STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK P. REED,

Petitioner,

vs. NO: 05 WC 1756

T.H. RYAN CARTAGE COMPANY,
AND LD DRIVERS SERVICES, INC.

Respondent.

ORDER

This matter comes before the Commission on the parties' "Terms of Agreement – Settlement of Pending 19(b) and 4(c) Litigation," which was entered into and approved by Commissioner DeVriendt on September 18, 2017. Although this agreement addressed various issues, including those under §19(b), §19(g), and §4(c), for the purpose of this Order and pursuant to the agreement, the Commission hereby dismisses with prejudice the Petition for Review, which was filed by Petitioner under §19(b) related to the Arbitrator's decision, dated June 10, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review, related to the June 10, 2016 Arbitrator's decision, is hereby dismissed with prejudice.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings.

DATED: SEP 2 2 2017

Charles J. DeVriendt

SE/
49

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIQUE KAY,

Petitioner,

vs.

NO: 05 WC 5517

CENTEGRA HEALTH SYSTEM AND
NORTHERN ILLINOIS MEDICAL CENTER,

17IWCC0531

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the May 27, 2016 decision of the circuit court of McHenry County, which affirmed in part and remanded in part the Commission's decision and directed "the Commission to reevaluate the request for penalties, solely, and render a Decision on that issue alone." *Cir. Ct. Dec. at 5.*

This case has a long procedural history, which is not necessary to address here, that culminated in the Commission issuing a decision on September 3, 2014, which modified the permanency award from 60% of a person as a whole under §8(d)2 of the Act down to 50% of a person as a whole. The Arbitrator's decision, dated December 17, 2010, was otherwise affirmed and adopted including the award for medical expenses, temporary total disability periods, and the denial of penalties.

Petitioner filed an appeal to the circuit court on whether the permanency award and the denial of penalties were against the manifest weight of the evidence. The court affirmed the award of 50% of a person as a whole. However, on the issue of penalties, the court found:

> This Court's review of the Decision as contained in the Record has led it to the conclusion that the portion of the Decision addressing penalties is missing. Attempts to obtain the missing page or pages have been unsuccessful.
>
> The section of the Decision addressing penalties ends in midsentence and the following page has not been located despite several months of effort. It is the Court's understanding that the Commission was contacted and denied possession of the subject pages. The absence, or apparent absence, of a portion of the

> document prevents a complete analysis of that Decision. Any attempt to review the underlying Decision regarding penalties would require this Court to speculate as to the basis of the Commission's analysis. Reluctantly, this Court has no alternative but to order the Commission to draft a new Decision on the issue of penalties or locate the missing pages and provide them to this Court.
>
> As a result, this Court is unable to review the Decision regarding penalties with any confidence that it has been fully appraised of the basis of that aspect of the Decision. Accordingly, this Court remands the issue [of] penalties to the Commission with instructions that it review the issue and draft a new decision providing the basis of their conclusion. *Cir. Ct. Dec. at 4-5.*

The Commission acknowledges the error that the Arbitrator's decision, which was attached to ours, ends in midsentence during the discussion of penalties. The Commission has been unable to locate the missing page(s). Although the "Penalties" discussion in the Arbitrator's decision is incomplete and did not clearly state a conclusion, the Order section states that penalties were denied and we affirmed the Arbitrator on that issue. After further review of the decision and the record, we modify that last incomplete sentence, "That respondent was given leave to respond to the penalty petition and has tendered to the arbitrator as Respondent" so that it ends with "Exhibit 26, letters to Petitioner's attorney as well as responses to two penalties petitions."

We also specifically add that Petitioner has failed to prove entitlement to penalties under §19(k) and §19(l), and attorney's fees under §16. We find that Respondent's behavior was not unreasonable nor vexatious and that it had a reasonable basis, at the relevant times, to dispute the requested temporary total disability and medical benefits.

Although the Commission agrees with the Arbitrator and affords greater weight to the opinion of the pain doctor over the opinion of Dr. Vender, Respondent's reliance on Dr. Vender's opinion was not unreasonable. *See Avon Products v. IC*, 82 Ill. 2d 297, 412 N.E.2d 468, 45 Ill. Dec. 117 (1980). Pursuant to the circuit court's order and to avoid any speculation by a reviewing court, we add that the Arbitrator's analysis on the issue of penalties is again affirmed by the Commission with the clarification that our decision is also based on a review of Respondent's Exhibit 26 and the record as a whole.

We hereby reissue and attach our September 3, 2014 decision, along with the Arbitrator's decision, with the additions, modifications, and clarifications noted above.

IT IS THEREFORE ORDERED BY THE COMMISSION that our September 3, 2014 decision is reissued, along with the Arbitrator's decision, with the additions, modifications, and clarifications noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $512.26 per week for a period of 41-4/7 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 $460.80 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 50% of the person as a whole.

17IWCC0531

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $21,802.12 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

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: AUG 30 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/1/17
49

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

Priscilla Bush,
Petitioner,
vs.

NO: 05WC 49171

Blue Cross/Blue Shield of Illinois,
Respondent.

17IWCC0543

DECISION AND OPINION ON REVIEW

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,400.00. 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: SEP 7 - 2017
MJB/bm
o-8/22/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSH, PRISCILLA
Employee/Petitioner

Case# **05WC049171**

BLUE CROSS/BLUE SHIELD OF ILLINOIS
Employer/Respondent

17IWCC0543

On 8/25/2016, 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:

0607 SACHS EARNEST & ASSOC LTD
CHARLES LEVY
3525 W PETERSON AVE SUITE 206
CHICAGO, IL 60659

0445 RODDY LAW LTD
STEVE CARTER
303 W MADISON 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

Priscilla Bush
Employee/Petitioner

v.

Blue Cross/Blue Shield of Illinois
Employer/Respondent

Case # **05 WC 049171**

17IWCC0543

An *Application for Adjustment 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 **10-1/2015, 12-22-2015 and 3-4-2016**. 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 **Prospective medical; Liability for medical liens, including IDHFS and Medicare**

17IWCC0543

FINDINGS

On **June 20,2005**, 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 **$61,397.96**; the average weekly wage was **$1,196.00.**

On the date of accident, Petitioner was **38** years of age, *single* with **2** dependent children.

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

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

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

Respondent is entitled to a credit for all medical bills paid by its group carrier, pursuant to the stipulation of the Parties, under Section 8(j) of the Act.

ORDER

Petitioner's claim for medical expenses and TTD is denied.

Respondent shall pay Petitioner **permanent partial disability benefits of $567.87/week for 37 ½ weeks** because the injuries sustained caused the **7 ½% loss of use of the person as a whole, in accordance with §8(d)2 of the Act.**

Respondent shall pay Petitioner all compensation that has accrued from 6/20/2005 through 3/4/2016, and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

August 24, 2016
Date

ICArbDec p. 2

AUG 25 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as a Senior Technical Business Analyst. This was a salaried position and predominately involved typing and computer work, analyzing data and running queries, at Petitioner's desk. Occasionally, Petitioner would carry document packets to meetings.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on June 20, 2005. Petitioner was putting a full bottle of water in a water cooler and felt a pop in her back as she lifted the bottle and twisted. She thought that the water bottle weighed 4 to 5 pounds. Petitioner testified that she felt the pop in her mid to low back. She said that she had excruciating pain in her mid to low back and going down into her legs and she was shaking. She continued to work for the rest of the day, although the pain increased in her mid to low back to the point that she found it difficult to sit or stand or even rotate her chair. She took Tylenol when she got home.

