienced some relief of those symptoms, the other symptoms may have been more noticeable to the Petitioner.

Dr. Gornet's reasoning makes sense to the Arbitrator. The Petitioner sustained a serious injury to his right knee. He was immediately taken off work by his family physician and the treatment records from January 9 through February 24, 2015 showed swelling, difficulty ambulating and decreased range of motion. (PX 5) Physical therapy did not help. In surgery on April 22, Dr. Werries found a tear of the medial meniscus as well as a lesion of the medial femoral condyle. (PX 4) After surgery, Dr. Werries began to notice more problems with the posterior aspect of the right knee and entire right leg. He testified that on June 15, 2015, he felt the Petitioner might have a radiculopathy for which he suggested further diagnostic testing. (PX 1 at 20-21)

Also, the medical records of treatment by Dr. Gornet from his initial exam on August 26, 2015 through July 14, 2016 show that the Petitioner's symptoms are increasing in severity. (PX 7) The ongoing radicular symptoms requiring treatment are clearly different than the rather short periods of pre-accident symptoms that the Petitioner treated with in June 2014 and periodically back to the year 2000. (PX 5) These ongoing symptoms and treatment are in contrast to the sporadic treatment with good results the Petitioner had prior to his accident. Dr. Gornet testified that the accident "...pushed him over the edge." When comparing his pre and post accident symptoms and functionality. (PX 2 at 26)

Dr. Beyer did not feel the lower back injuries were related to the Petitioner's accident. He first maintained that the Petitioner had no reported symptoms which could be attributed to the lumbar spine until June 2015, about five months after the accident. When informed that Dr. Werries noted numbness behind the knee during his initial meeting with the Petitioner in March 2015, Dr. Beyer concluded that the numbness was likely related to chondromalacia of the patella and not the spine. The Arbitrator has not been able to find in any of the medical records a diagnosis of chondromalacia of the patella. Moreover, Dr. Beyer provided no explanation as to how chondromalacia of the patella, if it were present, could be causing numbness and tingling in the posterior aspect of the Petitioner's right knee. When he was asked to explain his opinion, he said the posterior pain the Petitioner was having came from the chondromalacia. (RX 1 at 14-15) However, as all of the records from Dr. Werries first visit forward point out, the Petitioner's posterior leg symptoms involved numbness and tingling and not pain.

Petitioner testified that following the work injury, his primary area of pain was in the front of his knee as well as numbness down the back of his leg behind the knee. Petitioner's history and onset of symptoms is confirmed by way of medical records supporting numbness down the back of the leg that was separate from the pain in the front of the knee. At that time, Dr. Werries as well as Petitioner was unaware of the fact there were two separate conditions that were going on concurrently.

However, after Petitioner completed the repair of his medial meniscus, Dr. Werries as well as the physical therapist noted that there was ongoing numbness in the back of the leg as well as significant weakness that would normally not be seen with a simple medial meniscal tear. As a result, subsequent visits with Dr. Werries moved from the knee to testing the low back by way of a nerve conduction study and MRI to determine if there was a lumbar radiculopathy. By August of 2015, Dr. Werries had confirmed the lumbar radiculopathy and had recommended a neurosurgical consult which was initially approved then cancelled.

Both Dr. Werries and Dr. Gornet confirmed that an individual could have a lumbar radiculopathy while having symptoms predominantly in the lower extremity as opposed to having low back pain. This is consistent with Petitioner's testimony wherein he had stated that he did not have specific low back pain during his recovery of the surgical repair to his knee but simply had numbness and weakness when he attempted to walk or stand for any extended duration.

Given the evidence presented, the Arbitrator finds that Petitioner's current low back symptoms are causally related to Petitioner's accident of January 8, 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? The Arbitrator concludes as follows:

Petitioner entered into evidence medical bills for treatment from Dr. Matthew Gornet, Pain and Rehab Specialists, and CT Partners of Chesterfield, totaling $11,922.06. Additionally, Petitioner entered a receipt for $10.00 for a co-payment paid to Dr. Barry Werries. This medical treatment is for medical care exclusively to his low back that was contested based upon Respondent's Section 12 Examiner, Dr. Craig Beyer.

However, as noted above, I have found the low back condition is deemed to be causally related to the work accident of January 8, 2015 and all medical treatment surrounding Petitioner's back is deemed to equally be related to this work accident.

Based upon the above evidence, the Arbitrator finds Respondent responsible for payment of outstanding medical bills from Dr. Matthew Gornet, Pain and Rehab Specialists, and CT Partners of Chesterfield in the amount of $11,922.06. These medical bills should be paid pursuant to the medical fee schedule. Similarly, Respondent is responsible for reimbursing to Petitioner out-of-pocket expenses of $10.00 paid for a co-payment associated with a visit with Dr. Berry Werries.

Issue (K) Is Petitioner entitled to any prospective medical care? The Arbitrator concludes as follows:

Dr. Matthew Gornet testified that Petitioner had two defects in his low back stemming from this work injury. Dr. Gornet has recommended a two-level spinal fusion to correct the problems associated with these abnormalities. Respondent's Section 12 Examiner, Dr. Beyer offered no counter evidence to refute these recommendations for medical treatment. At the time of deposition, Dr. Beyer admitted that he did not do back surgeries himself but refers such treatment to other specialists. Moreover, Dr. Beyer was not provided the medical records from Dr. Gornet and therefore offered no counter opinion regarding Dr. Gornet's recommendations for surgical care.

Based upon the above evidence, the Arbitrator finds that Petitioner is entitled to prospective medical care consistent with the recommendations from Dr. Gornet.

Issue (L) What temporary benefits are in dispute? The Arbitrator concludes as follows:

In August of 2015, Petitioner was provided work restrictions by Dr. Werries pending an evaluation by a neurosurgeon due to low back problems that Dr. Werries believed were related to the work accident. Petitioner was seen by Dr. Gornet on August 26, 2015 and has been taken off work pending approval for the surgery to his low back. On September 29, 2015, Petitioner was seen by Respondent's Section 12 Examiner, Dr. Craig Beyer. Dr. Beyer released Petitioner to return to work full duty concluding that the low back conditions were not related to the work accident. As noted above, the medical opinions from Dr. Werries and Dr. Gornet are deemed more credible than Dr. Beyer. As such, Dr.

Gornet's off work status is deemed more valid than the full duty release by Dr. Beyer as Dr. Beyer's restrictions do not take into account the low back condition that has now been deemed causally related to the work accident.

Based upon the above evidence, Arbitrator finds Petitioner temporarily totally disabled since August 26, 2015 and ongoing. It is noted that Respondent paid lost time benefits up through November 4, 2015. Although there was a shortfall in the payment of these lost time benefits, Respondent agreed to apply a previous $2,000.00 advance as well as payment of an additional $2,371.38 to bring payments of temporary total disability benefits current up to November 4, 2015. Respondent is hereby ordered to pay ongoing lost time benefits from November 5, 2015 up to September 7, 2016, totaling 43-6/7 weeks at the corrected rate of $707.06. Respondent shall be entitled a 8(j) credit for the short-term disability benefits paid, totaling $6,049.98.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roy Sims,
Petitioner,

vs.

NO: 15 WC 26947

17IWCC0429

Aramark,
Respondent.

DECISION AND OPINION ON REVIEW

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

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. With regard to the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. Specifically, the Commission takes note of the fact that while the claimant did suffer a left ankle fracture, he returned to his regular employment and was able to continue in that work until he had a separate and unrelated injury.

The Commission notes the factors identified in Section 8.1b of the Act, as did the Arbitrator. The claimant had an AMA impairment rating of 12% to the left lower extremity. The Arbitrator further noted the petitioner's employment as a school custodian, his age (69 years at the time of the accident), and the petitioner's complaints as corroborated by the medical records, and assigned these issues appropriate weight. However, the Arbitrator gave no weight to the fact that there was no evidence that this injury had any effect on the petitioner's future earning capacity. The Commission finds that there was affirmative evidence presented on this point, specifically his ability to return to ongoing employment since the injury, which also weighed in on the petitioner's job history. The Commission assigns this some weight. In light of the above, the Commission

17IWCC0429

finds an award of permanent partial disability of 35% loss to the left foot to be more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. All other findings of the Arbitrator are affirmed.

The parties stipulated that the claimant was owed 12 & 3/7 weeks of TTD benefits incurred from 7/23/2015 through 10/18/2015, and that the respondent would be credited $5,028.57 in TTD benefits previously paid (see Arbitrator's Exhibit I). The Arbitrator acknowledged such at the hearing, and included the credit for TTD benefits in the "Findings" section of the decision, but did not overtly specify the TTD award in the "Order" section, so the Commission adds the following language to the "Order" section of the Arbitrator's Decision:

Pursuant to the parties' stipulations, the respondent shall pay the petitioner temporary total disability benefits of $393.33/week for 12 & 3/7 weeks, as provided in Section 8(b) of the Act. Against this amount, the respondent shall be given a credit of $5,028.57 for disability benefits paid to date.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $354.00 per week for a period of 58.45 weeks, as provided in §8(e) of the Act, as the injuries sustained caused the 35% loss of use of the Petitioner's left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the petitioner temporary total disability benefits of $393.33/week for 12 & 3/7 weeks, as provided in Section 8(b) of the Act. Against this amount, the respondent shall be given a credit of $5,028.57 for disability benefits paid to date.

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 $20,800.00. 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: JUL 3 - 2017

Joshua D. Luskin

o-06/07/17
jdl/ac
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIMS, ROY
Employee/Petitioner

Case# **15WC026947**

ARAMARK INC
Employer/Respondent

17IWCC0429

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0152 LINN CAMPE & RIZZO LTD
JACK M LINN
215 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

1739 STONE & JOHNSON CHTD
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
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

Roy Sims
Employee/Petitioner

Case # 15 WC 26947

v.

17IWCC0429

Aramark, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **November 23, 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 **July 22, 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 $**30,680.00**; the average weekly wage was $**590.00**.

On the date of accident, Petitioner was **69** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**5,028.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,028.52**.

ORDER

Respondent shall pay Petitioner the sum of $**354.00**/week for a further period of **70.975** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **the 42.5% loss of use of the Petitioner's left foot**.

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

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

Arbitrator Anthony C. Erbacci

December 22, 2016
Date

JAN 6 - 2017

FACTS:

On July 22, 2015 the Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent as a custodian. The Petitioner testified that, while he was performing the regular duties of his employment on that date, he slipped on a wet floor and fell injuring his left ankle. The Petitioner testified that he immediately noticed extreme pain in his ankle and, when he tried to stand up, his left foot was dangling.

The Petitioner reported his injury to his supervisor and drove himself to the emergency room at Condell Hospital where X-Rays demonstrated a comminuted intra-articular fracture of the medial malleolus, a slightly displaced and angulated fracture of the distal fibular metadiaphysis, and extensive soft tissue swelling and joint effusion. The Petitioner was referred to Dr. Roger Collins. who performed an open reduction internal fixation that same day. Dr. Collins' pre-operative and post-operative diagnoses were unstable bimalleolar fracture of the left ankle. The Petitioner was discharged from the hospital on July 23, 2015 and he continued to follow up with Dr. Collins. Dr. Collins applied a splint and then a short leg cast and on September 2, 2015 Dr. Collins ordered physical therapy and instructed Petitioner to begin weight bearing. The Petitioner attended a course of physical therapy and on October 19, 2015 the Petitioner returned to light duty work.

The Petitioner testified that upon his return to work he noticed pain and swelling in his ankle and he returned to Dr. Collins. Dr. Collins ordered an MRI which the Petitioner underwent on December 17, 2015. On December 22, 2015 the Petitioner asked Dr. Collins to release him back to full duty work and Dr. Collins agreed to release the Petitioner to full duty. The Petitioner last saw Dr. Collins for the left ankle on March 31, 2016. Dr. Collins noted that the Petitioner reported pain with activities, and discomfort in the left foot after a long day. Dr. Collins noted that the Petitioner was walking with an antalgic gait, had weakness on eversion, and had some dysfunction with the posterior tibial tendons. Dr. Collins stressed the importance of wearing shoes with good arch support, but placed the Petitioner at MMI.

The Petitioner testified that he had never previously injured his left ankle. He further testified that he has a scar on his left ankle where the permanent plate and screws were implanted and ongoing discomfort due to the raised nature of the implanted screws.

The Petitioner testified as to the continued complaints he has relative to his injured left ankle, including needing to take frequent breaks after being on his feet for extended periods of time at work, difficulty climbing stairs and walking on uneven surfaces, soreness and stiffness in the left ankle, and the inability to wear boots. He further testified that he has difficulty sleeping due to the ongoing discomfort in his left ankle, and had to purchase specialized shoes in order to walk with any degree of comfort, and that he walks with a limp which becomes more pronounced by the end of the day.

At the request of the Respondent, the Petitioner was examined by Dr. Holmes on September 2, 2015 and January 6, 2016, and Dr. Lee on October 17, 2016. On September 2, 2016, Dr. Holmes noted that "surgery was absolutely necessary," and that the "condition is casually related to the work injury." Dr. Holmes concluded that the Petitioner's treatment had been reasonable and necessary, appropriate restrictions were sedentary duty, and that a return to work three to four months following the accident could be expected. On January 6, 2016, Dr. Holmes noted that the Petitioner

complained of pain at the incision and Dr. Holmes recommended a desensitization program. Dr. Holmes did not recommend removal of the surgical hardware.

Dr. Simon Lee examined the Petitioner on October 17, 2016 and concluded that the Petitioner sustained a 12% impairment of the left lower extremity.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained an undisputed injury to his left ankle and immediately commenced a course of medical treatment, which included surgery, for that injury. Dr. Holmes, the Respondent's examining physician, opined that the surgery was absolutely necessary, and that the Petitioner's condition was casually related to the work injury.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work injury of July 22, 2015.

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 work 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.

In the instant case, the Petitioner suffered a bimalleolar fracture of the left ankle which was surgically repaired using a plate and screws. The Petitioner underwent a course of post-surgical physical therapy and was ultimately released to return to regular work.

With regard to the reported level of impairment pursuant to Section 8.1(b), the Arbitrator notes that the record contains an impairment rating of 12% of the lower extremity as determined by Dr. Simon Lee, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead

is a factor to be considered in making such a disability evaluation. The Arbitrator gives some weight to this factor.

With regard to the occupation of the injured employee, the Arbitrator notes that the record reveals that Petitioner was employed as a school custodian at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the Petitioner testified to complaints of pain after a full day of working and that the Petitioner had been off work for some time from an unrelated injury. The Arbitrator therefore gives greater weight to this factor.

With regard to the age of the employee at the time of injury, the Arbitrator notes that Petitioner was 69 years old at the time of the accident. Because of Petitioner's limited work life, the Arbitrator therefore gives greater weight to this factor.

With regards to the employee's future earning capacity, the Arbitrator notes there is no evidence that Petitioner's injury will limit his future earning capacity. The Arbitrator therefore gives no weight to this factor.

With regard to the evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner's treating physician, Dr. Collins, and the Respondent's examining physicians, Dr. Holmes and Dr. Lee, corroborate the Petitioner's testimony that he has been disabled. Because of the physicians documenting the Petitioner's limited motion and weakness of the left ankle, the Arbitrator gives significant weight to this factor.

The Arbitrator notes that 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 42.5% disability to his left foot.

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

Bryan Merriman,

Petitioner,

vs.

NO. 15WC 27351

State of Illinois/Vienna Correctional Center,

17IWCC0422

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 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 January 11, 2017 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.

17IWCC0422

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JUN 30 2017
SJM/sj
6/8/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MERRIMAN, BRYAN
Employee/Petitioner

Case# **15WC027351**

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

17IWCC0422

On 1/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JAN 11 2017

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0422

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Bryan Merryman
Employee/Petitioner

v.

State of Illinois/Vienna Correctional Center
Employer/Respondent

Case # 15 WC 27351

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **November 15, 2016**. By stipulation, the parties agree:

On the date of accident, **May 18, 2015**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$68,182.40**, and the average weekly wage was **$1,311.20**.

At the time of injury, Petitioner was **47** years of age, ***married,*** with **1** dependent child.

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

Respondent shall be given a credit of **$ALL PAID** for TTD, **$0** for TPD, **$0** for maintenance, and **$32,058.56** for other benefits, for a total credit of **$32,058.56**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$735.37**/week for a further period of **87.5 weeks**, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **17.5% loss of use of the person-as-a-whole,** consisting of 7.5% loss of use of the person-as-a whole attributable to the right shoulder condition and 10% loss of use of the person-as-a-whole attributable to the lumbar spine condition.

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

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

Signature of Arbitrator

1/4/17
Date

ICArbDecN&E p 2

JAN 11 2017

17IWCC0422

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Bryan Merriman
Employee/Petitioner

Case # 15 WC 27351

v.

Consolidated cases: N/A

State of Illinois/Vienna Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Vienna Correctional Center on May 18, 2015 when he sustained injuries to his back, right shoulder and right hand while trying to separate two combative inmates. (AX1). At the time of arbitration, Petitioner testified to immediate right shoulder pain as a result of the incident, briefly followed by the onset of low back pain. He testified that while the laceration on his right hand resolved, he continued to have difficulties with his right shoulder and back. He further testified that he previously sustained a work injury to his low back which resulted in a lumbar fusion surgery in 2010, but testified to no prior injuries or treatment for his right shoulder. He testified that he is right-hand-dominant.