Petitioner returned to work on June 21, 2005. She testified that she had pain in her mid to low back and in her legs. Petitioner called in and did not work on June 22, 2005. She worked on June 23, 2005. Petitioner completed an "Employee Statement" on June 24, 2005, stating that she injured her mid to lower back, changing out a bottle on a water cooler. (Rx 34) Petitioner's supervisor filled out a "Supervisor's Report" on July 21, 2005, noting that Petitioner reported back pain on June 21, 2005 and associated the pain with lifting a water bottle on June 20, 2005. (Rx 34)

Petitioner was seen in Employee Health on June 24, 2005. The history noted by Elaine Brown, RN was that she was trying to put water on a water cooler and thinks she hurt her back. The assessment was low back pain with limited range of motion. (Rx 1)

Petitioner was sent to Northwestern Corporate Health by Respondent on June 24, 2005. The history noted by Dr. Noven was that Petitioner developed immediate pain in her low back while she was bending and twisting, changing a water cooler. The chief complaint was lower back pain. The pain had increased in severity in the 4 days since the injury. She was experiencing left sided tingling, without numbness. When Dr. Noven attempted to examine Petitioner, she was in extreme pain, such that an injection of Toradol was given. After the injection, significant relief was noted. The physical exam did show that Petitioner had moderate pain to palpation over her lower thoracic and upper lumbar spine. Dr. Noven did not think there was evidence of disc or nerve disease. Petitioner was placed on light duty and given a prescription for Ibuprofin 3 times a day and Parafon forte to be taken at night. She was instructed on HEP. She was to follow up in four days. (Px 1, Rx 1)

Petitioner was again seen by Dr. Noven on June 28, 2005. She was seen for follow up on low back strain. She was feeling much better. She hadn't started HEP. She was said to be markedly improved. The assessment was resolving LBP strain. She was to institute HEP to prevent future problems and use the heating pad and medication as needed. She was to work light duty for a week and then could work full duty. She was discharged from care. The records of Northwestern contain no mention of pain radiating into the legs and the only mention of any thoracic spine pathology is the TTP in the lower thoracic spine noted on June 24, 2005. Petitioner testified that she had pain in her mid to low back and going down into her leg (not specified) during this time. (Px 1, Rx 1)

Petitioner continued to work for Respondent at her regular job, apparently being excused from work for the June 28th visit with Dr. Noven. She worked all through July. Sometimes people would help her with lifting. Petitioner testified that she went to the Employee Health at Respondent and tried to get a prescription refill and another appointment with Dr. Noven. She was unable to do so.

Petitioner next chose to receive treatment from her PCP, Dr. Hassan Ibrahim, on July 20, 2005. The chart note from this visit shows that Petitioner was seen for a check-up. She had a blistering lesion on her lower lip and complained of occasional muscle cramps. She was overall doing fine. There is no mention of lumbar, thoracic or leg pain. (Rx 34, {6}, Px 2, Rx 2)

Dr. Ibrahim apparently ordered PT, which took place at Ingalls Hospital from 8/3/2005 to 10/31/2005. The therapy was for neck and low back pain that began on June 20, 2005. The assessment was cervical dysfunction and lumbar derangement. (Rx 3)

Petitioner continued to work at her regular job through the month of August. She claimed that she was off work on August 17, 18, 19 and 26, 2005 due to her back injury. (Px 2, Rx 34 {5}) She was not excused off work by a physician for these absences.

Petitioner was again seen by Dr. Ibrahim on August 31, 2005. The chart note (typed 9/10/05) states: "She still has back pain that radiates down the right leg. No weakness." The physical exam showed that there was "tense paraspinal muscular area. She is unable to lie on the exam table because of lower back pain. She walks with some limp but without assistance." The assessment was lower back pain. Vicodin was prescribed and she was referred for a lumbosacral MRI. Petitioner was "OFF duty due to her medical condition." (Rx 34 {7,8})

Petitioner had the lumbar MRI on September 2, 2005. She underwent a thoracic MRI and a cervical MRI on September 3, 2005. There is no evidence as to who ordered the 9/3/2005 studies and as to why.

The lumbar MRI showed a tiny right disc protrusion accompanying a mild disc bulge at L4-L5 and a mild degenerative disc bulge at L5-S1. The thoracic MRI showed a small right herniated disc at T8-T9, with minor degenerative change, mild discogenic degenerative and hypertrophic changes at T9-T10 with central canal narrowing approaching borderline relative stenosis and minor foraminal encroachment, a bilobed pattern of disc bulge with degenerative and mild hypertrophic change at T10-T11 with foraminal and thecal sac narrowing, along with a bilobed bulging/protruding disc at T11-12, slightly more prominent on the left. The cervical MRI was remarkable for multilevel degenerative disc change, including a C4-C5 disc herniation with disc protrusions at C5-C6 and C6-C7. (Rx 23) Petitioner is not claiming that the cervical spine condition is causally related to the accident.

Petitioner returned to see Dr. Ibrahim on September 7, 2005, at which time he released her to return to work without limitation, effective September 12, 2005. (Rx 34 {9}) Increased glucose and cholesterol levels were noted. Dr. Ibrahim was concerned that Petitioner was developing Type II diabetes. Petitioner was to continue PT and a job site evaluation was recommended. (Rx 2)

Petitioner was again seen by Dr. Ibrahim on October 8, 2005. He noted that Petitioner had continued pain in the cervical and lumbar areas. The assessment was mechanical back pain and a referral to pain specialist, Dr. Elborno, was made. Continued follow-up regarding the DMII condition was also recommended. (Rx 2)

After returning to work on September 12, 2005, Petitioner continued to work at her regular job through October 15, 2005. October 15, 2005 was the last day that Petitioner worked at Respondent, or anywhere.

Petitioner was given an off-work slip from Dr. Ibrahim, dated October 25, 2005, stating that the patient is to be off work from October 17, 2005 until further notice because of "medical condition." (Rx 2) Another note from Dr. Ibrahim, dated 11-4-05, states that "Priscilla Bush is off of work because of Back injury. She is seeing a specialist because of he (sic) back Priscilla is currently being treated for her back. She is off of work from 10-17-05 through 12-15-05." (Rx 2) A further note, dated 11/12/05, states: "pt under my care for back injuries. She is seeing specialist, she is advised to stay OFF duty." (Rx 2) The chart note from 11-12-05 says that the patient was seen for result of cholesterol test and check-up of back injury. She also had a cough and a URI. The assessment was: sinusitis/URI/cough and back pain. When Petitioner followed up on 12/1/05, the visit was said to be for back pain and to make sure that her throat and ear infections had resolved. The chart note was typed on 3/24/2006. (Rx 2) The next visit with Dr. Ibrahim was on January 18, 2006. She was seen for follow up on mechanical back pain. Improvement after injections was noted. She was to continue to treat with Dr. Elborno. Dr. Ibrahim wrote a note on January 18, 2006 stating that Petitioner was under his care for multiple discogenic spinal pain, she is not released to work yet and is temporarily totally disabled. The tentative release back to work was "no sooner than 6,1,06. "Please note that we are dealing with work related injury happened on 6,20,05." (Rx 2)

Petitioner was first seen by Dr. Elborno on November 7, 2005. Petitioner gave a history of neck pain, mid back pain and low back pain and pain radiating to both lower extremities. The pain was said to have started when she twisted her body while changing a water cooler at work. Dr. Elborno read the MRI studies as showing a herniated disc at C5-C6; multiple thoracic disc herniations at T8-T9, T9-T10, T10-T11, and T11-T12; and a herniated disc at L4-L5. The diagnosis was cervical radiculitis, thoracic radiculitis and lumbar radiculitis, which was said to be correlated with the MRI studies. Recommended treatment was: pharmacological treatment, PT and ESI's. Dr. Elborno performed lumbar ESI procedures on January 3, 2006 and January 17, 2006. Petitioner had some relief with these injections. Dr. Elborno performed a thoracic ESI on February 1, 2006. Some relief was noted with this injection. Dr. Elborno prescribed a sequential nerve stimulator in April of 2006. The last visit with Dr. Elborno was on May 8, 2006. Petitioner was said to have chronic back pain. She had been experiencing bilateral hand numbness for 6 months. An MRI of the c-spine and an NCV study was ordered. (Rx 4)

Petitioner was seen by Dr. Charles Mercier for a §12 examination at the request of Respondent on November 15, 2005. Dr. Mercier diagnosed Petitioner with acute thoracic/lumbar muscle ligamentous strain by history. On examination, Petitioner demonstrated extensive nonspecific subjective pain. The back exam was normal, without muscle spasm. Petitioner demonstrated several non-anatomical findings, including contradictory SLR testing. Dr. Mercier was of the opinion that Petitioner has maximized the value of conservative care. She was not a candidate for epidurals and not a candidate for surgery. Petitioner was at MMI, needing no further medical care. She was capable of regular work. There were no reliable objective findings of functional permanent impairment. (Rx 24)

The NCV was performed on May 16, 2006 and was said to be consistent with mild left S1 radiculopathy. There was no upper extremity pathology. Repeat MRI's of the cervical and thoracic spine were done on May 25, 2006. The c-spine MRI showed no significant interval changes. The t-spine MRI showed no significant interval changes, being termed "stable." Further MRI studies of the lumbar and cervical spine and of the brain were performed in July of 2008. Another lumbar MRI was done on September 26, 2008. Dr. Ibrahim ordered an EMG/NCS (lower extremity) on September 22, 2008. The study showed mild L5-S1 radiculopathy and

polyneuropathy could not be ruled out. On November 18, 2008 an EMG/NCS was reviewed by Dr. Robinson of CINN and he concluded that he did not have an explanation for the electrodiagnostic findings – he was unsure of Petitioner's main pain generator. (Rx 23)

Petitioner continued to treat with Dr. Ibrahim. She had therapy at PTSIR. (Rx 5) In his note of August 6, 2006, Dr. Ibrahim stated that Petitioner was treating for cervical, thoracic and lumbosacral radiculopathy, multilevel disc herniations and suspected polyneuropathy. (Px 2)

Petitioner was again seen by Dr. Mercier for another §12 exam on August 15, 2006. Dr. Mercier's opinions remained the same. (Rx 24)

Petitioner was referred by Dr. Ibrahim to Dr. John Hong for further pain management and injections. Petitioner reported significant improvement from the injections. (Rx 6) Dr. Ibrahim's records show that Petitioner reported that her pain was much better and she wanted to return to work. Dr. Ibrahim provided Petitioner with a note stating that she could return to work effective February 26, 2007, 6 hours per day, 5 days per week. (Px 2)

Denise Bailey testified on behalf of Respondent. Ms. Bailey has worked as an Occupational Health Nurse at Respondent for 19 years. She functions as a disability claim manager. She deals with workers' compensation lost time, short term disability and FMLA leaves. She functions as a liaison to facilitate employees' return to work. Respondent kept Petitioner's job open for a long time after the 12 weeks allowed under FMLA (from October of 2005). Eventually, Petitioner's job was filled. Petitioner contacted Bailey around February 23, 2007 and was advised that her prior job had been filled. Petitioner was allowed to try for another position at Respondent. Unfortunately, she was not able to find another job. Petitioner's employment was terminated, effective March 16, 2007. She is eligible for re-hire, as her termination is coded "voluntary term". (Rx 34)

Petitioner did not find employment anywhere else.

Petitioner was seen by Dr. Michael Gross, at the request of her attorney, for an IME on March 21, 2007. Petitioner had complaints of low back pain, down the left buttock and left leg pain, with numbness and tingling in her left leg. She said that she was restricted to no prolonged sitting or standing and had lifting restrictions from her doctor. The Record does not support that these restrictions were in effect. The findings and complaints were isolated to the low back. Dr. Gross thought that Petitioner had suffered a moderate loss of use of the man as a whole on an industrial basis as a result of the accident. Dr. Gross did not address future medical treatment or ability to return to work. (Px 10)

Petitioner saw Dr. Ibrahim 10 times in 2008. It was noted that she had several falls which she related to her legs giving out and she developed left and right knee problems that she related to the falls. Petitioner was hospitalized 3 times at Ingalls in July of 2008. She intractable back pain and physicians at CINN tried to isolate the pain generator, without success. Eventually, Petitioner was using a walker and a scooter to get around. When Petitioner was seen by Dr. Luken in November of 2008, she was seen to be dragging her right leg. CINN was unable to explain Petitioner's extreme lower extremity weakness and pain. Petitioner again presented to Ingalls in January of 2009, with dramatic findings of right leg paraparesis and intractable pain. A thoracic MRI was performed and demonstrated the new finding of a massive right T10-T11 herniated disc that was said to be congruent with the paraperesis. Dr. Luken performed an emergent Transthoracic Resection procedure at T10-T11 on January 23, 2009. The post operative diagnosis was: Thoracic compressive neuropathy due to extruded disc herniation at T10-T11. Petitioner experienced remarkable improvement after the surgery. The last

treatment with Dr. Luken was in May of 2009. Petitioner was said to be optimistic about returning to work. She had residuals of the myelopathy and surgery. (Px 3, Px 5, Rx 23, Rx 7)

Petitioner continued to follow up with Dr. Ibrahim. (Px 2)

Petitioner was seen by Dr. John Andreshak for a §12 exam at the request of Respondent on December 2, 2011. Dr. Andreshak did not endorse a causal connection between the accident and the T10-T11 HNP that led to the January 2009 surgery. He thought that Petitioner's injury related to the accident was a low back strain, resolved. (Rx 24, Rx 25)

Petitioner had no treatment from August of 2011 until May of 2012, per Petitioner's testimony. Thereafter, Petitioner moved to Arizona in May of 2012. She had some treatment in Arizona in April of 2013 and some therapy in June of 2013. She then had treatment after a MVA on July 11, 2013. (Px 13-Px 16, Rx 27-Rx 33)

Petitioner was seen by Dr. Gross for another IME at the request of her attorney on February 27, 2014. Dr. Gross thought that, "to a probable degree of medical and surgical certainty" (he is not a board certified orthopedic surgeon), that Petitioner's findings and state of ill-being regarding her lumbar spine, thoracic spine and left knee were causally related to the accident of June 20, 2005. He thought that Petitioner was permanently and totally disabled, on an industrial basis (also opining that Petitioner sustained a major loss of use of the man as a whole). (Px 11)

IDHFS placed a lien against this claim, beginning payments on Petitioner's behalf in December of 2008. Interestingly, payments were made at the Glenwood Walmart for Hydrocodon in June, August and October of 2012 (after Petitioner moved to Arizona?). (Px 9) Petitioner's Bills Exhibit was No. 8. Petitioner's bills in Arizona were paid by Medicare.

Petitioner testified that when she sits for a long time, she has pain in her mid to lower back. She is awakened by pain. She is limited in stooping and bending. She is limited in walking.

Dr. Gross testified via evidence deposition at the request of Petitioner. He is not board certified. At the time of his first examination of Petitioner, his diagnosis was residuals of a low back injury and bulging discs at L4-L5 and L5-S1 by MRI results. He thought that Petitioner's lumbar condition was causally related to the accident of June 20, 2005. The diagnosis after the second exam was residuals of a back injury with bilateral neuropathy, residuals of a thoracic spine injury in a postoperative state, a herniated disc syndrome, postoperative state and residuals of a left knee injury with a medial meniscal tear in a previously operated knee (in high school) and an ACL tear in the left knee. These conditions were said to be causally related to the accident of June 20, 2005. (Px 12)

Dr. Mercier testified via evidence deposition at the request of Respondent. Dr. Mercier is a board certified orthopedic surgeon. He no longer performs spine surgery. Dr. Mercier confirmed the opinions in his reports and also opined that the thoracic surgery was not related to the accident of June 20, 2005. Petitioner had several positive Waddell's findings in both exams. Petitioner was at MMI, able to return to work at full duty and not in need of further treatment as of the date of his examination of her in November of 2005. On cross-examination, Dr. Mercier confirmed that at the time of his examination, Petitioner had some degenerative disc disease in her lower thoracic spine. (Rx 26)

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

Based upon the Arbitrator's finding regarding causation, as set forth above, the Arbitrator denies Petitioner's claimed medical bills.

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 claimed entitlement to TTD for the time period of June 21, 2005 through December 22, 2015 at trial.

Based upon the Arbitrator's finding regarding causation, as set forth above, the Arbitrator denies Petitioner's claim for TTD.

Further, it is noted that Petitioner was not taken off work by a physician until Dr. Ibrahim did so on August 31, 2005. She was released to return to work by Dr. Ibrahim, effective September 12, 2005. This is a period of 12 days, so the 3 working day waiting period would apply. After returning to work, she worked until October 15, 2005 and never returned to work. Dr. Ibrahim thereafter took Petitioner off work, effective October 17, 2005, on October 25, 2005. In no event should Petitioner be entitled to TTD when she has not been excused from work by a physician. Further, the Arbitrator would decline to award TTD based upon an ex post facto off work slip, such as that issued by Dr. Ibrahim on October 25, 2005.

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

Having considered all of the evidence, the Arbitrator finds that the injuries sustained caused the permanent partial loss of use of the person as a whole to the extent of 7½ % thereof.

WITH RESPECT TO ISSUE (O), LIABILITY FOR PROSPECTIVE MEDICAL AND LIABILITY FOR LIEN RIGHTS, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's finding regarding causation above, Petitioner's claim for prospective medical treatment is denied.

Based upon the Arbitrator's finding regarding causation above, the Arbitrator finds that no third party lien rights (including IDHFS and Medicare) exist, as any treatment that Petitioner has had after June 28, 2005 is not causally related to the accident of June 20, 2005.