Petitioner testified that as a result of the surgery, rhizotomies and physical therapy, he was able to return to full duty work. He testified that despite the improvement from these treatments, he continues to have symptoms. He testified that when he has to engage in strenuous activities at the prison he notices a reduction in his right arm strength. He testified that he suffered a loss in upper extremity endurance. He also testified that due to his back injury, he experiences numbness and tingling in his leg when he stands for long periods of time. He testified that he works eight hour shifts as well as overtime, and that 75% of that time is spent on his feet on concrete surfaces in Respondent's dietary department. He testified that at the end of a shift, his back feels "not very good." He testified that his ability to work on his farm and bow hunt has been adversely affected, and that he takes over-the-counter Ibuprofen and prescription Hydrocodone for his symptoms.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Brooke Miller, PA/Rural Health, Inc. were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on May 21, 2015 at which time it was noted that he was involved in trying to stop two inmates in a fight at work on May 18, 2015 in the kitchen and that during the fight, he sustained an abrasion to the right hand from a tooth which drew blood. It was noted that Petitioner needed an exam due to a painful shoulder, back and intermittent numbness in the right leg. It was noted that Petitioner reported right shoulder pain and low middle back pain as well as right leg intermittent numbness. The assessment was that of strain of back muscle, shoulder strain, shoulder pain, acute sciatica, low back pain and abrasion of hand. It was noted that Petitioner was to be off work, and that if the pain continued or worsened, imaging would be considered. (PX3).

The records of Brooke Miller, PA/Rural Health, Inc. reflect that Petitioner was seen on June 1, 2015 for follow-up of shoulder pain. It was noted that Petitioner had weakness and pain in the right shoulder intermittently. It was noted that Petitioner's back pain improved, that the Naproxen helped, that the right shoulder pain had worsened but was intermittent and that the right leg and hip intermittent numbness continued but had lessened. The assessment was that of shoulder pain, acute sciatica, shoulder strain and strain of back muscle. Petitioner was ordered to undergo an MRI of the shoulder and was recommended to undergo physical therapy. (PX3).

The medical records of Cedar Court Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on June 10, 2015 for an MRI of the lumbar spine, which was interpreted as revealing (1) posterior fusion of L5 and S1 with bilateral posterior rods and interpedicular screws; there are MR findings suggesting for fracture of the S1 screws bilaterally though this could easily be due to MR artifact; (2) neural foraminal narrowing is moderate at L3/L4 on the left and at L4/L5 bilaterally; (3) no significant spinal canal narrowing. The records reflect that Petitioner also underwent an MRI of the right shoulder on that date as well, which was interpreted as revealing (1) moderate supraspinatus and mild to moderate subscapularis tendinopathy, no tear; (2) mild to moderate osteoarthritis of the acromioclavicular joint. The records further reflect that Petitioner underwent x-rays of the lumbar spine on June 30, 2015 which were interpreted as revealing post-surgical changes of anterior and posterior spinal fixation at L5-S1; the hardware appears intact; Grade I retrolisthesis L4 over L5. (PX4).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 24, 2015 for a chief complaint of right shoulder pain and lumbar spine pain. It was noted that on May 18, 2015 Petitioner was involved in an inmate altercation. It was noted that Petitioner had had a spinal fusion performed in 2010 but was able to return back to full duty work following this and had no residual symptoms in his lumbar spine after the surgery. It was noted that since the accident, Petitioner had had right leg symptoms shooting from his lumbar spine down into his legs, that he complained of a dull, deep ache in his shoulder as well as pain on top of his shoulder, that he had worsening pain with sitting and that it felt better to extend in terms of the lumbar spine. The assessment was that of (1) right shoulder superior labral tear and AC joint sprain; (2) lumbar spine injury. Petitioner was recommended a Medrol Dosepak as well as physical therapy for his lumbar spine and it was further noted that if it did not improve his symptoms and pain, then Dr. Mall would recommend that he be seen by a lumbar spine specialist. As to the right shoulder, it was noted that Dr. Mall believed that the AC joint had some edema on the MRI indicating that he may have impacted the lateral aspect of the shoulder causing an AC joint sprain at the time of the altercation, and that it was also fairly evident that he had a superior labral tear based on both physical examination and MRI findings. Injections were given into the AC joint and into the glenohumeral joint on that date, which relieved almost 100% of his pain and symptoms. Petitioner was recommended to undergo physical therapy for the shoulder. A work slip was issued on that date, allowing Petitioner to return to work light duty with restrictions. (PX5).

The records of Dr. Nathan Mall reflect that Petitioner was seen on August 21, 2015 for follow-up of his right shoulder pain. It was noted that Petitioner stated that the injection he was given provided almost 100% relief of his right shoulder pain for approximately a week and then his pain had slowly returned since that time. The assessment was that of superior labral tear and AC joint arthrosis. It was noted that Petitioner had failed conservative treatment and it was recommended that he undergo shoulder arthroscopy and biceps tenodesis for his superior labral tear and an AC joint resection. A work slip was issued on that date, allowing Petitioner to return to work light duty with restrictions. At the time of the October 16, 2015 visit, it was noted that Petitioner continued to have problems in the right shoulder with pain in the posterolateral distribution and feelings of instability in the shoulder. The assessment was that of superior labral tear and AC joint arthrosis with rotator cuff weakness. Petitioner was recommended to

undergo physical therapy for rotator cuff strength and range of motion, and Dr. Mall again recommended right shoulder arthroscopy and superior labral debridement with biceps tenodesis and AC joint resection. (PX5).

The records of Dr. Nathan Mall reflect that Petitioner was seen on November 20, 2015, at which time it was noted that he continued to have pain in the shoulder. The assessment was that of superior labral tear and AC joint arthrosis with rotator cuff weakness. Petitioner was again recommended to undergo surgery, and was referred to Dr. Gornet for his lumbar spine "since he has been having lumbar spine issues some time now." At the time of the December 29, 2015 visit, it was noted that Petitioner was being seen in follow-up of his right shoulder debridement, AC joint resection and open biceps tenodesis for superior labral tear. It was noted that Petitioner was doing well and had minimal complaints. Petitioner was recommended to initiate physical therapy. At the time of the January 29, 2016 visit, it was noted that Petitioner was making substantial improvement with physical therapy, that his pain was improving and that his range of motion was improving as well. Petitioner was recommended to undergo additional physical therapy for range of motion and strengthening. At the time of the March 8, 2016 visit, it was noted that Petitioner continued to do extremely well, was basically pain-free and was doing most activities. Petitioner was placed at maximum medical improvement for his right shoulder and it was noted that Dr. Mall did not believe that Petitioner would require any additional treatment for the right shoulder. It was noted that Petitioner's lifting was restricted by his lumbar spine condition. It was noted that no restrictions were placed on the shoulder ad that Petitioner could return to work full duty as it related to the right shoulder. (PX5).

The medical records of St. Luke's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that x-rays of the right shoulder were apparently performed on July 24, 2015, although the interpretive report was not included in the exhibit. (PX6).

The medical records of Elite Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent a shoulder evaluation on August 4, 2015 and that he underwent therapy through August 19, 2015. The records reflect that Petitioner underwent another shoulder evaluation on January 5, 2016 due to pain and stiff status post shoulder surgery on December 17, 2015, and that he underwent therapy through March 7, 2016. The records further reflect that Petitioner underwent a back evaluation on February 18, 2016 and that he underwent therapy through March 17, 2016. (PX7).

The medical records of Orthopedic Ambulatory Surgery Center of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent surgery by Dr. Mall on December 17, 2015 which consisted of (1) arthroscopic debridement of the superior labrum and anterior supraspinatus; (2) arthroscopic subacromial decompression and acromioplasty; (3) open AC joint resection; (4) open biceps tenodesis. The pre-operative diagnoses were that of (1) right shoulder superior labral tear; (2) right shoulder biceps tendinitis; (3) right shoulder AC joint arthrosis, and the post-operative diagnoses were that of (1) right shoulder superior labral tear; (2) right shoulder biceps tendinitis; (3) anterior supraspinatus partial thickness tearing; (4) subacromial bursitis and acromial spur; (5) AC joint arthrosis. (PX8).

The records of Orthopedic Ambulatory Surgery Center of Chesterfield reflect that Petitioner underwent right L3-L4, L4-L5 facet MNBs on April 26, 2016 by Dr. Helen Blake. It was noted that the pre- and post-operative diagnoses were that of (1) lumbar spondylosis without myelopathy; (2) low back pain. The records also reflect that on May 10, 2016 Petitioner underwent radiofrequency ablation of left L3-L4, L4-L5 MNB by Dr. Blake for pre- and post-operative diagnoses of (1) lumbar facet arthropathy without myelopathy; (2) low back pain. (PX8).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on February 11, 2016, at which time it was noted that he presented with a chief complaint of central low back pain to the right buttock, right hip and right leg to his foot with numbness and tingling. It was noted that Petitioner had occasional symptoms also in his left leg. It was noted that Petitioner's current problem began on May 18, 2015 when he was involved in an altercation between two inmates. It was noted that Petitioner readily admitted to a history of low back pain, that he had a work-related injury in 2009 and underwent an AP fusion by Dr. Robson, that it failed and that he underwent a second procedure in 2010. It was noted that Petitioner stated that after his recovery from the second procedure, he had been doing well working full duty with no restrictions until the current event. It was noted that Petitioner's symptoms were constant and worse with prolonged sitting, standing, bending or lifting and were better with a change in position. It was noted that Dr. Gornet suspected it was a new disc injury at L4-5 as well as an aggravation of his previous facet condition at L3-4 and L4-5. Petitioner was recommended to undergo physical therapy as well as an MRI and CT. The Addendum noted that, after reviewing the CT and MRI, the working diagnosis was that of aggravation of some preexisting foraminal stenosis at L4-5 right, secondary to facet encroachment, and a disc injury centrally at L4-45 and on the left at L4-5. Petitioner was recommended to undergo physical therapy and a transforaminal steroid injection right L4-5. (PX9).

The records of Dr. Matthew Gornet reflect that Petitioner was seen on March 24, 2016, at which time it was noted that he had a good result with the transforaminal steroid injection which completely relieved his pain for about a week and now was back to about 70%. Petitioner was recommended to undergo facet rhizotomies at L3-4 and L4-5 with Dr. Blake. A work slip was issued on that date, allowing Petitioner to return to work with various restrictions. At the time of the May 19, 2016 visit, it was noted that Petitioner had had facet ablations by Dr. Blake which had "improved him." It was noted that Petitioner was still having symptoms but he felt improved. It was noted that Dr. Gornet recommended a "trial" of return to work full duty with no restrictions but that Petitioner had not yet attained maximum medical improvement and still may require surgery. At the time of the August 29, 2016 visit, it was noted that Petitioner seemed to be doing well and was placed at maximum medical improvement. It was noted that Petitioner was at full duty no restrictions, and he was instructed to return as needed. (PX9).

The medical records of MRI Partners were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent an MRI of the lumbar spine on February 11, 2016, which was interpreted as revealing (1) post-op change L5-S1 with metallic artifact; (2) broad based central disc protrusion L4-L5 with left sided annular fissure and bilateral foraminal narrowing; (3) broad based protrusion at L3-4 as well with flattening of the dura and bilateral foraminal narrowing. (PX10).

The medical records of CT Partners were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner underwent a CT of the lumbar spine on February 11, 2016, which was interpreted as revealing (1) solid interbody fusion with anterior and posterior plates at L5-S1 without complication; (2) small central disc protrusion with posterior element hypertrophy resulting in foraminal stenosis bilaterally at L4-5. (PX11).

The medical records of St. Louis Spine and Orthopedic Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent a transforaminal steroid injection under fluoroscopic guidance at L4-54 right with facet block at L4-5 right on March 2, 2016 for a pre- and post-operative diagnosis of lumbar radiculopathy. (PX12).

The TriStar Approval Letter was entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The Appearance of Representative was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Vienna Correctional Center Employee Injury Report was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Incident Reports by Bryan Merriman and K. Hoffard were entered into evidence at the time of arbitration as Respondent's Exhibit 5.[1]

The Initial Workers' Compensation Medical Report by Brooke Miller, PA-C was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Initial Workers' Compensation Medical Report by Dr. Nathan Mall was entered into evidence at the time of arbitration as Respondent's Exhibit 7.

CONCLUSIONS OF LAW

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

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to be employed by Respondent and was placed under no permanent restrictions from either of his treating physicians. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 47 years old on his date of accident. Given the younger age of Petitioner and the fact that his treating physicians have placed him under no restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that when he has to engage in strenuous activities at the prison he notices a reduction in his right arm strength. Petitioner testified that he suffered a loss in upper extremity endurance. Petitioner testified that due to his back injury, he experiences numbness and tingling in his leg when he stands for long periods of time. Petitioner also testified that he works eight hour shifts as well as overtime, and that 75% of that time is spent on his feet on concrete surfaces in Respondent's dietary department. Petitioner further testified that at the end of a shift, his back feels "not very good" and that his ability to work on his farm and bow hunt

[1] The highlighting that appears in Respondent's Exhibit 5 was not made by the Arbitrator.

has been adversely affected. At the time of the March 8, 2016 visit with Dr. Mall, it was noted that Petitioner continued to do extremely well, was basically pain-free and was doing most activities. Petitioner was placed at maximum medical improvement for his right shoulder and it was noted that Dr. Mall did not believe that Petitioner would require any additional treatment for the right shoulder. It was noted that no restrictions were placed on the shoulder ad that Petitioner could return to work full duty as it related to the right shoulder. (PX5). As to the lumbar spine, at the time of the August 29, 2016 visit with Dr. Gornet, it was noted that Petitioner seemed to be doing well and was placed at maximum medical improvement. It was noted that Petitioner was at full duty no restrictions, and he was instructed to return as needed. (PX9). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were minimally corroborated by his treating records at the conclusion of his treatment with Drs. Mall and Gornet. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **17.5% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act, consisting of 7.5% loss of use of the person-as-a whole attributable to the right shoulder condition and 10% loss of use of the person-as-a-whole attributable to the lumbar spine condition .

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORI OAKLEY,

Petitioner,

17IWCC0456

vs.

NO: 15 WC 027363

MENARD CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, and permanent partial disability and being advised of the facts and law, reverses the Decision of the Arbitrator which is attached hereto and made a part hereof. The Arbitrator found Petitioner to be a credible witness. The Commission places greater reliance on the accident reports, including ones signed by Petitioner, that are more contemporaneous to the date of the accident than is the testimony of Petitioner gave almost two years after the date of the accident.

It is undisputed that Petitioner struck her left shoulder against an open doorway as she attempted to leave her office on July 8, 2013. As recounted in the Decision of the Arbitrator, Petitioner "was under time constraints, running to her computer and then down the hallway to print a document to come back and answer the question of the Administrative Review Board agent on hold." Also recounted in the Decision of the Arbitrator is the claim that Petitioner exits her office fifty times a day to retrieve documents that are printed by a printer located in another room. Save the history of Petitioner leaving her office to retrieve a document from the printer on July 8, 2013, there is no evidence to corroborate the other details of Petitioner's testimony as set forth in the Decision of the Arbitrator.

Petitioner completed an Adult and Juvenile Incident Report on July 10, 2013, only two days after her accident. She wrote, "[T]he reporting staff was routinely exiting the Grievance

Office to retrieve documents from a printer located down the hall in the next office (Placement Office). Upon exiting the Grievance Office I caught my left shoulder on the edge of the door frame . . . ."

The Supervisor's Report of Injury or Illness was completed by Betsy Spiller on August 4, 2013. Ms. Spiller wrote, "As Mrs. Oakley was exiting her office, she caught her left shoulder on the door frame . . . ." It is uncertain who provided this history to Ms. Spiller. It is found unlikely that Ms. Spiller witnessed Petitioner's accident as the Supervisor's Report of Injury or Illness identified Kim Miner as the only witness to the accident. The Commission, nevertheless, finds Ms. Spiller's account mirrored that of Petitioner.

On September 3, 2013, the Workers' Compensation Employee's Notice of Injury was completed. It is uncertain who completed the report as the signature identifying the individual who completed the form is illegible, but the form does bear Petitioner's signature. With respect to the July 8, 2013, accident, the circumstances as how Petitioner came to be injured was described as "while walking and exiting office hit left shoulder into door frame." As to why Petitioner was exiting the office, it was noted in the form that Petitioner was retrieving documents from a printer down the hallway. Also the form included a comment about Petitioner having to use Placement Office equipment.

Also completed on September 3, 2013, was an Initial Workers' Compensation Medical Report. The form was completed by a Dr. Fuentes and included the history of Petitioner's accident as "Hit left shoulder against door frame of her office . . . ."

Ms. Miner completed a Workers' Compensation Witness Report on September 5, 2013. She wrote, "[T]his C.O. seen [sic] Lori Oakley exit the Grievance Office to retrieve documents from the printer located down the hall (Placement Office). When Ms. Oakley exited the room, she hit her left shoulder on the door frame."

Petitioner's testimony goes into greater detail than what was written in the above-referenced reports, but her testimony is often internally inconsistent, leaving the impression that her testimony is more of an embellishment rather than an accurate retelling of what occurred on July 8, 2013.

Petitioner testified that she was reading paperwork when she left the Grievance Office to retrieve the document from the printer. When asked about the paperwork, she was unable to recall what the paper was. She then indicated that she was unable to recall in what direction she was looking when she struck the doorframe. The Commission notes Petitioner had previously testified that she was reading the paperwork that was in her hand. The Commission further notes that none of the accident reports, including those signed by Petitioner, indicate that she had anything in her hand at the time of her accident.

Petitioner also testified that she was in a hurry when she exited the Grievance Office. No testimony was elicited as to why she was in a hurry. Her testimony appears to be contradicted by the Adult and Juvenile Divisions Incident Report Petitioner, herself, completed. As noted above, Petitioner completed this report on July 10, 2013, and indicated that she was "routinely exiting

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the Grievance Office" at the time she struck her left shoulder against the doorframe.

Repeatedly, Petitioner's testimony conflicts with the written reports as well as with her own testimony. For this reason, the Commission cannot agree with the Arbitrator's conclusion that Petitioner's work activities subjected her to a qualitative increased risk of injury.

The Commission also cannot reconcile the Arbitrator's conclusion that Petitioner's work activities subjected her to a quantitative increased risk of injury. Petitioner's testimony included her estimating that she went to her printer more than fifty times a day. She, however, had previously testified, "so on this day they took my printer away from me . . . ." As July 8, 2013, is the last day Petitioner referenced, the Commission concludes that Petitioner's printer was removed from her office on July 8, 2013. If this interpretation is correct, Petitioner going to the printer "more than fifty times a day" meant that she went to the printer that was within her office, not outside her office. She, therefore, was not confronted with an increased risk of running into the doorframe when retrieving documents from the printer prior to July 8, 2013.