Dr. Andreshak testified via evidence deposition at the request of Respondent. Dr. Andreshak is a board certified orthopedic surgeon, with a spinal fellowship in orthopedic neurosurgery. The thoracic herniated disc (T10-T11) is not causally related to the accident of June 20, 2005. Petitioner's injury was a lumbar strain, resolved. (Rx 25)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. The Arbitrator finds that Petitioner's testimony was not entirely credible, as is set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

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 is causally related to the accident only to the extent of a thoracic/lumbar muscule ligamentous strain, resolved, as diagnosed by Dr. Mercier. Dr. Noven was of the opinion that Petitioner's low back strain had resolved and was in need of no further treatment as of June 28, 2005. Dr. Mercier believed Petitioner to be at MMI as of that date. Dr. Andreshak supports this opinion, as do the medical records.

As is shown by the medical records, Petitioner's complaints did wax and wane and her leg complaints moved from side to side all through the course of her treatment. The opinions of Drs. Mercier and Andreshak (board certified orthopedic surgeons) are persuasive and best comport with the evidence adduced. Petitioner's testimony regarding her complaints mid to low back and down the leg (which leg?) mid to low back pain and down the legs sound reversed and is not credible. Certainly, Dr. Noven would have charted radicular leg pain if Petitioner voiced such complaints at either of the June, 2005 visits. Perhaps if the 7/20/2005 chart from Dr. Ibrahim documented orthopedic findings and Petitioner's complaints, the Arbitrator would have been persuaded that Petitioner's condition had not resolved, as per Dr. Noven and Dr. Mercier. However, that is not the case.

The massive thoracic herniated disc at T10-T11 is not causally related to the injury. The Arbitrator relies upon the credible opinions of Dr. Mercier and Dr. Andreshak in this regard. Further, none of Petitioner's treating physicians (most notably Dr. Luken) supported causal connection regarding this condition. A minor back strain due to a twisting/lifting incident (4 or 5 pounds?) does not lead to a massive thoracic herniated disc with compressive neuropathy and almost complete right lower extremity paraparesis, as was seen in Petitioner, three years after the injury.

Dr. Gross' opinions on causation are not persuasive. This is especially the case when the reports of March 21, 2007 and February 27, 2014 are compared.

Only the resolved thoracic/lumbar muscle ligamentous strain is related to the accident of June 20, 2005.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIECZYSLAW (MITCH) BUBNIAK,

Petitioner,

vs. NO: 06 WC 27969

REUNION INDUSTRIES d/b/a HANNA CYLINDERS,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to the parties' stipulation and request to modify the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract") as follows:

That by the terms of the Settlement Contract, approved by Arbitrator George Andros, on August 25, 2010, the parties agreed that medical benefits to Petitioner under Section 8(a) of the Act would continue, because no Medicare Set-Aside Arrangement (MSA) was required at the time the Settlement Contract was entered;

That since the approval of the referenced contract, the parties jointly agreed to obtain and submit 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, dated November 24, 2016, approving a WCMSA in the amount of $21,716.00. CMS has determined that $21,716.00 adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs;

That in conjunction with the terms of the Settlement Contract, approved on August 25, 2010, Respondent will fund said MSA by an initial deposit of $3,341.00, and subsequent equal

payments of $1,531.00 per year over 12 years. 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,

That by the parties' agreement, Petitioner's medical benefits under Section 8(a) of the Act will terminate upon the effective date of the WCMSA.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator George Andros, on August 25, 2010, is hereby modified by the terms of the stipulation of the parties, a copy of which is attached hereto and made a part hereof, so as to conform to the requirements of CMS;

2. That it is the further Order of the Commission that pursuant to the referenced Settlement Contract and the parties' subsequent stipulation, Petitioner's continuing rights under Section 8(a) of the Act are hereby closed as of November 24, 2016; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator George Andros, on August 25, 2010, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

DATED: SEP 1 - 2017
MJB/pm
8-24-17
052

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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM WAYNE KRUTUL,

Petitioner,

vs. NO: 06 WC 34802
06 WC 34803

DBM COTTON JV,

Respondent.

ORDER

This matter appeared on Commissioner Stephen Mathis' call on August 23, 2017, wherein Commissioner Michael Brennan substituted in his stead. A hearing was held on the record on August 23, 2017 on Petitioner's Petition for relief pursuant to Section 20 of the Illinois Workers' Compensation Act, 820 ILCS 305/20, otherwise known as a Pauper's Petition, which was filed on June 1, 2017.

With due notice given, the parties were present at said hearing: Petitioner appeared pro se and Respondent was present through counsel.

Upon a review of the record, including Petitioner's Petition and testimony regarding his assets and income, it is the finding of the Commission that the Petitioner is entitled to the relief that is set forth in Section 20 of the Illinois Workers' Compensation Act.

Therefore, it is the Order of the Commission:

1. That the relief requested in Petitioner's Pauper's Petition for waiver of costs incidental to obtaining a transcript of testimony and the record of proceedings, including photostatic copies of exhibits, at hearings and/or subsequent

proceedings, before an Arbitrator or the Commission, and as otherwise enumerated in Section 20 of the Act, be and it is hereby granted;

2. That the waiver of costs provided in Section 20 of the Act inure to the benefit of the Petitioner, William Wayne Krutul, and only the Petitioner herein, in any subsequent proceedings, unless proof to the contrary is brought before the Commission;

3. That in the event that a recovery is made by the Petitioner, that any such costs and expenses incurred as a result of this Order will be repaid to the Commission by Petitioner out of any recovery; and,

4. That in the event that a recovery is made by the Petitioner, the Respondent is ordered to forward a check in the amount of any costs and expenses from which the Petitioner has been relieved, pursuant to this Order and Section 20, and before any proceeds are paid to the Petitioner.

Dated: SEP 6 - 2017

Michael J. Brennan

MJB/pm
8-23-17
052

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIQUE KAY,

Petitioner,

vs. NO: 06 WC 32115

CENTEGRA HEALTH SYSTEM AND
NORTHERN ILLINOIS MEDICAL CENTER,

17IWCC0530

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the May 27, 2016 decision of the circuit court of McHenry County, which affirmed in part and remanded in part the Commission's decision and directed "the Commission to reevaluate the request for penalties, solely, and render a Decision on that issue alone." *Cir. Ct. Dec. at 5.*

This case was consolidated for hearing before the Commission with another case: 05 WC 5517. The circuit court's remand instructions regarding the penalties issue relate solely to that case. We have issued a Decision and Opinion on Remand in the 05 case separately to comply with those instructions. However, from our understanding of the court's order, the 06 case (subject of this decision) has been affirmed and there is nothing further for the Commission to do as it relates to this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that our September 3, 2014 decision stands, based on our understanding that it was affirmed by 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: AUG 30 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/1/17
49

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Monica Campos,

Petitioner,

vs.

NO: 07 WC 26161
11 WC 21368

School District U-46 Transportation,

Respondent.

ORDER

A "Motion to Adjudicate Fee Petitions" having been filed by Attorney Raymond M. Simard, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on January 11, 2017 in Geneva, Illinois. The Commission, having jurisdiction over the persons and subject matter, and after being advised in the premises, grants said motion and distributes attorneys' fees as set forth below.

The record shows that on June 18, 2007 an Application for Adjustment of Claim (07 WC 26161) was filed by the law firm of James Ellis Gumbiner & Associates alleging that Petitioner sustained a back injury on May 18, 2007. Petitioner subsequently terminated Mr. Gumbiner's firm, which in turn filed a petition for fees on January 2, 2008. Said fee petition was entered and continued to disposition.

On February 25, 2008, attorney Scott Shapiro of the firm of Shapiro & Vasilatos filed an appearance on case 07 WC 26161.

On June 6, 2011, attorney Michael Gerstein of the Law Office of Michael D. Gerstein filed an Application for Adjustment of Claim (11 WC 21368) on behalf of his client alleging injuries to her lower back on February 22, 2011. Mr. Gerstein also filed an Attorney Representation Agreement on that date with respect to claim 11 WC 21368. The Commission notes that while the file does not contain a substitution of attorney form by Mr. Gerstein for claim 07 WC 26161, the Commission's mainframe computer shows that a Stipulation to Substitute was filed with respect to 07 WC 26161 on September 12, 2008.

On April 16, 2013, claim 07 WC 26161 was dismissed by the Arbitrator for want of prosecution.

On July 1, 2013, the Arbitrator granted the motion to reinstate claim 07 WC 26161 filed by attorney Gerstein on May 10, 2013.

On July 24, 2014, attorney Christopher Bruneau of the Law Offices of Christopher R. Bruneau filed an appearance as co-counsel in regards to claim 07 WC 26161.