Stripping away the above-cited details of Petitioner's as-testified-to history of how she came to be injured on July 8, 2013, there remains a question of whether Petitioner injuring herself while simply retrieving a document from a printer arose out of and in the course of her employment.

"For an injury to 'arise out of' employment its origin must be in some risk connected with, or incidental to, employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Company v. Industrial Commission*, 129 Ill.2d 52, 58, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). Furthermore, a "risk is incidental to the employment where it belongs to or is connect with what an employee has to do in fulfilling his duties. *Caterpillar*, 129 Ill.2d at 58.

Petitioner has the burden of showing "that certain activities incidental to employment were performed . . . [and] that these activities were of a character to expose the employee to a greater risk of injury than if [she] had not been so employed . . . ." *City of Chicago v. Industrial Commission*, 45 Ill. 2d 350, 354, 259 N.E.2d 5 (1970). The multiple accident reports coupled with Petitioner's testimony about walking while attempting to leave the Grievance Room satisfy the burden placed on Petitioner to show an activity incidental to her employment was performed. That activity, however, was walking, an activity that put Petitioner in no greater risk of injury than is faced by any member of the general public.

In arriving at a conclusion that differs from that of the Arbitrator, the Commission finds the Arbitrator relied on the testimony of Petitioner to the exclusion of the accident reports. The Commission finds the accident reports, completed when they were, are more representative as to what occurred on July 8, 2013, than the testimony that was provided almost two years later. For this reason, the Commission reverses the Decision of the Arbitrator and finds Petitioner failed to prove that she experienced an accident on July 8, 2013, that arose out of and in the course of her employment.

17IWCC0456

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed with the Commission is reversed and no compensation awarded.

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

DATED: JUL 18 2017
KWL/mav
O: 06/20/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

It is undisputed that Petitioner injured her left shoulder when she slammed it into a wall while exiting her office to retrieve a document from a shared printer in another room down the hall. Petitioner testified that she had been speaking on the phone with a representative of the administrative review board, whom she had placed on hold, and was carrying paperwork in her hand at the time of the incident. Petitioner also credibly testified that she had to make this trip "50 plus" times a day in order to use the printer.

These factors, from both a qualitative and quantitative standpoint, speak to the employment related nature of the injury, and would not seem to differ appreciably from the fact scenarios set forth in two recent appellate court cases that found such injuries compensable.

In *Steak 'N Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC, 2016 Ill. App. LEXIS 798 (11/17/16), the claimant was a waitress/trainer/manager who was injured while wiping down a table at work. The appellate court noted that the claimant's unrebutted testimony established her duties as a manager were to keep the flow of customers moving in an efficient manner and that she credibly testified she would on occasion clean and bus tables if necessary to keep the customer flow moving. As a result, the court found that the record established claimant was injured while engaged in an activity that the employer might reasonably have expected her to perform in the fulfillment of her job duties and thus resulted from a risk distinctly associated with her employment.

Likewise, in *Mytnik v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152116WC, 2016 Ill. App. LEXIS 779 (11/10/16), the appellate court reversed the Commission and found that the act of bending down to pick up a bolt that had fallen on the assembly line was a risk distinctly associated with his job, given testimony to the effect that bolts had been dropped in the past and that failure to remove same could result in shutdown of the line.

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Thus, whether it's something as simple as wiping down a table (*Steak 'N Shake*) or bending down to pick up a bolt (*Mytnik*), the dispositive question is whether or not the risk of injury was distinctly associated with the employment.

In the present case, Petitioner was carrying paperwork in her hand as she was rushing to a shared printer in another room down the hall, in order to print a document relating to a conversation she was having on the phone with a member of the administrative review board. Also, she credibly testified that as part of her job duties for Respondent, she would have to travel back and forth between her office and the printer more than 50 times a day. These are activities that are directly related to her job and as such represent a risk of injury distinctly associated with her employment. Furthermore, even if one were to say that the risk was a neutral one, Petitioner was clearly exposed to an increased risk of injury compared to members of the general public based upon the frequency with which she would have to exit her office in order to print documents in the room down the hall.

As a result, I would affirm the Arbitrator's well-reasoned and fair-minded decision and find that Petitioner sustained accidental injuries arising out of and in the course of her employment on July 8, 2012.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0456

OAKLEY, LORI
Employee/Petitioner

Case# **15WC027363**

STATE OF ILLINOIS/MENARD CORR CTR
Employer/Respondent

On 7/21/2016, 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 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JUL 21 2016

RUTH ANN ARASCIA, Acting Secretary
Illinois Workers' Compensation Commission

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

17IWCC0456

LORI OAKLEY
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD CORR. CTR.
Employer/Respondent

Case # 15 WC 27363

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 23, 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 **July 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 **$63,992.00**; the average weekly wage was **$1,230.62.**

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent child(ren).

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$95,454.26**, as provided in § 8(a) of the Act.

Respondent shall be given credit for medical benefits that have been paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66**/week for **45** weeks, because the injuries sustained caused the **9%** loss of the **body as a whole**, as provided in § 8(d)2 of the Act.

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

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

Signature of Arbitrator

7/20/16
Date

JUL 21 2016

FACTS

Petitioner is employed as a Corrections Clerk III at Respondent's Menard Correctional Center. (T.9) She is exclusively assigned to the inmate grievance office. (T.9-10) She described her job as follows:

> They write own their grievances on paperwork and submit them to my office. I research them. Either I go through personal property and dig through personal property records just to make sure that Menard is following policy and if the inmate truly has lost something, then I reimburse him. I just make sure everybody's following procedure. (T.10)

In January of 2013, Tamms Supermax Correctional Center closed, and more inmates were transferred to Menard. This changed Petitioner's job significantly. (T.11) She stated:

> They came to Menard and we had a new warden come in so they changed policies, which inmates grieve every policy that changes. They were getting about 1800 a fiscal year and after I came in there it was almost 3000, it was 2800 plus, so on this day they took my printer away from me, they were going to put central printers in various locations and they had come in and asked questions about how many documents that I actually printed and copied previous to that and I'm not sure who made the decision to take the individual copiers but they did. I also had one working computer, I had one phone, the phone cord was taped to the floor with the chair strategically placed so I wouldn't trip on it. I had to go across the room to answer my phone, back to my computer to look stuff up and then out the door, down the hallway into the next office to retrieve documents off of the centrally located printer/copier. (T.11-12)

On July 8, 2013, Petitioner was looking up something for the Administrative Review Board with them on the phone. (T.12) She was running to her computer and then down the hallway to print a document to come back and answer the Administrative Review Board's question, and as she was exiting the room, she slammed her shoulder into the wall. (T.12-13)

The printer is far away from Petitioner's desk. (T.14) She has to go out of the door, down the hallway into another room after making several turns. (T.14) She does this 50 times a day, and the people in the placement office would joke with Petitioner that she was in their office so much they should put a desk in there. (T.14)

Prior to the accident, Petitioner had no workers' compensation claims, no prior injuries, and no prior diagnostic studies to her left shoulder. Following the incident, Petitioner filled out an incident report which reads, "Did not have printer/copier to properly conduct own work. Constantly had and has to use placement office equipment." (RX3)

When her symptoms did not go away, Petitioner sought treatment with her family doctor at Steelville Clinic. She saw Dr. Preuss's P.A., Karen Chamness, was diagnosed with left shoulder pain and referred her for physical therapy. (PX3, 9/9/13) When this did not improve her

condition, she was referred to Chester Memorial Hospital for an MRI. (PX3, 9/26/13) This showed mild inflammatory changes and edema anteriorly and inferiorly with an adjacent anterocartilaginous labral tear. (PX5) The radiologist recommended a higher-quality MRI if clinical symptoms persisted. *Id.*

On October 28, 2013, Petitioner saw Dr. George Paletta, a board certified orthopedic specialist. He took the history of the injury and noted that Petitioner had physical therapy and medication without relief. (PX7, 10/28/13) His exam showed limited ranges of motion. He reviewed x-rays which were normal and reviewed the MRI scan. *Id.* He diagnosed Petitioner with a contusion of the left shoulder and Stage II secondary adhesive capsulitis. *Id.* He stated:

> I had a long discussion with Lori regarding the diagnosis and treatment. It appears she likely suffered an initial contusion to the shoulder but now has developed a secondary adhesive capsulitis or frozen shoulder. She is clearly in the early stage II progression of adhesive capsulitis with both ongoing pain and progressive motion loss. Recommendation is for aggressive nonsurgical treatment including an ultrasound or fluoroscopically guided intraarticular injection, Medrol dose pack followed by non-steroidal anti-inflammatories, re-initiation of physical therapy a week after the injection and follow up in about four or five weeks. *Id.*

Dr. Paletta believed that Petitioner's current left shoulder condition was causally related to the work incident on July 8, 2013. *Id.* Dr. Paletta recommended additional physical therapy and range of motion exercises. *Id.* Petitioner also received the recommended injection on November 18, 2013. (PX8)

Follow-up visits showed that Petitioner's injection and therapy improved her condition and home exercises added benefit; but Petitioner's condition did not resolve. (PX7, 12/27/13-6/1/15) Dr. Paletta then ordered a new MRI scan. (PX7, 6/1/15) The MR arthrogram showed mild supraspinatus tendinopathy, a normal rotator cuff and labrum with a mild irregularity of the humeral attachment of the inferior glenohumeral ligament consistent with a small HAGL (humeral avulsion glenohumeral ligament) lesion. (PX9)

In May 2014, Petitioner developed atrial fibrillation and underwent a series of evaluations and treatment, resulting in a significant delay in her shoulder treatment, to get her atrial fibrillation under control. (PX7, 6/1/15) She returned to Dr. Paletta immediately upon getting clearance in June of 2015, and again he noted some limited range of motion and instability. *Id.* He recommended a repeat MRI scan, and if this continued to show evidence of a HAGL lesion or capsular defect and Petitioner continued to be symptomatic, he would recommend surgery. *Id.*

Petitioner had the new MRI on July 1, 2015, and Dr. Paletta compared it to the previous study of 4/2/15. (PX7, 7/6/15) His impression was anterior capsular attenuation following the previous HAGL lesion. *Id.* In short, he believed the HAGL lesion had healed, but there was a deformation of the interior band of the inferior glenohumeral ligament resulting in instability. *Id.* Because Petitioner's symptoms had persisted for over two years, Dr. Paletta recommended surgery. *Id.*

This was done on September 22, 2015, after Dr. Paletta received approval from Respondent's workers' compensation carrier in written form on September 10, 2015. (PX11) Dr. Paletta performed an anterior capsule-labral plication, which was designed to bring the capsule of the joint closer to the bones of the joint to make the joint tighter and reduce laxity. (PX10) He also performed extensive debridement of the subacromial bursa both anteriorly and posteriorly. *Id.*

Following surgery, Petitioner was off work for one week after which she was allowed to return to work light duty. She was paid TTD benefits for the time she was off. After her contractual 90 days of light duty ran out, Petitioner was again kept off work completely and again she was paid temporary total disability benefits. When she was able to return to work full-duty, she promptly did so.

Despite the improvement resulting from surgery, Petitioner credibly testified at Arbitration that lying flat on her back and sitting in the chair leaning back cause symptoms. (T.18) For this she uses a heating pad. (T.18) She also notices pain during weather changes. (T.18) While she is able to manage her symptoms at work because she has a largely sedentary job, she owns horses and has difficulty saddling horses because of the overhead lifting. (T.19) Prior to the accident, Petitioner was a bow hunter and cannot pull the bow back at this point. (T.19) Personal activities such as bathing, grooming and vacuuming all cause increased pain. (T.19-20) She also testified to limited range of motion. (T.20) She takes Aleve or Tylenol several times a week for her symptoms. (T.20)

Respondent did not have Petitioner examined.

CONCLUSION

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

The Supreme Court holds that the term "accident" encompasses anything that happens without design or any event that is unforeseen by the victim. *E. Baggot Co. v. Indus. Comm'n*, 125 N.E. 254, 255 (1919). If the injury is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act. *Laclede Steel. Co. v. Indus. Comm'n*, 128 N.E.2d 718, 720 (1955).

Petitioner's injuries clearly occurred in the course of his duties. An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). Stated another way:

> [A]n injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned

> duties. [Citations.] A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 204, 797 N.E.2d 665, 672 (2003)

In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work *or* (when the risk is a neutral risk encountered during the course of employment) that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.*; *Adcock v. Illinois Workers' Comp. Comm'n*, 2015 IL App (2d) 130884WC, ¶ 39, 38 N.E.3d 587, 596. This increased risk may be qualitative, such as some aspect of employment that contributes to risk, **or** quantitative, such as the number of times they are required to encounter the risk. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (4th Dist. 2013).

In *Adcock v. Illinois Workers' Comp. Comm'n*, the Appellate Court find that a welder, who was working under time constraints, was subjected to an increased qualitative risk of injury by virtue of those time constraints (an in addition to a quantitative increased risk by the number of times the claimant had to do so while under time constraints) and found that his injury arose out of his employment. *Adcock v. Illinois Workers' Comp. Comm'n*, 2015 IL App (2d) 130884WC, 38 N.E.3d 587.

The Arbitrator finds Petitioner to be a credible witness. She testified that the printer is far away from her desk. (T.14) She has to go out of the door, down the hallway into another room after making several turns. (T.14) She does this 50 times a day, and the people in the placement office would joke with Petitioner that she was in there office so much they would have to put a desk in there. (T.14) On the day of the accident, she was under time constraints, running to her computer and then down the hallway to print a document to come back and answer the question of the Administrative Review Board agent on hold, and as she was exiting the room, she slammed her shoulder into the wall. (T.12-13) In Petitioner's case, the Arbitrator notes that she was subjected to a qualitative and quantitative increased risk of injury by virtue of the setup of her work station, and the number of times she was required to leave and travel to the central printer. Consequently, Petitioner met her burden of proof on the issue of accident.

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

Respondent did not have Petitioner examined. It is not necessary to establish a causal connection by medical testimony. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 471, 397 N.E.2d 834, 835 (1979) A causal connection between an accident and a claimant's condition may be established by a chain of events including the claimant's ability to perform manual duties before an accident, a decreased ability to so perform immediately after an accident, and other circumstantial evidence. *Id.* The record demonstrates that prior to the accident Petitioner was able to work full-duty without incident and no symptoms in her shoulder. (T.18) Following her injury, Petitioner required diagnostic imaging studies, restricted duty/time off work, extensive

conservative care and ultimately surgical intervention. Based upon the clear circumstantial evidence, the Arbitrator finds no legitimate basis for a dispute as to causal connection. Petitioner has met her burden in establishing that her current condition of ill-being is related to her accidental injury.

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

Based upon the above findings as to causal connection, and Respondent's written representations to Petitioner's medical providers, Respondent shall pay reasonable and necessary medical services as outlined in Petitioner's group exhibit, pursuant to the medical fee schedule or a PPO agreement (whichever is less) 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.

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

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

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

(ii) **Occupation**: Corrections Clerk III at Respondent's Menard Correctional Center. Petitioner is able to perform her duties without incident (T.18-19); thus the Arbitrator gives no weight to this factor.

(iii) **Age**: Petitioner was 48 years old at the time of her injury. She must live and work with her disability for a number of working years. The Arbitrator gives weight to this factor.

(iv) **Earning Capacity**: There is no evidence of reduced earning capacity; the Arbitrator gives no weight to this factor.

(v) **Disability**: As a result of her accidental injury, Petitioner developed adhesive capsulitis and a HAGL lesion/capsular defect, which subsequently led to

deformation of the interior band of the inferior glenohumeral ligament resulting in instability. (PX7) When Petitioner failed to improve with conservative care, Petitioner underwent an anterior capsule-labral plication. (PX10) Despite the improvement resulting from surgery, Petitioner credibly testified at Arbitration that lying flat on her back and sitting in the chair leaning back cause symptoms. (T.18) For this she uses a heating pad. (T.18) She also notices pain during weather changes. (T.18) While she is able to manage her symptoms at work because she has a largely sedentary job, she owns horses and has difficulty saddling horses because of the overhead lifting. (T.19) Prior to the accident, Petitioner was a bow hunter and cannot pull the bow back at this point. (T.19) Personal activities such as bathing, grooming and vacuuming all cause increased pain. (T.19-20) She also testified to limited range of motion. (T.20) She takes Aleve or Tylenol several times a week for her symptoms. (T.20) Petitioner's testimony is corroborated by her medical records, wherein Dr. Paletta reflects residual loss of range of motion and discomfort post-operatively. (PX7)

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 9% loss of her body as a whole.

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

Before the Illinois Workers' Compensation Commission

MARIO SANCHEZ,

Petitioner,

vs.

NO: 16 WC 7544
17 IWCC 0413

FREIGHT CAR SERVICES,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to Petitioner's "Motion Under Section 19(f) to Correct Clerical Error" found in the Decision and Opinion on Review of the Illinois Workers' Compensation Commission dated June 28, 2017.

The Commission is of the opinion that the Commission's Decision and Opinion on Review, dated June 28, 2017, should be recalled due to the clerical error. The Decision should list the Petitioner as "Mario Sanchez" and not "Michael Sanchez."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review, dated June 28, 2017, be recalled and a Corrected Decision and Opinion on Review be issued simultaneously. The parties should return their original Decision to Commissioner Michael J. Brennan.

Dated: JUL 20 2017

Michael J. Brennan

MJB/pm
7-14-17
052

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mario Sanchez,

Petitioner,

vs. NO: 16 WC 7544

Freight Car Services,

Respondent.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed October 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 $13,300.00. 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 the Circuit Court.

DATED: JUL 20 2017
MJB/pm
O-6/20/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Montalvo,

Petitioner,

vs. NO. 16WC 08034

Staff Force/Andrews Staffing, Inc.

17IWCC0453

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 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 $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: JUL 18 2017

Stephen J. Mathis

Kevin W. Lamborn

David L. Gore

SJM/sj
o-6/29/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONTALVO, MARIA
Employee/Petitioner

Case# **16WC008034**

17IWCC0453

STAFF FORCE/ANDREWS STAFFING
Employer/Respondent

On 12/5/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2044 ALVARO COOK LTD
111 S LINCOLNWAY
SUITE B00
NORTH AURORA, IL 60542

1505 SLAVIN & SLAVIN LLC
BRIAN H DRISCOLL
100 N LASALLE ST SUITE 2500
CHICAGO, IL 60602

17IWCC0453

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
19(b)

Maria Montalvo
Employee/Petitioner

v.

Staff Force/Andrews Staffing
Employer/Respondent

Case # **16** WC **8034**

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 **Geneva**, on **10/12/16**. 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] Were the 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, **1/8/16**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,160.44**; the average weekly wage was **$368.47**.

On the date of accident, Petitioner was **51** 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 **$5,016.17** for TTD, **$NA** for TPD, **$NA** for maintenance, and $ for other benefits, for a total credit of **$5,016.17**.

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

ORDER

The Arbitrator finds that the surgical diskectomies and fusions recommended by Dr. Ross are necessary prospective medical care related to the accident of January 8, 2016 and orders the Respondent to authorize and pay for those procedures.

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

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

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

Signature of Arbitrator

11/29/16
Date

ICArbDec19(b)

DEC 5 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARIA MONTALVO	)	
	)	
Employee/Petitioner	)	
	)	
v.	)	Case #: 16 WC 8034
	)	
STAFF FORCE/ANDREWS STAFFING	)	
	)	
Employer/Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR
FINDINGS OF FACT

It is undisputed that just before midnight, January 8, 2016, in the course of her employment, the Petitioner was pulling on a large heavy plastic container when she felt a pop in her neck and experienced pain in her cervical spine.

On January 9, 2016 at 1:52 a.m. Petitioner presented to Delnor Hospital Emergency Department with complaints of sharp left arm and shoulder pain radiating up the left side of the neck and tingling in the left fingers after pushing a heavy container at work. She reported feeling a "pop" and experiencing severe pain to the left shoulder blade and neck area since. A history of left elbow surgery was noted. Cervical x-rays noted "straightening of the lordotic curve which can be seen with spasm" as well as subtle loss of disc space at C5-C6 and to a lesser degree at C6-C7. X-rays of the left shoulder were unremarkable. (Px 1). Petitioner was diagnosed with a trapezius strain, placed on light duty restrictions, given medication and referred to occupational medicine. (Id.).

Petitioner was treated at Physicians Immediate Care from January 14, 2016 through February 25, 2016. Clinic records document Petitioner's repeated pain complaints in her left upper extremity and neck pain radiating into the left arm and hand. In the course of her treatment, Petitioner was placed on light duty restrictions, provided with medication and received physical therapy for her left wrist and arm. (Px 3)

On February 24, 2016 Petitioner presented to Delnor Hospital Emergency Department with complaints of pain radiating from her left hand up to her shoulder. MRI of the cervical spine documented diffuse posterior disc spur complex C6-C7 with a further extruded left lateral recess disc herniation with slight superior and inferior migration of disc material causing compromise of the lateral recess. (Px 1, 2/24/16) Petitioner was diagnosed with cervical nerve root disorder and referred to a neurosurgeon.

On March 7, 2016 Petitioner was examined at Midwest Neurosurgery and Spine Specialists by Dr. Matthew Ross who also reviewed the recent MRI noting a left C7 radiculopathy stemming from the C6-7 disk herniation. Dr. Ross opined the most likely cause was the January 8, 2016 the work accident. He further noted, "there may be some contribution from the C5-6 foraminal stenosis as well." Dr. Ross recommended C5-6 and C6-7 anterior cervical diskectomies and fusion and placed Petitioner off work. (Px 4)

The Petitioner was examined pursuant to §12 by Dr. Michael Grear on March 31, 2016. Dr. Grear noted the history provided by the Petitioner and the medical records reviewed were consistent with a work related injury on January 8, 2016. Dr. Grear's diagnosed a herniated nucleus pulposus C6-7 lateralized to the left. (Rx 1 p.3). He recommended an EMG to confirm the paresthesias origination from the cervical spine. The doctor noted that if such EMG were positive, surgical intervention and removal of the discs would be considered. (Id., p 4). Dr. Grear recommended that Petitioner return to light clerical work. (Id., p 5).

The Petitioner underwent an EMG on May 13, 2016, noted as normal with no evidence of left median nerve mononeuropathy at the carpal tunnel, elbow or wrist. There was also no evidence of left cervical radiculopathy or brachial plexopathy. (Px 6)

Petitioner was re-examined on May 25, 2016 by Dr. Ross who reviewed the EMG results, noting:

> *Ms. Montalvo has symptoms and clinical signs of a left C7 radiculopathy. This correlates precisely with her left C6-7 disk herniation. The EMG ruled out the other causes for her symptoms including carpal or cubital tunnel syndrome. The absence of any ulnar nerve dysfunction conclusively eliminates any relation between her current symptoms and her previous work injury in the 1990s. I would again recommend that Ms. Montalvo undergo C6-7 anterior cervical diskectomy and fusion.* (Px 4)

On August 1, 2016, Dr. Grear prepared a supplemental report in which he reviewed the EMG report, recommending conservative treatment, light duty work in a clerical capacity with no overhead lifting greater than five pounds until maximum medical improvement was reached within six months. (Rx 2)

Dr. Ross last examined the Petitioner on October 3, 2016 at which time her complaints of increased left neck, shoulder, upper back and arm pain along with weakness of the left arm were noted. Petitioner also reported burning pain down the arm to the back of her hand. Dr. Ross stated that her symptoms suggest "worsening of her left C6 and C7 radiculopathies due to her C6-7 disk herniation and C5-6 foraminal stenosis." Because her symptoms had not improved with 9 months of conservative treatment, he recommended surgery. (Px 4)

Petitioner's Testimony

Petitioner testified that near midnight on January 8, 2016 she was pulling with both hands on a heavy plastic container called a gaylord when she felt a pop in her neck followed by extreme pain. She reported the incident to her employer and went to Delnor Hospital Emergency Department that night. Thereafter she was referred by the Respondent to Physicians Immediate Care for further treatment. During the course of her treatment, she continued to experience pain in her neck, left shoulder, arm and hand. She worked in the office for the Respondent in a light duty capacity. Toward the end of January 2016, she was transferred to a company called Freedom Graphics where her job involved stacking envelopes in trays and placing the full trays onto a skid. While performing those tasks, she began to experience increased pain in her neck and left arm which prevented her from completing the assigned duties of that job. She reported the situation to her supervisor at the Respondent and was told not to return until she was able to work 100%.

Thereafter, the Petitioner continued to receive treatment and therapy at Physicians Immediate Care. Her condition did not improve and she presented to Delnor Hospital Emergency Department on February 24, 2016 with severe pain radiating from her neck into her left arm.

She underwent an MRI and was referred to a surgeon. She was last seen at Physician's Immediate Care on February 25, 2016 when her MRI was reviewed and she was referred to a surgeon. She then received treatment from Dr. Matthew Ross, a neurosurgeon, who recommended fusion surgery. She was examined by Dr. Grear and at his request, submitted to an EMG.

Petitioner testified that after the EMG she was examined by Dr. Ross on two occasions and that he continued to recommend surgery. Petitioner testified that she had sustained a work related elbow injury more than twenty years prior to her current accident. She testified that she underwent surgery at her left elbow and was ultimately released. She returned to her normal activities after her release. She denied any other injuries to her neck or arm prior to the accident of January 8, 2016. She stated that she was hired by the Respondent on a full duty basis and was working her full duty on the date of her accident.
She stated that she currently had severe pain radiating from her neck down her left arm and that her condition had not improved with the care she had received thus far. She asserted that she was interested in pursuing surgical treatment of her condition. She testified that she continues to work in a light duty clerical position with the Respondent.

CONCLUSIONS OF LAW

Causal Connection

The Arbitrator finds that Petitioner has sustained her burden with respect to causal connection. The Arbitrator found Petitioner a credible witness whose testimony and complaints of pain are corroborated by the medical records in evidence. Dr. Ross noted that Petitioner's clinical history and pathology correlate with the January 8, 2016 work accident. (Px 5 p2) Dr. Ross' treatment note of May 25, 2016, stated:

> *Ms. Montalvo has symptoms and clinical signs of a left C7 radiculopathy. This correlates precisely with her left C6-7 disk herniation. The EMG ruled out the other causes for her symptoms including carpal or cubital tunnel syndrome. The absence of any ulnar nerve dysfunction conclusively eliminates any relation between her current symptoms and her previous work injury in the 1990s. I would again recommend that Ms. Montalvo undergo C6-7 anterior cervical diskectomy and fusion* (Px 4)

The Arbitrator further notes Dr. Grear's March 31, 2016 Section 12 report where he diagnoses a herniated nucleus pulposus at C6-C7 lateralized to the left which the doctor found causally related to the incident on January 8, 2016. (Rx 1 p. 3)

The opinions of Dr. Ross and Dr. Grear are supported by the Petitioner's unrefuted testimony and the medical records of treatment. The Arbitrator finds that the Petitioner's current condition of ill-being is causally connected to the accident and injury of January 8, 2016.

Prospective Care

The Petitioner credibly testified that her symptoms continue to be severe. Her symptoms of neck pain radiating down her left arm have been present since the date of accident. Petitioner testified that her elbow symptoms for which she underwent surgery more than twenty years ago, had resolved. She testified that she resumed her normal activities thereafter and did not have any other injuries to her neck or left arm prior to the accident of January 8, 2016.

Dr. Ross' report dated October 3, 2016 states the following,

> *I reviewed the independent medical examination report generated on Ms. Montalvo by the orthopaedic surgeon, Michael Grear, M.D. Dr. Grear was of the opinion that since the patient's EMG did not show evidence of ulnar or median nerve neuropathy, cervical radiculopathy or brachial plexopathy, continued conservative management was appropriate. He anticipated that she would reach maximum medical improvement in 6 months. I respectfully disagree with Dr. Grear's recommendation. To paraphrase Albert Einstein, the definition of insanity is to keep doing the same thing and expect a different result. Ms. Montalvo has undergone an appropriate course of conservative treatment without obtaining meaningful improvement of her symptoms. Basing a treatment decision purely on the result of an EMG study is not appropriate. The EMG/NCV is a helpful test for clinical decision with cervical radiculopathy when it is positive. It is not a reliable decision making tool when it is negative. Patients with symptomatic foraminal stenosis frequently have normal EMG studies. The only utility of the EMG is to help rule out other potential reasons for her symptoms such as carpal tunnel syndrome, cubital tunnel syndrome, or brachial plexitis/plexopathy as would be seen in such conditions such as the Parsonage-Turner syndrome or a brachial plexus stretch injury. The EMG findings leave us with the cervical spine as the most likely cause for Ms. Montalvo's symptoms. These opinions are stated within a reasonable degree of medical and surgical certainty."* (Px 5)

Petitioner has a disk herniation. This was first revealed and diagnosed by the radiologist interpreting the MRI and confirmed by Dr. Ross and Dr. Grear. The EMG ruled out alternative causes for Petitioner's radiculopathy such as brachial plexopathy or ulnar neuropathy. Dr. Ross' opinion that the EMG is not an appropriate tool for ruling out cervical radiculopathy when it is negative, is unrebutted.

The medical records confirm a persistence and severity in Petitioner's symptoms after the failure of extensive conservative measures.

Considering the evidence as a whole, the Arbitrator finds that the surgical diskectomies and fusions recommended by Dr. Ross are necessary prospective medical care related to the accident of January 8, 2016 and orders the Respondent to authorize and pay for those procedures.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carrie Urso,

Petitioner,

vs. NO: 16 WC 08158

Steak N Shake,

Respondent,

17IWCC0468

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 December 8, 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.

17IWCC0468

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: JUL 21 2017
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DLG/mw
045

David L. Gore

Stephen Mathis

Kevin W. Lamborn

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

URSO, CARRIE
Employee/Petitioner

Case# **16WC008158**

STEAK 'N SHAKE
Employer/Respondent

17IWCC0468

On 12/8/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4988 LAW OFFICE OF DAVID W CLARK
207 N WASHINGTON ST
WHEATON, IL 60187

1832 KLAUKE LAW GROUP LLC
GEORGE F KLAUKE JR
1900 E GOLF RD SUITE 950
SCHAUMBURG, IL 60173

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Carrie Urso
Employee/Petitioner

v.

Steak 'n Shake
Employer/Respondent

Case # **16** WC **8158**

Consolidated cases: _____

17IWCC0468

An *Application for Adjustment 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 **October 12, 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. ☐ 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 22, 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 **$11,630.97**; the average weekly wage was **$232.62**.

On the date of accident, Petitioner was **50** years of age, **married** with **no** dependent children.

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

Respondent shall be given a credit of **$4,868.89** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner suffered an accident on September 22, 2015 resulting in injuries to her left knee. Respondent is responsible for medical expenses related to the treatment of the left knee and for TTD at the rate of 232.62 during the period of time Petitioner was recovering from the injuries to the left knee.

Petitioner was temporarily totally disabled from left knee injuries from September 28, 2015 to October 7, 2015 (1 and 3/7ths weeks) when the treating doctor, Dr. Suchy, indicated that the left knee had resolved and required no further treatment.

The condition of Petitioner's right knee, right and left ankle, back and arms are not related to the September 22, 2015 work accident based on the credible opinion of Dr. Kevin Walsh and Dr. Suchy's record of December 23, 2015 indicating multiple areas of pain are disproportionate to the objective findings.

Respondent shall receive full credit for any benefits paid including reimbursement for medical expenses for non-work related conditions in the right knee, both ankles back and arms as well as TTD past October 7, 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 to the left knee, 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.

Jason C. Knott

Signature of Arbitrator

12/7/16
Date

ICArbDec19(b)

DEC 8 - 2016

17IWCC0468

IN THE ILLINOIS WORKERS' COMPENSATION COMMISSION

State of Illinois)
) SS
County of Kane)

CARRIE URSO,)
Petitioner,)
)
)
STEAK 'N' SHAKE,)
Respondent.)

Case #: 16 WC 8158

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

While at work on September 22, 2015, Petitioner tripped over some cardboard on the ground, landing on her back side. After her fall, she got up off the ground and finished her shift. (*Id.*). She felt pain and soreness in her legs during her shift. Upon returning home that day, she noticed swelling in her right knee. (Tr. 10) She did not seek immediate medical attention.

Records from Glen Oaks Hospital, show that Petitioner presented on Monday, September 28, 2015, with complaints of bilateral knee pain. (PX 3). A history of a left knee injury while at work on Tuesday followed by a fall on Wednesday causing injury to her right knee was noted. Petitioner reported lower back pain "from having knee pain". (PX 3 pg. 90) The history of present illness noted at page 72 of Petitioner's Exhibit 3 notes Petitioner twisted her left knee at work 6 days ago and then injured her right knee while walking down a cement steps days later.

Petitioner was diagnosed with a right knee effusion and sprain, placed in a right knee immobilizer and prescribed Norco for pain. (PX3 74)

Petitioner sought treatment with Dr. Theodore Suchy on September 30, 2015 with bilateral pain complaints in her knees and ankles. She was noted to be using a cane. (PX 2 pg. 16). The history outlined indicated Petitioner:

> Slipped on a box, did the splits and injured both knees. She was able to get up and walk, and continued to work to the end of the shift. The pain worsened and she was seen the next day. She was X-rayed and placed on anti-inflammatory medications and splinted. She has not worked since the day after her injury. She denies any recent problems with her knees. She did have an ACL reconstruction on the right side about 10 years ago. She complains now of bilateral knee pain,

right greater than left, and states that her left ankle is also somewhat symptomatic, she feels probably from favoring the right side when ambulating. She denies any head, neck or back injuries. (PX 2 pg. 15)

On exam, Dr. Suchy noted the right knee was stable with generalized synovitis. Collateral ligaments were intact. Complaints of pain and tenderness over the medial joint line was noted with no gross instability. McMurray test was positive referable to the medial side. The left knee was minimally symptomatic with very slight swelling, full range of motion and no significant pain.

Dr. Suchy diagnosed Petitioner with internal derangement of the right knee and contusion of the left knee. Petitioner was provided with crutches to keep weight off the right leg.

On October 7, 2015, Petitioner returned to Dr. Suchy with complaints of right knee pain, mostly to the medial side. (*PX2*). Bilateral ankle soreness and a bit of stiffness in her left knee was also reported. (Id.). On exam, the doctor noted pain and tenderness over the right medial joint line with a positive McMurray's test. Dr. Suchy recommended a right knee MRI and physical therapy. Petitioner's left knee problem was noted to be resolved. (Id.).

On October 12, 2015, a right knee MRI revealed Grade IV chondromalacia at the femoral trochlea and a Grade III horizontal tear in the posterior horn, the body of the medial meniscus was noted to be reaching up to the inferior surface. (PX2 at 39).

On October 14, 2015, Dr. Suchy reviewed the MRI with Petitioner noting a right torn medial meniscus for which he recommended a partial medial meniscectomy.

On November 13, 2015, Petitioner reported to ATI that she fell down her stairs because her left leg gave out. (PX4 at 113)

On November 17, 2015, Petitioner was discharged from ATI Physical Therapy prior to surgery.(PX4 at 116)

Petitioner underwent a right knee partial medial meniscectomy, chondroplasty of the patella and trochlear groove and synovectomy of the anterior and suprapatellar compartments. (PX2) On November 25, 2015, following her surgery, Dr. Suchy ordered a left knee MRI pursuant to Petitioner's complaints of pain. (Id.)

On December 4, 2015, MRI revealed vertical increased signal intensity in the posterior horn of the medial meniscus communicating with articular surfaces, representing a Grade III tear as well as small knee joint effusion. (Id.)

On December 9, 2015 Petitioner's complaints of left medial joint line pain with popping and clicking was noted by Dr. Suchy. The doctor administered a left knee epidural steroid injection and kept Petitioner off of work. *(Id.)*.

On December 14, 2015, Petitioner began physical therapy at ATI where she complained of bilateral knee pain.