On September 22, 2014, attorney Gerstein filed fee petitions with respect to claims 07 WC 26161 and 11 WC 21368. Said fee petitions were entered and continued to disposition.

On September 23, 2014, attorney Raymond M. Simard filed a Stipulation to Substitute Attorneys on case 07 WC 26161 that was also signed by withdrawing attorney Gerstein. In addition, attorney Simard filed a Stipulation to Substitute Attorneys on September 23, 2014 in regards to case 11 WC 21368 that was likewise signed by withdrawing attorney Gerstein.

On January 26, 2015, the Arbitrator dismissed claim 07 WC 26161 for want of prosecution.

On March 2, 2015, the Arbitrator granted the motion to reinstate filed by attorney Simard on February 4, 2015.

On August 26, 2015, attorney Simard filed a petition for fees and expenses with respect to claims 07 WC 26161 and 11 WC 21368. Said fee petitions were entered and continued to disposition.

On September 8, 2015, attorney Todd A. Strong of the firm Strong Law Offices filed separate Stipulations to Substitute Attorneys with respect to claims 07 WC 26261 and 11 WC 21368. These forms were also signed by withdrawing attorney Simard.

Attorney Gerstein subsequently passed away in March of 2016.

On July 14, 2016, the Arbitrator approved separate settlement contracts with respect to claims 07 WC 26161 and 11 WC 21368, in the amounts of $43,731.42 $12,254.00, respectively. At the time of contract approval, Petitioner was represented by Strong Law Offices and there were fee petitions pending by several of Petitioner's former attorneys, including attorney Simard. The Arbitrator ordered that the last attorney of record, Strong Law Offices, hold attorneys' fees in escrow pending the resolution of the aforementioned fee petitions.

On December 2, 2016, Mr. Simard filed the present Motion to Adjudicate Fee Petitions.

A hearing was held before Commissioner Tyrrell in regards to the motion in question on January 11, 2017. Appearing at the hearing were attorney Simard, on behalf of Raymond M. Simard, P.C., and attorney Hania Sohail on behalf of Strong Law Offices. At the time of this hearing, attorney Simard represented, as an officer of the court, that said motion was served "... via regular mail on all of the attorneys who have touched this case." (T.4). Specifically, attorney Simard noted that in addition to Strong Law Offices he had spoken to attorney Shapiro, whom he noted had expressed no interest in the matter, having been a member of the firm of Shapiro & Vasilatos at that of his representation, and that the Vasilatos law firm had since signed a statement waiving any rights to fees in this matter. (T.4). In addition, attorney Simard represented that the law firm of James Ellis Gumbiner & Associates had been notified and failed to appear not only at the January 11, 2017 hearing but on a previously scheduled hearing date as well. (T.4-5). Furthermore, attorney Simard represented that he had sent notice to attorney Bruneau at the address listed for him on the ARDC website as well as the address that the latter had "... when he was helping Mr. Gerstein after Mr. Gerstein took ill ...", with no apparent response. (T.5).

With respect to deceased attorney Gerstein, attorney Simard noted that the former "... did Yeoman duty in this case... I sent a notice to the P.O. Box, several of them... We have not heard from any representative, so I made a good faith effort to contact everybody who may have an interest in this case. I also served respondent's attorney." (T.5-6). Attorney Simard also noted that attorney Gerstein "... got them to pay for surgery from Dr. Malek ... and he obtained a settlement offer of $43,731.42." (T.6). Attorney Simard stated that he then took on the case and was able to increase the settlement offer by $12,254.00, for a new total of $55,985.42 – or the combined settlement amount of both cases that were approved by the Arbitrator ($43,731.42 [07 WC 26161] + $12,254.00 [11 WC 21368]). (T.6-7).

Attorney Sohail, on behalf of Strong Law Offices, noted that her firm took over the cases in August of 2015 and eventually settled the matter for the previously negotiated amount. (T.8-10). Attorney Sohail represented that "[w]e were not aware of the offer. We were not aware that we would be the fifth attorney. That being said, we still worked the file. We pre tried, we were getting the case ready for trial. We pre tried the case in front of Arbitrator Granada and on Arbitrator Granada's recommendation settled the case. We convinced our client, as the arbitrator indicated that the case proceeds to trial could be that he would award less than what was being offered. But we did settle the case even though the offer had been there prior to us taking over." (T.10).

Based on the above, the Commission grants the Motion to Adjudicate Fee Petitions and hereby finds that the law firm of Raymond M. Simard, P.C. is entitled to attorneys' fees associated with settlement of the above-captioned claims in the amount of $6,823.94 and that Strong Law Offices is entitled to $4,373.14 of said proceeds. Attorney Simard's share is based on half of the attorneys' fees relating to the $43,731.42

settlement offer procured by attorney Gerstein, now deceased, as well as the full amount of attorneys' fees relating to the additional settlement offer of $12,254.00 obtained by attorney Simard on behalf of his client ($4,373.14 + $2,450.00). While the Commission recognizes the value in ultimately bringing the client to the finish line, as it were, and agreeing to settle her claim, the fact of the matter is that Strong Law Offices failed to increase the offer beyond that which had already been procured by Petitioner's prior attorneys. For that reason, the Commission finds, based on a theory of quantum meruit, that attorney Simard has a better claim to attorneys' fees based on the amount of the increased offer obtained through his efforts.

IT IS THEREFORE ORDERED BY THE COMMISSION that the law firm of Raymond M. Simard, P.C. receive attorneys' fees associated with settlement of the above-captioned claims in the amount of $6,823.94 and that Strong Law Offices receive attorneys' fees in the amount of $4,373.14.

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

DATED: SEP 6 - 2017

Thomas J. Tyrrell

r-1/11/17
TJT/pmo
51

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HELEN AGUILAR,

Petitioner,

vs. NO: 07 WC 57380

FERRARA PAN CANDY COMPANY,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to the parties' stipulation and request to modify the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract") as follows:

That by the terms of the Settlement Contract, approved by Arbitrator Robert Williams, on December 23, 2014, the parties agreed that the Respondent reserved the right to close benefits under Section 8(a) of the Act, pursuant to the contract;

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, dated June 2, 2017, approving a WCMSA in the amount of $12,961.00. CMS has determined that $12,961.00 adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs;

That in conjunction with the terms of the Settlement Contract, approved on December 23, 2014, Respondent will fund said MSA by an initial deposit of $1,439.00, and subsequent equal payments of $576.00 per year for 20 years. 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,

That by the parties' stipulation, Petitioner's medical benefits under Section 8(a) of the Act will terminate as of June 1, 2017.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Robert Williams, on December 23, 2014, is hereby modified by the terms of the stipulation of the parties, a copy of which is attached hereto and made a part hereof, so as to conform to the requirements of CMS;

2. That it is the further Order of the Commission that pursuant to the referenced Settlement Contract and the parties' subsequent stipulation, Petitioner's continuing rights under Section 8(a) of the Act are hereby closed as of June 1, 2017; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator Robert Williams, on December 23, 2014, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

DATED: SEP 27 2017
MJB/pm
9-25-17
052

Michael J. Brennan

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

Edward Hood,
Petitioner,
vs.

NO: 07WC 44404

17IWCC0540

Best Buy,
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 regarding the right eye, notice regarding the right eye, temporary total disability, medical, permanent partial disability, penalties, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 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 $1,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 6 - 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

o083017
CJD/rlc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

HOOD, EDWARD
Employee/Petitioner

Case# **07WC044404**

BEST BUY
Employer/Respondent

17IWCC0540

On 2/4/2016, 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 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4084 DEFFET, TIMOTHY J LAW OFFICE
4848 N CLARK ST
CHICAGO, IL 60640

2337 INMAN & FITZGIBBONS LTD
STEPHEN M McCLARY
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

17IWCC0540

STATE OF ILLINOIS)
)SS.
COUNTY OFCOOK)

☐ 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

Edward Hood
Employee/Petitioner

Case # 07 WC 44404

v.

Best Buy
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **8/31/2015 & 11/17/2015**. 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 **10/15/2005**, 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 with his right eye ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$14,000.48**; the average weekly wage was **$269.24**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Based upon the evidence presented, Petitioner is not entitled to temporary total disability benefits.

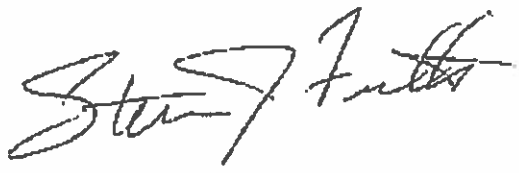
Respondent shall pay Petitioner permanent partial disability benefits of **$161.54**/week for **9.72** weeks, because the injuries sustained caused the **6%** loss of the left eye, as provided in § 8(e) of the Act.