Petitioner presented to Glen Oaks Hospital Emergency Room on December 21, 2015, with complaints of left low back nonradiating. (*PX3 at* 12, 14) Petitioner reported that while getting out of bed earlier that morning, her knee gave out and she twisted her back. (*Id.* at 14.) Lumbar spine X-rays indicated mild to moderate degenerative disc disease at L5-S1 and L3-L4 with mild degenerative disc disease throughout the remainder of the lumbar spine as well as facet arthropathy at L5-S1 and L4-L5. (*Id.* at 16) Petitioner was diagnosed with a lumbar strain and advised to follow up with Dr. Suchy. (*Id.)*

On December 23, 2015 Petitioner presented to Dr. Suchy with a history of getting out of bed when her left knee buckled. (PX2) She complained of severe back pain, and hurting "all over." (*Id).* Dr. Suchy indicated that he had a discussion with Petitioner regarding pain and that he could not explain why she was having pain everywhere. (*Id.)* On examination, he noted left knee pain and tenderness over the medial joint line. (*Id.)* His examination of Petitioner's low back was negative. (*Id.)* Dr. Suchy noted she ambulated with a cane but could not explain why she needed a cane to ambulate. (*Id.)* He further noted Petitioner ambulated with a halting antalgic limp. After a discussion with Petitioner, Dr. Suchy advised her to consult with another orthopaedic surgeon as he would not treat her after thirty (30) days. Dr. Suchy continued to keep Petitioner off of work due to her complaints. (*Id.*).

Petitioner continued to attend physical therapy at ATI until she was discharged on March 25, 2015. (PX4) At the time of her discharge, her complaints of bilateral knee pain with decreased range of motion and extension were noted. (Id.).

On February 18, 2016, Petitioner submitted to a Section 12 exam with Dr. Kevin Walsh pursuant to Respondent's request. (RX 1) Dr. Walsh noted her report of bilateral knee pain, left greater than right. Petitioner also reported that she twisted her lower back when she fell. (*Id.)* Petitioner told Dr. Walsh she injured her right knee and her ankle as well as her left knee from the fall at work. (*Id.)* She reported needing assistance with daily activities of walking, standing and going up and down stairs. She told Dr. Walsh physical therapy offered her temporary relief. (*Id.)* She had not taken any pain medication for the prior two (2) months. On exam, Dr. Walsh found that her right knee had no effusion. Lachman and drawer tests were negative. (*Id.)* Petitioner was noted to have full extension and flexion in her right leg and strength was noted to be 5/5. (*Id.)*

Examination of her left knee showed no effusion, no medial or lateral instability. (*Id.)* Lachman and drawers tests were negative. (*Id.)* She had good motion and strength. (*Id.)* Medial joint line tenderness was noted. (*Id.)*

Examination of her back showed no paraspinal muscle spasm, no sciatic notch tenderness and she was able to flex forward touching her fingertips to her toes. (*Id.)* She was able to hyperextend to 20 degrees and laterally bend to the right and left 45 degrees and laterally rotate 90 degrees. (*Id.)* She had a negative straight leg raise, 5/5 motor strength and equal and symmetrical reflexes. (*Id.)*

Dr. Walsh noted that the Petitioner's MRIs showed evidence of a torn meniscus in the right and left with significant degenerative changes involving the trochlear groove in the right. The doctor noted the left showed osteoarthritic disease in the weight bearing joint. (*Id.)*

Dr. Walsh opined that it is not at all likely that the meniscal pathology described on the MRI scan is causally related to the injury described, indicating that if she had injured her left knee at the time of the trauma, significant findings on physical examination would have manifested. (*Id.*) In his opinion, Petitioner's current symptoms and pathology in her left knee were neither caused, aggravated or accelerated by the accident of September 22, 2015. (*Id.*)
Further, Dr. Walsh indicated that Petitioner's complaints of low back pain were not causally related to the September 22, 2015 accident. (*Id.*) No additional orthopaedic treatment for her work-related injury of September 22, 2015 was necessary and Petitioner could return to her job with Respondent with no restrictions due to her work injury. (RX 6)

Dr. Walsh agreed that Petitioner should undergo additional arthroscopic intervention of her left knee. (RX 6,7)

Petitioner testified that she continues to have pain in both her knees since the termination of physical therapy. She has pain in her left knee especially when using stairs and she uses a cane for additional support. (Tr. 23). She continues to have pain and soreness in her right knee. (*Id.*). Her back is sore from walking "unevenly." (*Id.*). She takes pain medication and ibuprofen to help with pain and swelling. (Tr. 24)

From the date of the accident until the date of her IME with Dr. Walsh, Petitioner was receiving TTD payments. (Tr. 22) Currently, Petitioner has outstanding medical bills from Glen Oaks Hospital, Suburban Radiology, Dr. Suchy and ATI Physical Therapy for a sum of One Thousand Six Hundred Ninety Four Dollars and ninety eight cents ($1,694.98).

CONCLUSIONS OF LAW

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

The Arbitrator finds, based on the above factual findings and the record as a whole, that Petitioner did suffer a work-related accident on September 22, 2015 when she slipped on some broken down cardboard boxes. She worked the remainder of the shift and was off work from that point to the hearing date. Her first treatment was six days following the accident on September 28, 2015 at Glenn Oak Hospital when she provided a history of the work incident and an injury to her left knee. She stated at least twice that the right knee injury occurred days later when descending concrete steps. Judging the credibility of the witness through her testimony at trial and review of medical records including the report of Dr. Suchy on December 23, 2015, the Arbitrator finds that the most accurate description of the accident was provided to Glenn Oaks Hospital 6 days after the event. Petitioners credibility is suspect given the well documented unsubstantiated ongoing complaints to multiple body parts.

The Arbitrator finds that injury to the right knee occurred days later and is not a work-related condition. There has been no proof that the right knee was in any way the result of a weakened condition of the left knee and thus even an inference could not be supported. When Petitioner later saw Dr. Suchy, the history merely stated she slipped on

boxes injury both knees. Dr. Suchy did not have the benefit of the true history of the events at the time he provided a causation opinion.

The other various complaints throughout the medical records to the back, ankles, arms etc. are also not related to the September 22, 2015 incident. The records of Dr. Suchy and Dr. Walsh clearly establish a lack of evidence linking such complaints to the work-related event.

The Arbitrator finds that the September 22, 2015 injury to the left knee resulted in a contusion as diagnosed by Dr. Suchy on September 30, 2015. The left knee was thereafter fully healed as documented by Dr. Suchy on October 7, 2015 when he noted: "The L knee problem has resolved and I do not feel that any further diagnostic studies, therapeutic modalities or surgical intervention are indicated related to the left knee."

Medical Expenses

The Arbitrator finds that medical expenses for treatment to the left knee are the responsibility of the Respondent and to the extent that they cannot be separated from treatment of other maladies, the Arbitrator awards medical expenses through October 7, 2015 subject the Medical Fee Schedule pursuant to Section 8.2 of the Illinois Workers' Compensation Act. Medical expenses incurred after October 7, 2015 are not related and not reasonable or necessary to cure the ills of the work-related accident. Respondent is not liable for medical expenses after October 7, 2015. Respondent paid $36,848.56 for medical expenses. Respondent shall be provided full credit for any expenses paid and be reimbursed for expenses paid subsequent to October 7, 2015. Claimed unpaid medical expenses (PX 5) for which Respondent is liable, subject to the medical fee schedule include; 1) Illinois Emergency Medicine/AR Adventist Glen Oaks date of service 9/28/16 total charge $399.00, 2) Adventist Glen Oaks Hospital date of service 9/28/16 total $592.87; 3) Suburban Radiology at Glen Oaks Hospital $152.00 and any other unpaid medical expenses related to treatment of the left knee incurred prior to October 7, 2015 if contained in the record.

Temporary Total Disability

The Arbitrator finds that Temporary Total Disability is due from September 28, 2015 to October 7, 2015, a period of 10 days. While Petitioner did not return to work after September 22, 2015, she did not have a doctor note keeping her off work until September 28, 2015 at first medical treatment. While the off-work recommendation of Dr. Suchy may have been for the right knee, there is no way to determine whether Dr. Suchy would have kept Petitioner off work solely for the left knee contusion. However, clearly, when Dr. Suchy found that Petitioner's left knee had recovered and did not need further treatment on October 7, 2015, she was no longer temporarily totally disabled from that point forward as it relates to a work related injury. Respondent therefore owes 10 days of TTD at the rate of $232.62 or $332.31. Respondent shall receive credit for all TTD paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Pletsch,

Petitioner,

vs.

NO: 16 WC 8875

17IWCC0436

Southern Wine & Spirits,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes on the face sheet, the Arbitrator noted the award of temporary partial disability commencing September 21, 2015 through February 28, 2016 in the amount of $2,426.50. However, the Arbitrator also noted, "Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 18, 2015 (date of accident) through October 7, 2016 (date of arb hearing) and shall pay the remainder of the award, if any, in weekly payment." The Commission notes the Arbitrator did not award temporary total disability benefits but awarded temporary partial disability benefits. Therefore, the Commission corrects the clerical error on the face sheet to "temporary partial disability benefits."

The Commission further notes on Page 10 of her Decision, the Arbitrator noted, "In light of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits beginning September 21, 2015 through February 28, 2016 totaling $2,426.50 as claimed." Again, the award was for temporary partial disability benefits, not temporary total disability benefits. Therefore, the Commission corrects the clerical error on Page 10 to "temporary partial disability benefits."

The Commission affirms the Arbitrator's finding of accident on September 18, 2015 with accidental injury to the left shoulder, based upon Petitioner's credible testimony and the medical records, particularly those of Physicians Immediate Care. Petitioner voiced left shoulder complaints the day after the accident and sought treatment for same two days later. PX1. The Commission affirms the Arbitrator's finding of causal connection for the left shoulder based on the preponderance of medical evidence. The Commission notes Dr. Atluri did not review the Physicians Immediate Care records. RX1 and RX2. Dr. Durkin opined the accident was consistent with a rotator cuff injury. PX4. The Commission affirms the Arbitrator's finding of Petitioner being entitled to prospective medical care of left shoulder surgery recommended by Dr. Durkin. Both Dr. Durkin and Dr. Atluri opined surgery was reasonable and necessary. PX4; RX2.

The Arbitrator ordered Respondent to pay reasonable and necessary medical services as reflected in Petitioner's exhibits for Hinsdale Orthopedics that remain unpaid, pursuant to the Medical Fee Schedule. The Commission notes that the medical bills were admitted as PX6, charges from Hinsdale Orthopedics for dates of service February 29, 2016 and the left shoulder MRI performed March 7, 2016. Total charges were $2,955.00; there was a discount applied of $217.86 and insurance payment of $145.47. The amount not paid and outstanding is $2,591.67, and the Commission awards this amount pursuant to the Medical Fee Schedule. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016 is hereby affirmed and adopted with the above noted corrections of clerical errors.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $2,426.50, that being for the period of temporary partial incapacity commencing September 21, 2015 through February 28, 2016 under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay the medical bill from Hinsdale Orthopedics balance due of $2,591.67 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical expenses that have been paid, if any, and Respondent shall hold Petitioner

harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and awards left shoulder surgery prescribed by Dr. Durkin.

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 COMMISION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,100.00. 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: JUL 13 2017
LEC/maw
o06/21/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

PLETSCH, JAMES
Employee/Petitioner

Case# **16WC008875**

17IWCC0436

SOUTHERN WINE & SPIRITS
Employer/Respondent

On 11/28/2016, 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 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0146 CRONIN & PETERS
KENNETH D PETERS
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

17IWCC0436

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

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

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

James Pletsch
Employee/Petitioner

v.

Southern Wine & Spirits
Employer/Respondent

Case # 16 WC 8875

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton** on **October 7, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective medical treatment, TPD, accident (shoulder) and causal connection (shoulder)**

FINDINGS

On the date of accident, September 18, 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 as explained *infra*.

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

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

In the year preceding the injury, Petitioner earned $54,600.00; the average weekly wage was $1,050.00.

On the date of accident, Petitioner was 59 years of age, *married* with no dependent child.

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

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

Respondent is entitled to a credit as agreed reflected in Respondent's Exhibits under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that he sustained an injury to his left shoulder on September 18, 2015 as claimed and that there is a causal connection between Petitioner's current left shoulder condition and his accident at work.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $2,426.50[1] commencing September 21, 2015 through February 28, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 18, 2015 through October 7, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits for Hinsdale Orthopaedics that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit as agreed by the parties for any payments made with respect to Petitioner's medical bills. *See* AX1.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective medical care in the form of a left shoulder surgery as prescribed by Dr. Durkin pursuant to Section 8(a) of the Act.

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[1] At the time of the hearing, the parties stipulated that, should Petitioner prevail in establishing that he sustained an injury to the left shoulder on September 18, 2015 as claimed as well as a causal connection between his left shoulder condition and accident at work, the amount of temporary partial disability benefits payable totaled $2,426.50.

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

November 21, 2016
Date

ICArbDec19(b) p 3

NOV 28 2016

17IWCC0436

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

James Pletsch
Employee/Petitioner

v.

Southern Wine & Spirits
Employer/Respondent

Case # **16** WC **8875**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include whether Petitioner sustained a compensable accident relative to his shoulder on September 18, 2015, whether there is a causal connection between Petitioner's shoulder condition and a compensable accident on September 18, 2015, whether Respondent is liable for certain unpaid medical bills from Hinsdale Orthopaedics, whether Petitioner is entitled to temporary partial disability benefits totaling $2,426.50 for the period beginning on September 21, 2015 through February 28, 2016, and whether Petitioner is entitled to prospective medical care in the form of a left shoulder surgery as ordered by Dr. Durkin. Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

James Pletsch (Petitioner) testified that he is employed as a delivery driver for Southern Wine & Spirits (Respondent) and has been so employed for 22 years. He described his duties to include the delivery of wine and liquor to Respondent's customers, which requires him to unload cases of various products from the truck, usually with a wheeler, to the customer's premises. Petitioner testified that the amount of cases he has to deliver differs for each location and he described in detail how he would take the cases off of the truck and deliver them to the customer. For example, Petitioner explained that boxes of wine weigh about 50 pounds, so if there are two cases he has to put those on a wheeler to get it to the customer's premises. Depending on the customer, Petitioner explained that he has to traverse various doors and stairways, and perform different physical activities including placing these products behind counters and the like.

September 18, 2015

On Friday, September 18, 2015, Petitioner testified that he went to make a delivery to Judy's, one of Respondent's customers. He saw the side door and picked her order off of the truck placing it on the wheeler. Petitioner explained that when he got to the door, he saw a mud room or add-on to the building measuring about four by three feet. This room also had a screen door that opened out toward the street. Petitioner testified that he opened the door and propped it open with the wheeler. The door had automatic closure mechanism. Petitioner explained that he reached behind him with his left arm and opened the inside door. As he stepped back, Petitioner testified that the wheeler was caught under the screen door. He used his left foot to hold the inside door open and his left hand to push the screen door out. However, Petitioner explained that there was a four inch step in the doorway of which he was unaware. Petitioner testified that he tripped, went down hard on his back, and the door shut on his left foot.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Petitioner explained that he felt excruciating pain and he could not move. The bartender or owner opened the door and tried to help him up, but Petitioner testified that he is a big guy, so he lay on the floor. Petitioner described extreme pain all over at this time. Eventually, Petitioner was able to get up himself and he later completed the delivery with the lady's help. Petitioner believed that she may have brought the boxes all the way into the bar.

Thereafter, Petitioner called his boss to report that he was hurt and explained that he was unsure whether he could climb back into the truck. Respondent sent a security officer and a substitute driver to Petitioner's location. Then, the security officer drove Petitioner to Physician's Immediate Care (the company clinic).

Medical Treatment

The medical records reflect that Petitioner presented to Physicians Immediate Care on September 18, 2015. PX1. Petitioner reported that he fell on his back that day. *Id.* Specifically, the attending physician noted the following mechanism of injury:

> The patient presents with a chief complaint of back pain of the lower back since Fri. Sep 18. 2015. The patient describes the severity is 10/10, with 10 being the worst imaginable. Context: The patient reports it was the result of an injury that occurred on 9/18/2015, which was work related, which had a sudden onset. Patient reports he does delivery for Southern wine and spirits.Today he was going through screen door, his wheeler caught under the door and he fell backwards hitting his back. He was unable to get up. needed help to get up.Has severe pain back and back is very stiff.Has difficulty ambulating.No weakness or tingling or numbness of legs.Has very limited mobility The patient also reports muscle pain as an abnormal symptom related to the complaint.

Id. Petitioner's height was noted to be 5'10 with a weight of 279 pounds. *Id.* Petitioner was diagnosed with a backache, dispensed with medication, and scheduled for return visit on September 25, 2015. *Id.* He was also placed on sedentary work restrictions. *Id.*

Petitioner testified that he then returned to Respondent's location, filled out an accident report, and retrieved his personal vehicle. The form entitled "Employee Statement of Incident" was submitted into evidence and reflects Petitioner's report that he was injured while "[b]ringing in cases using 2 wheeler, wheeler caugh[t] screen door, in side door closed on my foot, fell flat on my back[.]" RX5. Regarding the affected body parts, Petitioner reported that it included both his right and left side "right ankle knee, whole lumbar back[.]" Id. On cross examination, Petitioner acknowledged the contents of the accident report.

Petitioner testified that his work restrictions were accommodated. He explained that he did not get medical treatment over the weekend, but sat in his lazy boy chair and soaked his aches and pains. Petitioner testified that he noticed a tingling sensation to his left two fingers and feeling as though someone was gripping his biceps. The following Monday, Petitioner went to Respondent's human resources department and was sent back to the clinic.

The Physicians Immediate Care records reflect that Petitioner returned to the clinic on Monday, September 21, 2015. PX1. The attending physician noted the following history:

> Patient came in for a follow-up of back pain in the lower back which was originally seen on 09/18/2015. Original onset was Fri. Sep 18, 2015. The patient describes the severity as 5/10, with 10 being the worst

imaginable, which has improved since last visit when it was 10/10.

Follow-Up Triage Notes: Pt. states he fell on his back today 9/21/2015-back is somewhat better, achy pain is constant but if he coughs or turns a certain way it shoots up. Also c/o left-sided neck, shoulder and arm pain. "feels like someone is grabbing his upper arm and butt cheek at times"

Context – Initial History: The patient reports it was the result of an injury, which was work will related, which had a sudden onset. Patient reports he does delivery for Southern wine and spirits.Today he was going through screen door, his wheeler caught under the door and he fell backwards hitting his back. He was unable to get up. needed help to get up.Has severe pain back and back is very stiff.Has difficulty ambulating.No weakness or tingling or numbness of legs.Has very limited mobility

Context – Interval History: Patient is doing better, but as things have called down, patient has noticed some pain to left shoulder with occasional tingling to left hand. On occasion, patient has tingling to back of left side that can get severe. Patient also reports severe exacerbation of pain with sneeze. pain at rest is a 5-6 but with sneeze 10.

Id. On physical examination, the following abnormalities were noted: spasm in the bilateral paraspinal lumbar muscles, reduced lumbosacral range of motion, mild tenderness in the left biceps tendon groove, and moderate tenderness in the left rotator cuff. *Id.* Petitioner was diagnosed with a backache and sprains/strains of the shoulder and upper arm rotator cuff capsule. *Id.* He remained on work restrictions and was scheduled for a follow-up visit. *Id.*

Petitioner testified that he had a prior neck condition and received treatment with Dr. Kazen. Once he started feeling the left sided neck, shoulder, biceps and fingers act up, Petitioner testified that he may have "goofed up" his spinal fusion from 8-9 years previously so he called Dr. Kazen to get the earliest appointment available.

The West Suburban Neurosurgical Associates medical records reflect that Petitioner presented to Robert Kazan, M.D. (Dr. Kazan) on October 19, 2015. PX2. Dr. Kazan noted the following history:

> Mr. James Pletsch, a 59 yearold male, who was seen in the office today, 10-19-15. He works for Southern Wine & Spirits. On 9-18-15, he was delivering alcoholic spirits and had a door close down on his left foot, trapping him and he went straight backwards and fell with his full body weight hitting his low back and neck. He had very severe pain immediately and had some difficulty with walking. Now he reports that he has pain in the left shoulder, down the triceps area into the lateral fingers on the left. Also, he has low back pain and pain in the left leg down to the achilles area.

Id. Dr. Kazan ordered MRIs of the cervical and lumbar spine. *Id.*

On November 4, 2015, Petitioner underwent the recommended MRIs at Hinsdale Hospital. PX2. With regard to the lumbar spine, the interpreting radiologist noted mild spondylotic changes at the lower lumbosacral spine particularly at the L3-L4, L4-L5, and L5-S1 levels with multilevel neural foraminal encroachment. *Id.* With regard to the cervical spine, the interpreting radiologist found mild spondylotic changes, bilateral neural foramen encroachment at the C4-C5, C5-C6, and C6-C7 levels, as well as an anterior cervical fixation at the C5-C6 level.

Petitioner returned to Dr. Kazan on November 9, 2015. PX2. Dr. Kazan noted his review of the MRIs, including the cervical MRI which he indicated showed wide open foramen bilaterally and a mature fusion, but with an asymmetric mound of bone on the left C5-C6 level. *Id.* Dr. Kazan thought that "the patient when he

fell (on 9-18-15) with his full body weight probably stretched the nerve root in the foramen around the mound of bone. I think with physical therapy he should be able to retain his normal strength on that side. On static testing, he has no weakness of the biceps or deltoid muscle. It is only when he elevates his arm above his head that he feels a pulling sensation in the arm." *Id.* Dr. Kazan ordered physical therapy. *Id.*

On November 12, 2015, Petitioner presented to ATI Physical Therapy for an initial evaluation. PX2-PX3. Thereafter, he underwent physical therapy several days per week. *Id.* Petitioner testified that he was also working in the office during this period of time.

On December 7, 2015, Petitioner returned to Dr. Kazen reporting that he was improving in physical therapy, but he "still can not elevate his arm above his shoulder. He feels some soreness but not extreme pain that would be probably present with a rotator cuff injury." PX2. Dr. Kazan reviewed Petitioner's cervical MRI again noting a perfect fusion, but ordered an EMG to determine if Petitioner had a traction injury. *Id.* Petitioner testified that he was still feeling symptoms in the biceps and tingling down the arm. He explained that he felt a pulling sensation when he would lift with left arm out to the left and he could not get the arm above shoulder without feeling something pulling.

Petitioner underwent the recommended EMG on December 30, 2015. PX2; PX5. The physician, Thomas Sullivan, M.D. (Dr. Sullivan) noted Petitioner's report of "left shoulder pain and limited range of motion of his left arm, especially with abduction or arm elevation. The patient was involved in work-related accidents in September 2015, tripping on the floor and landing on his left arm." *Id.* Dr. Sullivan found chronic neurogenic changes in C5, C6, and C7 muscles that were most likely residual from previous pathology required by his surgeries 8 to 10 years previously. *Id.* Dr. Sullivan indicated that these muscles did not show any acute denervation to suggest a more recent or active axon degenerative process. *Id.* He also found that there was some mild conduction slowing of the ulnar nerve across the elbow. *Id.* Dr. Sullivan noted that "[t]he patient's main complaint appears to be limited and pain full movement on abduction and arm elevation over his head with his left arm. The symptoms may reflect some left shoulder joint impairment or injury. Would recommend further investigations with MRI to rule out a rotator cuff injury or other pathology in the left shoulder." *Id.*

Petitioner returned to see Dr. Kazan on January 8, 2016. PX2. Dr. Kazan noted his review of Dr. Sullivan's EMG report and suggestion of the possibility that Petitioner sustained a rotator cuff injury. *Id.* Dr. Kazan agreed with Dr. Sullivan and referred Petitioner to Dr. Durkin for an orthopedic evaluation of the left shoulder. *Id.*

Petitioner testified that every time that he saw his doctors, there was a representative of the workers' compensation carrier present and she scheduled his appointment with Dr. Atluri.

Section 12 Examination – Dr. Atluri

On February 2, 2016, Petitioner saw Prasant Atluri, M.D. (Dr. Atluri) at Respondent's request. RX1. Dr. Atluri's report reflects that he took a history from Petitioner, examined him, reviewed various treating medical records, and rendered opinions regarding the relatedness of his physical conditions, if any, to the accident at work. *Id.* Dr. Atluri noted the following mechanism of injury:

> The patient reports an injury from September, 2015. He states he was tracked by a closing door. He states that he fell backwards. He states "I can't even tell you if I was knocked out." He was unable to describe any specifics about how he landed. However, he reports that he felt severe pain in his back. He

> states that a day or two later, he realized that his left arm was hurting. He states he had been holding his left arm against his body without realizing it. However, when he tried to move his arm, he felt pain.

Id. At the time of this examination, Petitioner also reported "pain involving the left side of his neck extending into his shoulder and left elbow. He states this radiates into the small and ring fingers of his left hand. He states that it 'feels like someone is holding my biceps', describing a sensation of constriction around his left upper arm. He states he is unable to rotate his left arm, such as when trying to reach behind his back. He denies any prior left upper extremity complaints work injuries." RX1.

Dr. Atluri diagnosed Petitioner with left upper extremity pain with numbness and tingling that was unrelated to the accident at work. *Id.* He stated that "[b]ased upon the history as related to me by the patient, his physical findings, the x-rays and records available for my review, Mr. Pletsch has pain as well as numbness and tingling in his left upper extremity of unclear nature. The distribution of symptoms is suspicious for a cervical radiculopathy. There may even be a component of mild cubital tunnel syndrome, based upon the subjective complaints and the electrodiagnostic findings." *Id.*

Dr. Atluri opined that there was no traumatic injury identified involving Petitioner's left shoulder and that his left shoulder complaints were unrelated to the reported work injury from an upper extremity standpoint. *Id.* he indicated that no left shoulder MRI was necessary although it "will likely reveal some mechanical abnormalities, including arthritis and possibly even rotator cuff pathology. However, his exam suggests that these types of abnormalities are not symptomatic and would be considered incidental findings." *Id.* Dr. Atluri also opined that Petitioner had no work-related condition involving the left shoulder for which medical treatment, work restrictions, or permanent disability was necessary. *Id.*

Continued Medical Treatment & Return to Work

Petitioner returned to Dr. Kazan on February 22, 2016. PX2. Dr. Kazan noted his review of Dr. Atluri's report in which Dr. Atluri indicated that Petitioner could return to his regular work in spite of Petitioner's diagnostic test results such that no left shoulder MRI was necessary. *Id.* Dr. Kazan did not recommend any further spinal surgery and indicated that Petitioner had chronic changes at C5-C6 and C6-C7. *Id.* However, Dr. Kazan ordered physical therapy three times per week for one month to address Petitioner's left shoulder. *Id.*

Petitioner testified that he returned to work on February 28, 2016 because he was informed by Respondent that Dr. Atluri had released him back to full duty work.

On February 29, 2016, Petitioner presented to Michael Durkin, M.D. (Dr. Durkin) at Hinsdale Orthopaedics for an initial evaluation. PX4. Dr. Durkin noted the following history:

> James Pletsch is a pleasant 60 year old male. **Type of visit:** New
> The patient is here for left shoulder pain. Reports that he fell on September 18, 2015 while delivering liquor. He states that he fell backwards when his foot got stuck under the door and landed on the left shoulder. FOr a few weeks, his arm had very limited mobil[it]y. This injury occurred during work. She states of having a pulling sensation. Reports of having limited ROM. Difficulty reaching out. 5 out 10 is his pain level. Reports of having neck pain and numbness and tingling sensation on the left fingers. Hx of cervical fusion by Dr Kazan. Has done physical therapy for the shoulder until it was stopped.

Id. Dr. Durkin noted abnormalities on examination of the left shoulder and reviewed x-rays of Petitioner's left shoulder which he indicated revealed inferior glenoid osteophyte. *Id.* Dr. Durkin diagnosed Petitioner with left

shoulder pain that was most likely a large rotator cuff tear, and he ordered a left shoulder MRI. *Id.* He noted that Petitioner was working full duty before his injury at work without any difficulty in his left shoulder. *Id.* Dr. Durkin also released Petitioner back to full duty work based on Petitioner's report that he believed he could complete his job without restrictions. *Id.*

Petitioner testified that he is the most senior driver and, thus, he can select to work any route. The first week he returned to work, Petitioner explained that Respondent sent him out with another regular driver to ease him back in to his work duties. Normally, Petitioner testified that he would be picking, pulling, and writing orders, but on the first day back at work he probably spent more time easing in and out of the truck and opening customer doors. Petitioner testified that his shoulder and arm were bothering him and his back was stiff.

Petitioner underwent the recommended left shoulder MRI on March 7, 2016. PX4; RX3. The interpreting radiologist noted: (1) a high grade articular surface partial thickness tear of the anterior supraspinatus tendon at its greater tuberosity footprint with some mild retraction of articular surface fibers and no significant atrophy; (2) framing of the superior labrum but no definite detachment; and (3) a strained or partial tear of the humeral insertion of the IGL. *Id.*

On March 14, 2016, Dr. Durkin noted his review of Petitioner's left shoulder MRI as well as Petitioner's report of a dull, achy pain over the anterior aspect of the left shoulder. PX4. Dr. Durkin diagnosed Petitioner with a left shoulder rotator cuff tear. *Id.* He also stated that "he may have had a small rotator cuff tear prior to his accident but, was not experie[nc]ing any symptoms or mechanical problems. Explained that the fall while on the clock at work caused a significant tear of the rotator cuff. Recommend return to work full duty without restrictions because if the patient does not return to work he will lose his job. Explained that due to the injury he is limited in his performance and ability to do his job." *Id.* Dr. Durkin recommended surgery as well as physical therapy for strengthening. *Id.*

Petitioner last saw Dr. Durkin on April 11, 2016 reporting pain when he used his arm and difficulty holding a cup of coffee. PX4. Dr. Durkin reiterated that Petitioner's injury at work was consistent with a rotator cuff injury and recommended surgical repair. *Id.*

Addendum Report – Dr. Atluri

On August 17, 2016, Dr. Atluri issued an addendum report after being provided with additional materials by Respondent. RX2. Specifically, he reviewed records from Dr. Durkin from February through April of 2016 and Petitioner's March 7, 2016 MRI report and images. *Id.* Dr. Atluri opined that Petitioner's MRI showed chronic abnormalities in the left shoulder consistent with his impression at the time he examined Petitioner. *Id.* He maintained his opinions regarding a lack of causal connection between Petitioner's left shoulder condition and his accident at work on September 18, 2015. *Id.*

Additional Information

Petitioner testified that the recommended surgery has not been approved, but he wishes to undergo the surgery. He testified that he continues to work every day as a driver for Respondent. Because of his seniority, Petitioner explained the he looks for a route that is the best suited for his needs with lowest amount of cases or a good helper. While Petitioner testified that he still does lifting, he keeps his elbows tucked in and does not lift products too high so that he can still perform the job.

Petitioner is right handed and explained that he had no prior problems with either shoulder, or any other accidents or injuries. Petitioner testified that he earns a higher income now than he did on the date of accident.

Regarding his current condition, Petitioner explained that he cannot lift the left shoulder above his head with any strength. He also experiences difficulty sleeping and weakness in his left arm and shoulder.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

It is undisputed that Petitioner was injured at work on September 18, 2015. He immediately reported the injury and was taken by one of Respondent's security officers to Physicians Immediate Care for medical treatment on the date of accident. The parties' dispute centers on whether the mechanism of injury was competent to cause an injury to Petitioner's left shoulder.

Petitioner relies on his report of left shoulder symptoms at the time of his second visit for any medical treatment after his accident on February 21, 2015 at Physicians Immediate Care, and to his treating physicians thereafter, as well as the opinions of his orthopedic surgeon, Dr. Durkin. Respondent noted that Petitioner did not report any injury to the left shoulder in his accident report. Respondent also asserts that Petitioner did not report any injury to the left shoulder at the time of his first visit to Physicians Immediate Care on September 18, 2015, the undisputed date of accident, and the opinions of its Section 12 examiner, Dr. Atluri, that Petitioner's left shoulder condition was not caused by the mechanism of injury as he understood it. Based on a review of the record as a whole, the Arbitrator finds that Petitioner did sustain an injury to his left shoulder as claimed on September 18, 2015.

To recover in a preexisting condition case, a claimant need only establish a causal connection between his work-related injury and claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)). As in this case, even where an employee has a pre-existing condition that renders him more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)).

Petitioner's testimony regarding the mechanism of injury is consistent with his reports as documents by Physicians Immediate Care, his own treating physicians (Drs. Kazan and Durkin), his physical therapists at ATI, the radiologists performing his EMG and MRIs, as well as Respondent's Section 12 examiner, Dr. Atluri. At the hearing, Petitioner explained how the customer's door and attached screen door opened in different directions. He described how he had to open the doors reaching behind him with his left arm while simultaneously propping the screen door open with the wheeler such that, when he stepped into the doorway, he fell backwards on a four inch step he had not seen.

Petitioner's testimony regarding the onset of symptoms in the left arm is also consistent with the medical records. On the first Monday after his accident on a Friday, Petitioner returned to the company clinic—at his request—reporting that his back was somewhat improved, but he also had "left-sided neck, shoulder and arm

pain[that 'felt] like someone [wa]s grabbing his upper arm and butt cheek at times[.]'" On physical examination, the clinic's physician noted mild tenderness in the left biceps tendon groove and moderate tenderness in the left rotator cuff. Petitioner denied having any left shoulder symptoms or medical treatment prior to his accident at work and the record is devoid of any evidence to establish the contrary.

The opinions of Petitioner's treating physician, Dr. Durkin, regarding causal connection between Petitioner's left shoulder condition and accident at work are also persuasive given the totality of this record. At Petitioner's initial visit, Dr. Durkin noted that Petitioner was working full duty before his injury at work without any difficulty in his left shoulder. There is no evidence to the contrary contained in the record. Dr. Durkin later opined after reviewing Petitioner's MRI that Petitioner "may have had a small rotator cuff tear prior to his accident but, [he] was not experie[nc]ing any symptoms or mechanical problems. [...and] the fall while on the clock at work caused a significant tear of the rotator cuff." Respondent's Section 12 examiner, Dr. Atluri, agreed that the MRI showed pre-existing degeneration in the left shoulder and noted no prior left shoulder injury or medical treatment before September 18, 2015.

It is reasonable given Petitioner's mechanism of injury (i.e., reaching behind him with his left arm to open an inside door while holding an adjacent outside door open then falling backwards due to an unseen four inch step) as well as Petitioner's body habitus (i.e., 5'10 and 279 pounds) that he sustained an injury to the left shoulder and had an onset of symptoms over various body parts that were initially more prominent than the left shoulder symptoms. It is also significant in the context of the record as a whole that Petitioner did not wait until his next scheduled appointment of September 25, 2015 to seek medical care for his left shoulder complaints, but reported the left shoulder pain immediately on Monday, September 21, 2015 when he returned to work less than three days after his fall at work. There is no evidence that Petitioner had any other injury or medical treatment to the left shoulder before his accident at work and Petitioner's onset of left shoulder symptoms began on the date of accident, but became prominent over the weekend prompting Petitioner to seek medical attention for the left shoulder complaints within three days of the fall at work.

Thus, given the totality of the medical evidence in this record the Arbitrator finds that Petitioner has established causal connection between his left shoulder condition of ill-being and his accident at work on September 18, 2015 as claimed.

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

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the left shoulder is causally related to his accident at work relying on Petitioner's testimony which is corroborated by the medical records as well as the recommendations and opinions of his treating physician, Dr. Durkin. The

medical bills submitted into evidence from Hinsdale Orthopaedics that remain unpaid are for reasonable and necessary medical services rendered to Petitioner to address his left shoulder condition.

Accordingly, the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid from Hinsdale Orthopaedics are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties. *See* AX1.