Based upon the evidence presented respondent is not liable for any medical bills.

The Petition for Penalties and attorney's fees is denied.

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

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



February 4, 2016

FEB 4 - 2016

Signature of Arbitrator Date

Edward Hood v. Best Buy
07 WC 44404

INTRODUCTION

This matter proceeded to hearing on August 31, 2015 and November 17, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***G:*** What were Petitioner's earnings?; ***J:*** Were the 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?; and ***M:*** Should penalties be imposed upon Respondent?

Petitioner, Willie Ray Bunkley, and Lashaun Stokes testified at trial. The evidence depositions of Cynthia Carpo, M.D. and Carrie Golden- Brenner, M.D. were admitted in evidence along with various documents submitted by the parties.

The parties stipulated to accept delivery of the Arbitrator's decision via e-mail.

STATEMENT OF FACTS

Petitioner testified that on the date of the alleged accident, October 15, 2005, he was single with two children under the age of 18.

Petitioner testified that he began working for Best Buy in March 2005. He was corrected and testified that his employment began on July 23, 2005. He was a wireless phone consultant. His duties involved activating cellular phones and selling IPods and other cellular accessories. His normal schedule was the morning shift, between 8:00am and 3:00pm, 4 to 5 days a week.

Petitioner identified PX #7 as a wage statement, which was admitted in evidence.

Petitioner testified that on October 15, 2005 he was working a Saturday 8:00am to 3:00pm shift. He described his eyesight as perfect before his injury. He had ever had his eyesight checked before October 15, 2005, stating, "I didn't have to have it checked."

On October 15, 2005 Eric, his supervisor, told him to blow up balloons with helium. He had never blown up balloons before. He stated that while blowing up a balloon it burst into his right eye. He had immediate pain over the entire right side of his face and right eye. He reported the incident to the store manager, Mike Schultz, who told him to go to the hospital. This was between 9-9:30am. Petitioner stated that he did

not fill out an accident report before going to the hospital but did so with Mr. Schultz when he returned about 10 to 10:30am

Petitioner further testified that when he arrived at Rush Northshore Hospital (Northshore) on the date of the accident he was first seen in registration and gave a history of the injury occurring at work to his right eye. He stated that he was then seen by the doctor and reported that he had injured his right eye when a helium balloon burst into the eye. He said that the doctor looked into his right eye but examined both eyes before recommending drops and putting a patch over his right eye.

Petitioner testified that he called off of work on the day following the accident, Sunday October 16, and believed he was scheduled to be off or work on Mondays and Tuesdays.

At the time of the accident Petitioner testified that he was living with one of his girlfriends. He said that he spoke with his cousin, Willie Ray Bunkley, on October 18 by phone and told him he had injured his right eye at work. He said that this was the first time he talked to him after the accident.

Petitioner testified that he wore the patch until Tuesday night and then went back to work on Wednesday, October 19. He said that he spoke to his department lead, Onica, about how he was feeling when he returned. He did not take any more time off of work after the accident until he left his employment on January 27, 2006.

Petitioner then testified that he did not seek additional medical care to his eye until August 20, 2006, when he was seen at Stroger Hospital because he had no insurance. When asked why he did not return to Stroger which did not require insurance he said that he was raised to just deal with his medical problems because he had to work in order to eat. He said that his eyesight was good enough to work after the accident but over time his eyesight was deteriorating. He said over time he was having difficulty doing things he normally could do because of his failing eyesight and this is why he went to Stroger. He said he was running into doors and fire hydrants at that time.

He was given eye drops at Stroger and prescribed Tylenol 3 for his headaches.

Petitioner next testified that he was seen at the Specialty Care Eye Clinic on August 21, 2006 as a part of the Cook County Network where they found nothing wrong with his left eye but recommended drops to the right eye.

On August 27, 2010, he was seen by Dr. Sandep Jain at University of Illinois Medical Center (PX #3). The records document his history of a history of a helium balloon exploding in his eye "2-3 years ago", causing a corneal abrasion. He reported that he had not received any medical care to his eye since January 22, 2007. Again, Petitioner testified that he waited so long to obtain additional medical treatment due to a lack of insurance. He said that his eye was getting worse between January 2007 and August 2010. On September 2, 2010 Petitioner's history of right eye trauma from an exploding helium balloon "3 years ago" was noted.

Petitioner testified that when he saw the doctor in August 2010 he discussed whether he would be able to drive. Earlier he had stated that his drivers' license had been suspended due to unpaid parking tickets before the accident.

Dr. Jain referred him to Dr. Jacob Wilensky of the University of Illinois at Chicago Hospital, Eye and Ear Infirmary in September 2010. Surgery to the right eye was discussed at that time. He returned to Dr. Wilensky on November 4, 2010 and again surgery was prescribed but he had no insurance.

He next received medical care from Dr. Howard Reinglass of Lakeshore Eye Physicians (PX #4) on May 9, 2011. Dr. Reinglass recommended surgery. He eventually had surgery with Dr. Reinglass on October 5, 2011 at St. Francis Hospital and was kept off of work at that time. He saw Dr. Reinglass in follow up with continued problems and by January 27, 2012 he was beginning to have problems with his left eye.

Dr. Reinglass wrote a letter to Mr. Rajesh Kanuru on August 19, 2011. The letter states Petitioner's history of right eye trauma with a helium balloon "six years ago." Dr. Reinglass also states his opinion that the right eye injury caused "instantaneous" vision loss and was possibly the cause of underlying glaucoma. The letter appears to be for the purposes of litigation.

On January 12, 2013, he began seeing Dr. Weissburg at the Midwest Eye Center on January 12, 2013 because he had moved further south and Dr. Reinglass was located too far north. At that point, his right eye was still throbbing and constantly running fluids and he could not see. Dr. Weissburg recommended surgery to the right eye.

He was referred to glaucoma specialist, Dr. Sriram Sonty also located at the Midwest Eye Center and seen by him on March 9, 2013.

Petitioner also stated that in March 2013 he was placed on Social Security Disability for reasons unrelated to his eye.

He had a right cataract removal surgery with Dr. Nicole Albright of the Midwest Eye Center on October 8, 2013.

Petitioner testified that at some point he started to become depressed and had seen a social security physician and reported this when he was applying for disability. He also stated that he told his physicians treating him for his eye condition that he was depressed because he could no longer perform the activities he was able to do before the accident.

Petitioner testified that on October 17, 2013, he followed up with a physician at the Midwest Eye Center and was told that he needed a third surgery on his right eye. He also said that the sight in his left eye was deteriorating as well.

On December 8, 2014, he was seen at the Illinois Glaucoma Center. He complained that his vision was slowly deteriorating in his left eye and that he had light sensitivity in both eye. He was seen again in follow up on December 22, 2014.

He testified that he last saw a doctor from the Illinois Glaucoma Center in June 2015 and had similar complaints of runny eyes, pain in his eyes and lack of vision.

Another surgery has been recommended. He believed that he had an appointment to follow up in about 2 weeks.

With regard to his condition he testified that he cannot see out of his right eye at all and that his left eye was deteriorating due to the buildup of pressure in his right eye. He had not been recommended for any surgery in his left eye.

Petitioner then testified to his employment after leaving Best Buy, which started with the company Mobile Solutions in February 2006. He then stated that he worked at Office Max from March 2006 until January 2007 as a supervisor and was laid off. He then worked for TruGreen ChemLawn from February 2007 until November 2007 in sales and was laid off and then received unemployment benefits. In February 2008 he began working at Administrative Resource Options (ARO) on the loading dock. He worked there for about a year and then was laid off for preparing improper paperwork. He stated that the layoff occurred in about January 2011. He said that he had last worked in January 2010.

On cross-examination Petitioner stated that he did not voluntarily leave his position but instead he was let go. Petitioner denied that his original job offer with Best Buy reflected that he was being offered work of less than 32 hours per week. Nevertheless, Petitioner agreed that based upon the wage statement that he reviewed during his direct examination he had been working part-time during his entire employment with Best Buy. At the second hearing Petitioner admitted that he was hired for part time work but had been asked if more hours were offered would he accept. When he left Best Buy he was looking for employment that would offer more hours and better pay.

Petitioner was not working when seen at Stroger. He had been laid off by Best Buy on January 27, 2006. He did not remember signing a document stating that he was leaving his job because he could not get enough hours. Upon further questioning he admitted that he had agreed to leave because he was not getting enough hours.