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

As explained above, the Arbitrator finds that Petitioner's the Arbitrator finds that Petitioner's current condition of ill-being in the left shoulder is causally related to his accident at work. Petitioner's left shoulder condition has not improved thereafter such that his treating physician, Dr. Durkin, recommends surgery.

In consideration of the record as a whole, the Arbitrator awards the recommended prospective medical care in the form of a left shoulder surgery as prescribed by Dr. Durkin pursuant to Section 8(a) of the Act as the treatment is reasonable and necessary to alleviate Petitioner from the effects of his injuries at work.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary partial disability benefits for the disputed period beginning September 21, 2015 through February 28, 2016.

"When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working." 820 ILCS 305/8(a) (LEXIS 2011).

At the time of the hearing, the parties stipulated that, should Petitioner prevail in establishing that he sustained an injury to the left shoulder on September 18, 2015 as claimed as well as a causal connection between his left shoulder condition and accident at work, the amount of temporary partial disability benefits payable totaled $2,426.50. As explained above, the Arbitrator finds that Petitioner has met his burden of proof.

In light of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits beginning September 21, 2015 through February 28, 2016 totaling $2,426.50 as claimed. Respondent shall receive a credit, if any, as agreed by the parties. *See* AX1.

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

Estevez Rafael
Petitioner,
vs.

NO: 99WC 57807

Courtyard by Marriott ,
Respondent.

17IWCC0447

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 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 $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: JUL 14 2017
MJB/bm
o-7/11/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESTEVEZ, RAFAEL
Employee/Petitioner

Case# 99WC057807

17IWCC0447

COURTYARD BY MARRIOTT
Employer/Respondent

On 5/13/2016, 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 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0800 BARRY E BLUMENFIELD
3424 W 26TH ST
SUITE 202
CHICAGO, IL 60623

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RAFAEL ESTEVEZ,
Employee/Petitioner

Case # **99 WC 57807**

v.

Consolidated cases:

COURTYARD BY MARRIOTT,
Employer/Respondent

17IWCC0447

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **FEBRUARY 11, 2016 and MARCH 16, 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 **Chain of Referral**

17IWCC0447

FINDINGS

On **10/1/1999**, Respondent ***was*** operating under and subject 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 **relative to the lumbar spine.**

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

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

In the year preceding the injury, Petitioner earned $**14,019.20**; the average weekly wage was $**269.60**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**7,000.83** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**7,000.83**. Respondent is entitled to a credit of $**19,377.49** under Section 8(j) of the Act for medical bills paid.

ORDER

Respondent shall pay for all lumbar spine treatment from 10/1/99 through 4/6/01 and shall hold Petitioner harmless from any provider or payor for which Respondent is receiving this credit.

Respondent shall pay Petitioner temporary total disability benefits of $179.73/week for 3-1/7th weeks, commencing 3/16/01 through 4/6/01, as provided in Section 8(b) of the Act. Respondent shall be given credit for $7,000.83 for TTD benefits paid from 11/27/00 through 12/18/00 and from 2/9/01 through 10/13/01 under Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $161.76/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. The Arbitrator orders any TTD overpayment to be credited against the PPD award.

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

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

5-13-2016

MAY 13 2016

Signature of Arbitrator

Date

FINDINGS OF FACT

Rafael Estevez ("Petitioner") testified via a Spanish interpreter/translator Carmen Kinney, that on 10/1/99, he was employed by Courtyard by Marriott ("Respondent') as a houseman and attempted to lift a full garbage bag from the floor when he felt pain to his back. Petitioner testified that he began to feel pain to his right knee following the accident. Following the incident, Petitioner presented to Good Samaritan Hospital. Petitioner testified at length regarding his subsequent course of treatment, symptoms and his return to work.

On 11/9/99, Petitioner began treating with Dr. Maurice Velasco. Px4, Rx2. Petitioner completed intake forms indicating low back pain and pain down the right leg. Petitioner said he was seen at Good Samaritan immediately after the work injury.[1] Assessment was sciatica. On 12/13/99, Dr. Velasco noted that subjectively and objectively Petitioner was improving. He was released to without restrictions.

On 1/3/00, Dr. Velasco noted that Petitioner had an increase in his lumbar spine pain, 6/10 in intensity since Friday after lifting some boxes from the floor. He assessed exacerbation. On 1/11/00, lumbar spine MRI showed disc degeneration with mild disc bulging. On 1/24/00, Petitioner related to Dr. Velasco that the day before, while at work, he scooped and picked something up from the floor and later he had to sweep and mop the lobby and had to push a cart full of sheets from the first floor to the third floor. He also described picking up garbage and he described twisting and lifting. He again assessed exacerbation.

On 2/28/00, Dr. Hadesman first saw Petitioner. The accident was noted. He read the MRI as showing disc degeneration with mild disc bulging. Exam was negative except for decreased range of motion and subjective SLR. He recommended an EMG/NCV and physical therapy. EMG failed to show objective signs of nerve damage or radiculopathy. On 3/21/00, Petitioner returned to Dr. Hadesman. He did not attend physical therapy per the prior recommendation. The doctor again recommended physical therapy and a pain clinic consultation. Dr. Hadesman then prescribed epidural steroid injections. He noted that recent EMG result. Rx3. He again recommended therapy and pain management.

On 3/22/00, Petitioner returned to Dr. Velasco. Assessment was sciatica. The doctor issued work restrictions through 4/21/00. On 4/12/00, Petitioner was ordered to follow up after an upcoming Section 12 exam. Petitioner would not return to Dr. Velasco until 10/9/00, at which time Petitioner related he had not returned because the Section 12 doctor told him everything was okay.

On 5/1/00, Petitioner saw Dr. Hadesman. He had not attended the pain clinic. He still described pain in his low back radiating to the right. Neurovascular exam was within normal limits. Petitioner complained physical therapy was not helpful. Light duty was prescribed.

On 7/25/00, Petitioner presented Dr. Kassa. Px13, Rx3. Dr. Kassa noted 3 injections without relief. Dr. Kassa noted that Petitioner's "affect does not appear to match his stated condition." Petitioner advised he did not want surgery.

Four months later, on 11/27/00, Petitioner was evaluated Good Samaritan on an emergency basis. Diagnosis was lumbar muscle strain. That same date, Dr. Michael Hendrick diagnosed lumbar sprain/strain. Six months later, on 12/8/00, Petitioner returned to Dr. Velasco. At that time, a notation was made that Petitioner

[1]The records from Good Samaritan were not submitted into evidence.

hurt himself while throwing garbage out one week prior. He went to the emergency room, received a shot and was given meds. He was told to follow up with a therapist but did not because he unsure if Marriott covered. Dr. Velasco diagnosed lumbar spine/strain. Subjective pains were not reproduced during exam.
On 12/15/00, Dr. Velasco recommended Petitioner refrain from lifting heavy objects and bending at the waist.
On 12/29/00, Dr. Velasco released Petitioner to light duty work until 1/12/01.

On 1/9/01, a second MRI demonstrated disc herniation at L5-S1, a progression from prior MRI. All other findings were unchanged. On 1/12/01, Dr. Velasco recommended a new EMG to assess nerve status. Dr. Velasco felt Petitioner had psychosocial issues that would be better handled by an appropriate professional. He was referred to Dr. Piekos. On 2/9/01, Petitioner saw Dr. Piekos. Px1, Rx8. Petitioner said the pain is constant especially when walking and heavy lifting. Petitioner believed his pain is getting worse and more severe. Petitioner reported no significant relief. Dr. Piekos suspected radiculopathy. The doctor recommended off work or light duty.

On 2/20/01, video surveillance obtained by Respondent showed Petitioner walking without difficulty to and from his vehicle, traversing steps leading into a building, carrying mail, bending at the waist and driving. He is seen picking someone up, bending, getting in and out of a car and driving. Petitioner then walks through a parking lot and into a building. He is later observed walking out of the building, driving, dropping his companion off and shopping at a grocery store. He is seen carrying a grocery bag. On 2/23/01, Dr. Piekos found the EMG was consistent with an acute S1 radiculopathy on the right. Px1, Rx8. He referred Petitioner to neurosurgery and placed him on light duty.

On 3/10/01, Respondent obtained additional video surveillance of Petitioner. A vehicle is visualized and after some time, Petitioner exits and walks to a building. He is observed walking with a slight limp. On 3/15/01, Petitioner was issued a written warning by Respondent for watching television in one of the hotel rooms without permission and in violation of workplace rules. Rx15. At trial, Petitioner admitted he was written and up and eventually fired for this. On 3/16/01, Dr. Piekos noted continued pain with radiation. The pain occurred when bending, twisting, pulling or heavy lifting. He rated his pain 10/10. He did not believe he could go back to work due to pain. Therapy and off work were prescribed. He was referred to Dr. Zelby.

On 4/6/01, Petitioner saw Dr. Andrew Zelby. Px5, Rx4. A history was taken. Symptoms were aggravated by lifting, bending and prolonged walking. He was able to drive a car. Petitioner described his pain as 10/10. Exam showed mild antalgic gait, decreased range of motion, negative SLR. Non-organic physical findings were positive for pain on superficial light touch, pain on simulation and diminished pain on distraction. MRIs were reviewed. The doctor concluded that Petitioner's symptoms were degenerative, that he was not a surgical candidate and that he should follow up with his primary.

On 5/24/01, Dr. Gary Skaletsky performed a Section 12 exam at the request of Respondent. Rx5. Physical exam revealed subjective complaints of pain. Dr. Skaletsky opined there existed no causal connection between Petitioner's current complaints and the 11/27/00 date of injury. He agreed with Dr. Zelby. The doctor noted that based on abnormal EMG/NCV, it was apparent that there was an acute process ongoing of recent origin. He agreed further treatment for acute right lumbar radiculopathy would be appropriate. He recommended a selective nerve root block.

On 7/27/01, Dr. Piekos recommended therapy, Celebrex and to avoid heavy lifting, twisting, turning, pulling and pushing. On 9/7/01, additional video surveillance showed Petitioner entering a vehicle. He holds onto the roof of the car for support and slowly sits down. He is later walking fluidly with two children toward a

car. He puts the children in the vehicle. He enters and exits the vehicle without the need for support and without a limp on several occasions.

On 10/5/01, Dr. Piekos' impression was persistent lower back pain with radiation to the right leg most likely related to radiculopathy. Recommendations were unchanged. On 10/11/01, Dr. Skaletsky issued a second report after reviewing the surveillance video contained Rx16. Rx6. Dr. Skaletsky opined Petitioner's performance in the video footage indicated a far greater ability than was demonstrated at the initial examination by Dr. Piekos. Dr. Skaletsky found the video footage to be an objective finding as opposed to Petitioner's subjective pain complaints and further found Petitioner to be at maximum medical improvement. Dr. Skaletsky opined that there was no organic basis for Petitioner's symptoms. Dr. Skaletsky noted Petitioner could return to work immediately without any restrictions.

On 10/18/01, Dr. Skaletsky re-examined Petitioner. Rx7. Petitioner reported increased low back pain with pain and discomfort into the right lower extremity. Petitioner reported no complaints to the left leg. Dr. Skaletsky diagnosed resolved chronic low back and right leg pain. Dr. Skaletsky opined Petitioner had undergone reasonable conservative management and based on the video surveillance was at maximum medical improvement and could return to work without restrictions.

One year and 8 months later, in June 2003, Petitioner presented to DuPage County Health Crisis Unit with suicidal ideations and plan. Px6, 10, 14. He reported hopelessness due to inability to work and financial concerns. Petitioner denied prior psychiatric history or outpatient treatment. On 6/5/03, Petitioner presented to Glen Oaks Hospital. Px9. He had been more depressed recently. Impression was depression exacerbation. On 6/6/03, DuPage County admission form noted increased depression since the back injury. He said he needed surgery and was unable to work. In another form, Petitioner reported he needed surgery which might lead to better results or being crippled. On 6/16/03, Petitioner presented to Dr. Oscar Canales, staff psychiatrist. Petitioner related that his depressive symptoms began 3 years ago after low back injury at work, which he said led to an inability to work since that time.

In July 2003, Dr. Canales noted Petitioner had an appointment with Cook County for an evaluation of his low back. On 8/25/03, Dr. Canales noted physical therapy was scheduled for October. On 10/13/03, Dr. Helen Gardner, staff psychiatrist, noted Petitioner said he became depressed in the year 2000 after losing his job. He had a back injury that further exacerbated his depression. On 12/16/03, Petitioner told Dr. Canales he was contemplating surgery but had not seen a doctor recently.

In January 2004, Petitioner told Dr. Canales he was in physical therapy. On 2/6/04, Petitioner returned to Dr. Piekos, who last saw Petitioner on 10/5/01 for lower back pain. Dr. Piekos acknowledged Dr. Zelby's recommendation that it was unlikely Petitioner would need surgery. In March 2004, Petitioner told Dr. Canales he was scheduled to see a neurosurgeon to discuss surgery. In April 2004, Dr. Canales noted Petitioner recently began physical therapy. He reported the surgeon did not recommend surgery. In June 2004, Petitioner told Dr. Canales he was in therapy 2-4 times a week. Petitioner was ambivalent about returning to work due to fear of losing disability income. In August 2004, Dr. Canales noted Petitioner's frustration by lack of progress in pain management. In October 2004, Petitioner told Dr. Canales he was still in therapy. In November 2004, Petitioner told Dr. Canales there was a second opinion that recommended surgery. He denied significant changes in his pain or ability to do light work.

In February 2005, Petitioner reported to Canales no change and frustration over the lack of progress in working with his attorney and the issue of accident. In April 2005, Petitioner reported that continued lower back pain was impacting mood and depression. In August 2005, Petitioner told Dr. Canales he was concerned with

selling home and finding a new place. He denied changes in his back pain. In September 2005, Dr. Canales noted Petitioner was preoccupied with selling his home and looking for another place.

On 10/18/05 and 11/14/05, Petitioner underwent psychological testing with Dr. Alexander Obolsky at the request of Respondent. Rx10. Dr. Obolsky was later deposed on 10/12/09. Dr. Obolsky opined Petitioner suffers from psychotic major depression in full remission, not causally related to a work accident given more than 3 years had elapsed since Petitioner's alleged accident and his admission for psychiatric care.

From November 2005 through August 2006, Petitioner continued to see Dr. Canales, reporting ongoing pain, legal issues, financial issues and concern over buying/selling property. He felt discouraged with a diminished sense of worth due to not having employment. In September 2006, it was noted that Petitioner's chronic pain contributed to his symptoms of depression and client mobility. In January 2007, Petitioner reported increasing financial concerns. He stated his chronic back pain limited his potential job search.

On 3/12/07, Petitioner began treating with Dr. Babak Lami. Px7. Petitioner gave a history of his work accident and treatment. He admitted he had not seen a back doctor in several years. Impression was chronic back pain with radiation to the right leg. Dr. Lami felt a new MRI showed degenerative disc. He did not think Petitioner needed surgery. He was referred to Marianjoy. Three months later, in June 2007, Petitioner began physical therapy at Marianjoy. Px2-3, Rx11-12. Petitioner said he cracked in his back from a work accident. Petitioner related he needed surgery but the doctor could not guarantee that he would be okay and if surgery failed, he would be in a wheelchair. Petitioner said he then got a second opinion who told him the same thing. He said he then saw a third doctor and was told he did not need surgery. Therapists noted inconsistent complaints of lower back pain and noncompliance with home exercise.

On 12/10/07, Dr. Lami reiterated he did not believe Petitioner was a surgical candidate. While in therapy with Marianjoy, he reported decreased pain with a TENS unit. Several months later on 3/13/08, Petitioner saw Dr. Lami and told him the TENS was not helping. Exam of the lumbar spine revealed no particular pathology. Diagnosis low back pain. Petitioner returned to Marianjoy for therapy. A leg length discrepancy was found, corrected and Petitioner reported walking better with alignment. He was discharged in May 2008 and began again in June through July.

In May 2008, Petitioner told Dr. Penepacker he was in therapy. In September 2008, DuPage County Health professionals wrote that Petitioner's depression was related to severe financial stressors due to current inactivity of lawsuit for a work injury many years ago. In September 2008, Petitioner followed up with Dr. Penepacker. He reported feeling depressed, desperate and anxious about his pending lawsuit and financial problems. On 12/1/08, Dr. Lami referred Petitioner to an orthopedic surgeon for left leg pain. Petitioner started seeing Dr. Kevin Tu in January 20099. Px11. A tear of the left knee was discovered, surgery was performed in June 2010 and Petitioner attended post-op therapy at Marianjoy.

From February through July 2009, Petitioner returned to Dr. Penepacker, who noted financial stressors, chronic pain and sadness, desperation and anxiety he thought was triggered by his pain primarily in the whole left leg. The doctor wrote that "depression symptoms do appear to be direct consequences of his pain and related physical impairments."

Two months later, on 8/12/09, Petitioner saw Dr. Lami who did not feel the pain was consistent with radiculopathy and that symptoms were not from his lumbar spine. A new MRI was ordered and Dr. Lami again felt Petitioner was not a surgical candidate. In October 2009, Dr. Penepacker noted feelings of worthlessness and anxiety due to physical pain resulting in financial problems. Petitioner reported ongoing pain and

restrictions. The doctor noted that "ongoing depression, stable intensity, appears to be a direct consequence of limitations from physical pain and injury."

In January 2010, Petitioner returned to Dr. Penepacker who noted the "Dr. Lami's evaluation does not support clt's [sic] worker's comp case." Petitioner related he saw 3 doctors before Dr. Lami and Dr. Lami told him he could not lift more than 15 pounds but Petitioner felt he would never get a job with that limitation. Petitioner related he was anxious about an upcoming knee surgery. In August 2010 Petitioner returned to Dr. Penepacker, reporting feeling depressed about a foreclosure notice. In October and November 2010, Petitioner returned to Dr. Penepacker reporting worry about a loan modification.

In February 2011, Petitioner returned to Dr. Penepacker, worried about foreclosure and loan modification. Petitioner considered his depression to be the result of the accident because he could not work since then. In May 2011, Petitioner returned to Dr. Penepacker, worried about losing his house due to financial difficulty and about his case.