Willie Ray Bunkley was called to testify for Petitioner. Mr. Bunkley is Petitioner's first cousin. Petitioner was Mr. Bunkley's best man at his wedding.

Mr. Bunkley testified that he remembered Petitioner calling him on Sunday morning October 16, 2005 to tell him that he had injured his right eye at work while filling up a balloon. Mr. Bunkley then went on to testify of the difficulties that he has seen Petitioner have with his eyesight.

On cross-examination, Mr. Buckley stated that he had no conversations with Petitioner about his testimony in preparation for trial. He testified to an independent recollection of the conversations he had with Petitioner at the time of his injury. He admitted that he would like his cousin to be successful with his Workers' Compensation case.

Lashaun Stokes was called to testify on behalf of Petitioner. Ms. Stokes is Petitioner's wife. When they first met she noticed he had tears come from his right eye and that his eye was red. After dating Petitioner for several years she placed him on her

health insurance as a domestic partner. She said that she had encouraged him to go to a public hospital before she added him on her health insurance but that he said "he had went to the County prior before and that was basically it; and they didn't really do anything for him."

On cross-examination, she testified that "He told me that when he got his eye messed up that he went to Cook County and he went to the emergency room." She then said that she never asked him why he did not go back to Cook County because she did not know too much about public assistance. She said that she did not know why he did not go back to Cook County.

She said that she has not noticed him having any improvement with his vision since his 2 surgeries. Ms. Stokes testified to Petitioner's problems navigating and ambulating with his eye problems. She had seen him fall and walk into glass doors. She then went on to describe specific incidents where Petitioner had problems due to his failing eyesight. Ms. Stokes went on to describe how she handled most of the cleaning and cooking responsibilities at the home.

Ms. Stokes admitted that she would like for Petitioner to be successful with his claim.

Petitioner's counsel stated his intent to call claims adjuster Elvia Martinez. It was represented to the Arbitrator that Ms. Martinez was the claims adjuster for Respondent's insurer responsible for the handling of Petitioner's claim. He stated that Ms. Martinez had been served with a subpoena to testify at the August hearing of the trial. Both counsel agreed that Ms. Martinez did not appear in August due to a reported illness. Ms. Martinez did not appear for the November hearing of the trial.

Petitioner's counsel did not serve another subpoena on Ms. Martinez for the November hearing of the trial. Petitioner's counsel stated that he was relying on Respondent's counsel to produce Ms. Martinez at the November hearing of the trial. Respondent's counsel disputed Petitioner's counsel's position, stating that he, as counsel for Respondent and not Respondent's insurer, that he had control over Ms. Martinez.

Petitioner's counsel argued that the Arbitrator should weigh the absence of Ms. Martinez and her lack of testimony in accord with Illinois Pattern Jury Instruction, Civil 5.01. Petitioner did not make an offer of proof of what he expected Ms. Martinez's testimony would be. Petitioner also declined the Arbitrator's offer to keep proofs open pending Petitioner seeking relief in the Circuit Court to enforce the subpoena.

Petitioner has therefore waived the issue of missing testimony.

Rush Northshore Hospital

Two versions of Petitioner's emergency department records of October 15, 2005 were admitted in evidence: Petitioner's Exhibit #1 (PX #1) and Petitioner's Exhibit #1A, amended records (PX #1A). The exhibits are substantially identical but for addenda dated 1/17/14.

PX #1 bears the notation on the registration form that Petitioner's presenting complaint was "injury left eye". The Emergency Nursing Record documented Petitioner's history that a helium balloon exploded in his left eye and that he could not open the left eye. It was also documented that Petitioner had washed his left eye with water. The Emergency Physician Record the examination of the left eye cornea, noting an abrasion (page 1 of 2). The Physician Record also noted a marking on a drawing of the left eye, apparently showing the location of the abrasion (page 2 of 2). Further, the Clinical Impression was noted as left eye corneal abrasion. The Emergency Physician Order and Documentation Sheet notes the chief complaint was left eye injury.

PX #1A contains alterations in the Emergency Physician Record notes a scratch-out of left and a notation of right cornea abrasion, with the note "right eye affected", initials of "cc", and the date of 1/17/14 (page 1of 2). PX #1A is further altered under Clinical Impression with left scratched out and right circled for corneal abrasion with the 1/17/14 date along with added hardwiring of "R corneal abrasion, cc, 1/17/14."

PX #1A has not alteration to the registration form, the Emergency Nursing Record, the drawing of the left eye, or the Emergency Physician Order and Documentation Sheet.

AIG Claim File

Petitioner offered his Exhibit #10, the AIG claim file. The claim log was opened August 18, 2008. Petitioner's hire date of July 23, 2005 at part time status was noted. The accident date was noted as August 20, 2006. A First Report of Injury (also PX #13) is dated August 28, 2008 and documents first notice to employer as August 28, 2008. The date of injury is noted as August 20, 2006. It notes Petitioner's pay rate as $380.80 per week.

Pettioner's Application for Adjustment, filed October 4, 2007 states Petitioner sustained a right eye injury on August 20, 2006. There is also a Patient Referral/Consultation Form from Scott B. Ford, O.D. dated August 25. 2007, which notes Petitioner's history of OD (right eye) injury "1 year ago".

Testimony of Cynthia Carpo, M.D.

Dr. Carpo's evidence deposition was taken on September 12, 2014 (RX #2).

Dr. Carpo is board certified in emergency medicine. She was the physician who saw Petitioner in the emergency department of Rush North Shore Hospital (Northshore) on October 15, 2005. She had no independent recollection of Mr. Hood's care.

Dr. Carpo described the processing of patients through the Rush emergency department, which included registration with a registrar and then an assessment by a nurse prior to seeing a doctor.

She testified that prior to seeing the patient she reviews chief complaints, vital signs, visual acuity, etc., noted by the emergency nurse. The attending physician signs the document if it is accurate based upon her examination of the patient. Dr. Carpo then described the process for examining for an eye injury, including ordering a dye (fluorescein) in order to assess whether there was a scratch or corneal abrasion. Once the dye was applied she would have looked at the eye under a Woods Lamp. According to her original notes an injury was noted to the left eye.

Dr. Carpo acknowledged that all throughout the records Petitioner's left eye was noted. She diagnosed a corneal abrasion of the left eye which she believed to be consistent with his injury.

Dr. Carpo stated that she released Petitioner to return to work the following day and instructed him to see an ophthalmologist. She also prescribed an antibiotic drop and pain medication for inflammation.

Dr.Carpo testified regarding her changing Petitioner's Northshore records. She stated that she was informed by a hospital email that Petitioner's record "needed to be looked at". She went on to state, "I recall there was a letter written by the patient to look at the record again." She stated that at the request of the patient she amended her notes. Dr. Carpo then went on to state that she had received a letter from Petitioner stating that when she had documented a left eye injury it was a right eye injury. She said she had no other reason not to believe the patient not knowing why he wanted it other than she had made a mistake." Dr. Carpo then stated that she had been contacted by the patient with a letter that Petitioner had written to her which was given to her by the Hospital.

On cross-examination, Dr. Carpo stated that there was nothing in the original emergency room records that would lead her to conclude that she had been incorrect in how the injury was designated that date. She further testified that there was nothing in the original hospital record that would reflect that there was anything other than a left eye injury that Petitioner was treated for on October 15, 2005. She agreed that others made left eye notations of the injury in the record. She further acknowledged that the registrar and the emergency nurse both noted Petitioner's complaints were with the left eye. Dr. Carpo had no reason to believe that what the nurse noted was incorrect (Rx. 2, p. 46). Furthermore, Dr. Carpo noted that the visual acuity documented in the record which showed somewhat less acuity in the left eye than the right was consistent with the noted left eye injury.

Dr. Carpo testified that she could not recall ever being requested to change a record 8 ½ years after the treatment had occurred. Dr. Carpo ultimately stated that the only reason that she altered the record was because of the patient's request and that she had never reviewed any additional records of treatment that Petitioner had subsequent to the emergency room visit.

She stated that had she known the context in which Petitioner was asking for the record to be changed she would not have amended the record.

On re-direct examination Dr. Carpo was given the hypothetical as to whether she would believe that Petitioner was treated for a right eye condition in the emergency room if she learned that he later was treated for a right corneal abrasion. She responded that she would "have to stick to my original record of the left eye being injured."

Testimony of Dr. Carrie Golden- Brenner, M.D.