On 6/3/11, Dr. Steven Mash issued a Section 12 report on behalf of Respondent. Rx13. Petitioner alleged an injury date of 12/9/99 with an onset of low back discomfort. It was difficult to obtain a history from Petitioner. Petitioner continued to complain of back discomfort. On spine exam, Petitioner demonstrated minimal range of motion, reciprocal gait, negative SLR, normal reflexes. Exam of the bilateral knees was essentially normal. The doctor opined Petitioner's lumbar condition was not causally related to the 1999 work accident based on a lack of objective findings. Dr. Mash believed the lumbar conditions were age-related. He further felt Petitioner was capable of working with restrictions but that such restrictions would not be work-related. Dr. Mash believed no further lumbar spine treatment was warranted.

One year and 7 months later, on 1/30/13, Petitioner returned to a Dr. Cespedes for back pain. Px13, Rx3. Assessment was lumbar disc displacement with myelopathy. Approximately 4 months later, on 5/15/13, Petitioner returned to Dr. Cespedes, in part for low back pain. Petitioner continued to be unsure whether to see a spine surgeon. Approximately 5 months later, on 10/22/13, Petitioner returned to Dr. Cespedes for back pain.

Three years after last seeing Dr. Penepacker, Petitioner returned in March 2014, Petitioner returned to Dr. Penepacker. Target symptoms were obsessive thoughts about stressors and motivation. Chronic pain was the primary issue. In April 2014, Dr. Penepacker noted Petitioner felt he could not spend time on his feet due to back pain.

On 4/12/14, Petitioner presented for psychiatric evaluation with Dr. Suzanne Cooperman at the request of his attorney. Px15. Petitioner did not feel he was able to return to work since that time due to chronic pain and depressive symptoms. Petitioner related he became depressed following his injury. He attributed his depression to chronic pain into financial difficulties associated with being off of work. Dr. Cooperman noted that he recovered rapidly from his very severe 2003 depression with ongoing symptoms.

On 6/8/14, Petitioner returned to Dr. Cespedes for back pain. It was noted to be severe, stable, persistent, burning and deep. Symptoms were aggravated by daily activities. He denied relieving factors. In September 2014, Petitioner told Dr. Penepacker he was considering back surgery because he was so unhappy with limitations from back pain. On 11/13/14, Dr. Cespedes saw Petitioner for follow up of chronic back pain. He reported his pain had gotten worse. He was still not sure if he wanted surgery. In January 2015, Petitioner returned to Dr. Penepacker and stated that his pain still prevented him from doing anything more than light housework. At trial, Petitioner testified he still suffers from significant lumbar spine pain. He did not testify as to any ongoing left knee or mental health disability.

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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 concludes that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment relative to any mental injury/disability and the left knee or that such conditions are causally related to his work accident. The Arbitrator concludes that Petitioner proved he suffered a lumbar sprain/strain as a result of the work accident, which resolved itself on 4/1/01. The Arbitrator notes the following in support thereof.

a. Petitioner's current lumbar spine condition is not causally related to his work injury and reached maximum medical improvement on 4/6/01

Based on the stipulation of the parties, the Arbitrator finds Petitioner sustained a low back/lumbar injury on 10/1/99 that arose out of and occurred while in the course of Petitioner's work for the Respondent. Petitioner's testimony that he injured his back at work while lifting a garbage bag is corroborated by his lumbar spine treatment records.

Petitioner initially treated at Good Samaritan Hospital, whose records were not in evidence. Thereafter, Petitioner began treating with chiropractor Dr. Velasco. He diagnosed Petitioner with sciatica based on Petitioner's complaints and exam. Petitioner returned on 1/3/00, stating that he had an increased in pain and described lifting boxes. Dr. Velasco assessed exacerbation and Petitioner began therapies again. On 1/11/00, an MRI showed bulges. On 1/24/00, Petitioner again related he performed various work tasks and Dr. Velasco again assessed exacerbation. Petitioner continued to treat with Dr. Velasco through April 2000 and the doctor issued light duty restrictions through 4/21/00. Final diagnosis was sprain/strain.

Petitioner also began treating with Dr. Hadesman. The doctor read the January 2000 MRI to show degeneration and mild bulges. Exam was negative other than decreased range of motion. An EMG/NCV failed to show any objective signs of radiculopathy, which Dr. Hadesman acknowledged. On 3/21/00, Dr. Hadesman recommended pain management and therapy. Petitioner returned to Dr. Velasco for therapy 3/22/00 – 4/12/00. Petitioner did not return to Dr. Velasco until October 2000, having told him that a Section 12 doctor told him everything was okay. No such report, if it existed, was submitted into evidence. In July 2000, Dr. Kassa noted that while Petitioner had undergone 3 injections, Petitioner's affect did not match his stated condition.

The next record appears 4 months later, when Petitioner presented for emergency care at Good Samaritan in November 2000. A Dr. Hendrick of Hinsdale Orthopedic removed Petitioner from work until follow up. On 12/8/00, Petitioner also returned to Dr. Velasco, stating that he injured himself the week before while throwing out garbage. Petitioner failed to address this incident at trial. Dr. Velasco diagnosed lumbar sprain/strain and returned Petitioner to light duty through 1/12/01. A new MRI showed progression at L5-S1. All other findings were essentially unchanged. A new EMG/NCV showed evidence of radiculopathy. However, on 4/6/01, Dr. Zelby examined Petitioner and found non-organic signs. He read the MRIs as showing progression of degenerative changes and felt Petitioner's symptoms stemmed from these changes. Dr. Zelby never casually related Petitioner's low back/lumbar condition to his work accident. The doctor recommended home exercise. Shortly thereafter, on 5/24/01, Dr. Skaletsky examined Petitioner at the request of Respondent

and opined Petitioner's condition was not causally related to his work accident. The doctor felt Petitioner's complaints were related to degenerative findings.

Six months later after seeing Dr. Zelby, on 10/5/01, Petitioner returned to Dr. Piekos complaining of leg pain. The doctor made treatment recommendations but Petitioner did undertake any of them. Two years and 4 months later, or from 10/6/01 to 2/5/04, Petitioner failed to obtain any medical treatment for his low back/lumbar condition. At trial, Petitioner offered no credible explanation for this.

Video surveillance obtained by Respondent in February 2001, March 2001 and September 2001 show Petitioner performing daily activities without any apparent difficulty, pain or problem. Petitioner did not rebut the video and offered no explanation for his conduct. Dr. Skaletsky reviewed the video surveillance and opined Petitioner had reached maximum medical improvement. The doctor also re-examined Petitioner and noted that Petitioner's subjective complaints were contradicted by the video. Dr. Mash performed an additional Section 12 examination almost 12 years after Petitioner's alleged injury and found Petitioner's lumbar condition was not causally related to the work accident and placed him at maximum medical improvement.

Based on the foregoing, the Arbitrator concludes that the medical evidence most credibly suggests Petitioner suffered, at most, a lumbar sprain/strain as a result of the 10/1/99 work accident. This conclusion is supported by Dr. Velasco's revised diagnosis of lumbar sprain/strain and Dr. Zelby's impression that Petitioner's symptoms were related to degenerative changes. There is nothing in Petitioner's treatment records to suggest that any herniation or radiculopathy resulted from his original 10/1/99 work accident. In fact, the record shows that Petitioner reported on two separate occasions to Dr. Velasco that he had an acute increase in pain after performing some work, both of which occurred after the original date of accident. Dr. Velasco characterized these as exacerbations. It was only after the second "exacerbation" that a second MRI was thought to show progression or a change. Also of note, Dr. Skaletsky found that based on abnormal EMG, it was apparent that there was an acute process ongoing of recent origin. Thus, the Arbitrator could reasonably infer that any causal connection was cut off by virtue of Petitioner's subsequent lifting injury, resulting in an acute progression as shown on MRI.

Alternatively, the record also supports a conclusion that no acute injury existed as noted by Drs. Zelby and Skaletsky. Again, both doctors related Petitioner's complaints to degenerative changes. Drs. Kassa and Zelby expressed concerns about the veracity of Petitioner's complaints and stated condition. There are multiple medical opinions stating he was not a surgical candidate. The Arbitrator notes Petitioner's repeated and significant gaps in back treatment, suggesting to the Arbitrator that Petitioner's lumbar condition had long resolved. The Arbitrator adopts the opinions of Drs. Zelby, Skaletsky and Mash. Therefore, the Arbitrator concludes that Petitioner's lumbar sprain/strain reached maximum medical improvement on 4/6/01, the date on which Petitioner saw Dr. Zelby, who opined Petitioner's condition was related to degenerative changes.

b. Petitioner's mental injury/disability is not causally related to his lumbar spine work accident

Petitioner failed to prove by a preponderance of the evidence that he sustained a mental injury/disability arising out of and in the course of his employment. Petitioner did not testify that his mental disability was caused by the accident when he was asked to described what occurred on 10/1/99. He only testified he injured his back and felt a pain in his right leg. He did not testify as to any emotional shock at the time of the injury. Further, his medical records fail to establish any mental disability resulting from the accident.

Petitioner also failed to establish that his mental injury/disability is causally related to his work accident. The Arbitrator bases this conclusion on the lack of credible evidence as well as inconsistent statements between

Petitioner and his treatment record and between Petitioner and himself. More than 3 ½ years after the work accident, Petitioner began treating for major depression. Between October 1999 and June 2003, Petitioner did not mention any mental injuries, disabilities or conditions resulting from the work accident.

Petitioner specifically denied a prior psychiatric history. However, several records suggest otherwise. For example, DuPage County noted increased depression since having his back injury. Glen Oaks' impression was "depression exacerbation." On 10/13/13, Dr. Gardner noted Petitioner further exacerbated his depression after experiencing a back injury on the job.

Petitioner also related to his mental health provider inconsistent statements regarding the need for back surgery. He repeatedly told doctors he needed back surgery. Not a single recommendation for back surgery appears in the record to corroborate Petitioner's statements. Contrary to Petitioner's unreliable representations to his own mental health providers, Drs. Zelby, Skaletsky, Lami and Mash all opined Petitioner was not a surgical candidate based on repeated exams and re-exams. In February 2004, Dr. Piekos acknowledged Dr. Zelby's conclusion on this issue. Dr. Penepacker acknowledged that Dr. Lami's evaluation did not support Petitioner's worker's comp claim.

Also of note are the conflicting statements Petitioner related to his mental health providers regarding his ability to work. On various occasions, Petitioner stated he was unable to work as a result of his back injuries and in turn was contributing to his depression and anxiety. See June 2003, March 2004, April 2005, April 2014. However, there are no such medical restrictions any point in time removing Petitioner from work during each of the times Petitioner related this. In addition, Petitioner's assertion that he could not work is at odds with his own conflicting statements. For example, in April 2004, he told, Dr. Canales he was considering "light-duty work" during this time but there was no such restriction issued before or around this time. In January 2007, Petitioner related that he felt his pain limited his potential job search, suggesting to the Arbitrator Petitioner could work not but did not want to try. In October 2009, Petitioner told Dr. Penepacker that he was restricted from lifting more than 10 to 15 pounds. In January 2010, Petitioner related that Dr. Lami told him he cannot lift more than 15 pounds. No such restrictions appear in the record during that time. The Arbitrator concludes that Petitioner's limitation regarding work was self-imposed.

The Arbitrator also finds unpersuasive, unreliable and conflicting that to which Petitioner attributed his mental injury/disability. For example, on 6/11/03, Petitioner related his depressive symptoms to a work accident occurring 3 years prior. He related his worries and subsequent depressed mood were the result of not getting financial compensation, rather than work accident itself. Petitioner related to Dr. Gardner that he became depressed in 2000 as a result of losing his job. Petitioner did not cite the work accident as the precipitating cause. Rather, Dr. Gardner noted that Petitioner had experienced a back injury on the job which further exacerbated his depression. Petitioner related to Dr. Piekos that he became depressed due to pain. Again no mention is made of a work accident. In addition, Petitioner cited various stressors as causes for his ongoing depression such as: the inability to work, worry over receipt of disability benefits, his pending workers comp lawsuit, a foreclosure notice, the home loan modification, buying and selling residential property and an unrelated knee surgery. None of these relate to the 10/1/99 work accident.

Finally, Petitioner lacked credibility and reliability regarding ongoing back treatment. For example, in mid-2003, in April 2004 and June 2004 he advised Dr. Canales he was in physical therapy but no such physical therapy records exist for this time period to corroborate these statements. In August 2004, Petitioner expressed frustration regarding pain management yet he was not in any pain management program. In October 2004, Petitioner again told Dr. Canales he was in physical therapy. In November 2004, Petitioner related there was a recommendation for back surgery. Again, no such records exist. In March 2007, Petitioner told Dr. Lami he

had not seen any back doctor in 3 to 4 years - in direct contradiction of what he told Dr. Canales in 2003 and 2004. September 2014, Petitioner told Dr. Penepacker he was again considering back surgery. However, the record fails to disclose any such recommendation.

Thus, to the extent Petitioner's mental health treatment team opined any causal connection between his mental disability and the 1999 work accident, the Arbitrator concludes those opinions are based on the foregoing inaccurate and unreliable information. Based on the foregoing, Petitioner's mental injury/disability is not causally related to his work accident.

c. Petitioner did not sustain accidental injuries to his left knee injury and his left knee is not causally related to any work accident

The Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries to the left knee arising out of and in the course of his employment with Respondent on 10/1/99 or that the left knee is related. Records show that between 1999 and 2009, Petitioner failed to mention any left knee or leg injury and/or symptoms as a result of the accident. He did not relate any history of work accident involving the left knee to Dr. Tu. Petitioner did not testify or explain how his left knee was injured during or as a result of the accident. Dr. Tu did not opine or explain how Petitioner's left knee condition was injured by or caused by the work accident. Petitioner presented no causal opinion regarding how his left knee was injured as a result of the accident. Moreover, Marianjoy noted an onset date for the left knee of 1/29/09. Px3, Px11. The Arbitrator's conclusion is supported by Dr. Mash, who opined, in part, that any bilateral knee complaints were not related to his work accident. Based on the foregoing, the Arbitrator concludes Petitioner's left knee condition is not related to his work accident.

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 (O) Chain of Referral

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. Having concluded that Petitioner's mental injury/disability and left knee condition are not causally related to his work accident, the Arbitrator finds that all such medical services for same are not related to the instant claim and therefore Respondent shall not be held liable for same.

Further, having concluded Petitioner current condition of ill-being relative to his lumbar spine is not causally related to his work accident, having reached maximum medical improvement on 4/6/01, the Arbitrator finds Respondent liable for all lumbar spine medical treatment from 10/1/99 through the date of MMI or 4/6/01. At trial, Respondent disputed Petitioner's chain of referrals. As it relates to Petitioner's causally related lumbar spine treatment, the Arbitrator concludes Petitioner was within his allowed chain of referrals between 10/1/99 and 4/6/01. The record showed that Petitioner sought emergency treatment with Good Samaritan, which does not count as a choice. Thereafter, Petitioner sought treatment via his first choice of physician with Dr. Velasco, who referred Petitioner to two MRIs, an EMG and to Dr. Piekos. Dr. Piekos, in turn, referred Petitioner to Dr. Zelby. Dr. Hadesman was a second choice as there is no specific referral noted from any doctor. Dr. Hadesman referred Petitioner to an EMG and for pain management with Dr. Kassa. Petitioner again sought emergency care in November 2000 with Good Samaritan, where he was diagnosed with lumbar sprain/strain. Therefore, Respondent shall pay for all lumbar spine treatment from 10/1/99 through 4/6/01 and shall further hold Petitioner harmless from any provider or payor for which Respondent is receiving this credit.

ISSUE (K) ***What temporary benefits are in dispute?***

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. Having concluded Petitioner's lumbar spine condition reached maximum medical improvement on 4/6/01 and having further concluded that Petitioner failed to prove his knee and mental health conditions are not causally related to his work accident, the Arbitrator makes the following findings and conclusions relative to the issue temporary benefits (temporary total disability).

The only disputed portion of TTD noted was Petitioner's claim for TTD 3/15/01 through the date of trial. Ax1. Thus, any period of time prior to 3/16/01 is not at issue before the court. At trial, Petitioner did not testify as to whether he was on light duty or off work per medical restrictions on 3/15/01. Petitioner did not attend any medical appointment on 3/15/01. Rather, on that date, he was fired. On 3/16/01, Dr. Piekos recommended Petitioner stay off of work until further work up. On 4/6/01, Petitioner saw Dr. Zelby, who did not recommend any further restriction. Having found Petitioner reached MMI as of 4/6/01, Respondent shall pay Petitioner temporary total disability benefits of $179.73/week for 3-1/7th weeks, commencing 3/16/01 through 4/6/01, as provided in Section 8(b) of the Act. Respondent shall be given credit for $7,000.83 for TTD benefits paid from 11/27/00 through 12/18/00 and from 2/9/01 through 10/13/01 under Section 8(b) of the Act. Ax1.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. Having concluded Petitioner's mental disability/injury and left knee condition are not causally related to his 10/1/99 work accident, the Arbitrator need not address the nature and extent of any such injuries or conditions as they are moot.

Having concluded Petitioner's lumbar sprain/strain reached maximum medical improvement on 4/6/01, the Arbitrator makes the following findings and conclusions relative to the issue of nature and extent of the lumbar sprain/strain.

Petitioner testified he has ongoing symptoms and pain from his low back injury as a result of the 10/1/99 work accident. Without reiterating the entire medical record, the Arbitrator concludes that Petitioner is not credible in his subjective description of his lumbar spine condition. The Arbitrator relies on the multiple inconsistencies noted in the record relative to Petitioner's need for back surgery, his ability to work as a result of the back injury and the course of his back treatment as he related it to various providers. The Arbitrator also notes the multiple and significant gaps in lumbar spine treatment, which were not explained at trial. The Respondent's surveillance video supports the conclusion that Petitioner lacks serious credibility.

Based on the foregoing, the Arbitrator concludes that Respondent shall pay Petitioner permanent partial disability benefits of $161.76/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.

5-13-2016