Dr. Golden-Brenner's testimony was taken by evidence deposition on January 28, 2015 (RX #1). Various exhibits were identified but were not attached to the transcript. Dr. Golden is a board certified ophthalmologist. She examined Petitioner pursuant to §12 and also reviewed his medical records.

Dr. Golden-Brenner diagnosed Petitioner with end stage glaucoma of the right eye, post glaucoma surgery, an intraocular lens in the right eye (pseudophakia) and dry eye syndrome. In the left eye she diagnosed severe glaucoma and an early cataract with dry eye syndrome. She further opined that Petitioner sustained a minor corneal abrasion to his left eye in October 2005.

Petitioner gave a history of a right injury from a balloon popping. He reported that he walked to the doctor's office behind Best Buy where he was examined. Dr. Golden-Brenner made note that Petitioner gave a history of being seen at Cook County Hospital a couple of weeks after the incident when in fact the records demonstrate he was seen more than 10 months later.

Dr. Golden-Brenner reviewed the original records of the Rush North Shore emergency room visit on October 15, 2005. She noted that here is no indication of any injury other than to the left eye. Dr. Golden- Brenner opined that the results of the visual acuity tests done in the emergency room were consistent with a left eye injury.

Based upon her examination of the records and Petitioner's eyes, Dr. Golden-Brenner found no relationship between her diagnoses and the left sided corneal abrasion of October 15, 2005. She stated further that even assuming an original right eye injury there was no relationship between his conditions at the time he saw her with such an injury. It was her opinion that Petitioner's glaucoma in both eyes was a developmental condition that had been aggravated by his lack of follow up to his treatment.

On cross-examination, Dr. Golden-Brenner testified that she typically sees these kinds of examinees for several hours and did so in this case.

Dr. Golden-Brenner stated that she determined that Petitioner's conditions were not related to the work accident because there was no evidence of significant blunt trauma associated with angle-recession glaucoma. There was nothing in the medical records suggestive of traumatic glaucoma, noting the Petitioner's condition was present in both eyes. Dr. Golden-Brenner then went on to outline the types of clinical findings (bleeding within the eye, retinal contusions, contusions within the eye and subconjunctival and intraocular hemorrhage) that can be associated with traumatic

glaucoma. Dr. Golden-Brenner stated upon further questioning that there was no evidence of angle-recession glaucoma in any of the stages of his treatment and all of his findings in the records and her evaluation were consistent with open-angle glaucoma. Specifically, she stated that the records do not support Dr. Reinglass' conclusions in his August 2011 letter that Petitioner sustained instantaneous vision loss. She said the records demonstrate that his vision gradually went down which is consistent with chronic open-angle glaucoma.

Dr. Golden-Brenner stated that any of the treatment documented beyond the emergency room in the records would not have been related to the corneal abrasion in the left eye. She did not even find evidence of corneal scarring in the left eye which might have suggested a significant corneal abrasion.

Dr. Golden-Brenner stated that it was highly likely that Petitioner had chronic open angle glaucoma prior to the accident of October 15, 2005. She said this was based upon the fact that his glaucoma was so severe 10 months after the accident. She stated further that the recommendations were for African Americans to start getting their examinations in their 30s for glaucoma because of the higher incidence at a younger age. She also stated that glaucoma in one eye in and of itself does not cause glaucoma in the other eye.

Dr. Golden-Brenner further stated that it was quite common to develop a cataract after glaucoma surgery.

On re-direct examination, Dr. Golden-Brenner stated that there were 3 separate individuals in the original emergency room records that documented a left eye injury and nothing inconsistent with findings of a left eye injury. She found it surprising that the attending E.R. physician would simply cross out left eye and write in right eye as to her portion of the records, 8 ½ years after the treatment. She also said it would be surprising that the E.R. doctor made those changes simply at the request of the patient 8 ½ years later. Finally, she found it surprising that Dr. Carpo made the change she did to the record without an independent recollection of having seen the petitioner, which she thought was normal as it had been 8 ½ years.

corrected CONCLUSIONS OF LAW

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

Whether Petitioner was injured in an accident arising out of and in the course of his employment by Respondent was not genuinely disputed. Petitioner was credible to the extent that he described a balloon bursting while he was inflating it as a part of his job duties on October 15, 2005. The Emergency Department records from Rush North

Shore Medical Center of that date corroborate enough of Petitioner's account to sustain Petitioner's burden of proof of accident.

Therefore, Arbitrator finds that Petitioner proved that he sustained a left eye injury that arose out of and in the course of his employment by Respondent.

E: Was timely Notice of the Accident given to Respondent?

Petitioner testified that he notified the store manager Mike Schultz at the time of this accident. It is plausible and credible that Petitioner would report such an event to his supervisor. Respondent offered no rebuttal evidence on the issue of notice.

Therefore, Arbitrator finds that Petitioner gave timely notice of his injury to Respondent.

C: Is Petitioner's Current Condition of Ill Being Causally Related to the Accident?

The Arbitrator finds that Petitioner proved that he sustained an abrasion to his left eye that arose out of and in the course of his employment by Respondent. The Arbitrator further finds that petitioner failed to prove that he sustained an injury to his right eye as a result of his workplace accident on October 15, 2005.

The Arbitrator is particularly persuaded in making this decision by the original Emergency Department records from Rush North Shore Medical Center, by the deposition testimony of Dr. Carpo as it related to her treatment of the petitioner and later amendment of his records and by the testimony of Respondent's independent Medical Examiner, Dr. Carrie Golden-Brenner. In particular, the Arbitrator does not find Petitioner to be a credible witness.

First, the original records of North Shore Medical Center clearly and consistently establish that the petitioner had injured his left eye and was treated for and diagnosed with a left eye corneal abrasion. The Arbitrator takes specific note that 3 different individuals at North Shore documented a left eye injury. There was even a drawing noting the injury to the left eye. The visual acuity testing demonstrated a greater loss of visual acuity loss in the left eye than in the right eye. Both Dr. Carpo and Dr. Golden-Brenner testified that the visual acuity test was consistent with a minor corneal abrasion to the left eye. Moreover, both physicians testified consistently that the original record from North Shore was completely consistent for treatment of the left eye injury.

Petitioner was the only source of information to his healthcare providers. His complaints in the Emergency Department of North Shore were akin to excited utterances and are therefore accorded more credibility that statements made months and years later. Also, on several occasions in 2010 Petitioner reported to healthcare providers at the University of Illinois Eye, Ears and Nose clinic that his right eye

problems arose 2 to 3 years before. Finally, Petitioner's original Application for benefits stated that the date of his accident was August 6, 2006.

Dr. Carpo's testimony was also supportive of the conclusion that petitioner had sustained a left eye injury. While it is true that she amended some of her clinical notes in 2014 after some type of request to do so by Petitioner, it is equally clear from her testimony that she was simply changed the record because she was asked to. There was no evidence that she reviewed or evaluated the request in accord with any policy or protocol for amended clinical records. It is clear from the evidence that there was no objective basis for altering the record. Dr. Carpo's cross-examination and redirect examination indicated her regret in doing so.

In this light the Arbitrator finds no credibility whatever in Petitioner's Exhibit #1A.

As discussed above Dr. Reinglass's opinion of causation set forth in his note of August 19, 2011 was clearly written for purposes of litigation and was therefore in violation of §16 of the Act. The Arbitrator disregarded Dr. Reinglass's causation opinion.

Finally, the Arbitrator is also persuaded by the credible testimony of Dr. Golden-Brenner. Her reasoning in finding that Petitioner's condition of ill-being was not related to his accident was not only based upon the original record from North Shore Medical Center documenting a left eye injury, but a well-reasoned opinion that irrespective of which eye was injured on October 15, 2005, Petitioner's medical history did not support a conclusion that his current condition was or could have been related to the simple corneal abrasion.

Dr. Golden-Brenner opined that Petitioner suffers from and had been treated for a type of glaucoma (chronic open angle) rather than the type that could be the result of trauma (angle recession). She pointed out that Petitioner had been repeatedly tested for angle-recession glaucoma and the tests were negative. She also explained that the original treatment records did not document the type of sufficient trauma that would be necessary to result in angle recession glaucoma. Overall, Dr. Golden-Brenner's testimony was persuasive.

The Arbitrator also notes the testimony of Petitioner's cousin, Willie Ray Bunkley, and accords no weight to his testimony. Mr. Bunkley's testimony regarding Petitioner's report of his accident was too good, too precise to be true. The Arbitrator does not find it credible that Mr. Bunkley could recall the time and date details of conversations with Petitioner with such precision after the passage to 10 years. Despite his denial, Mr. Bunkley's testimony was clearly coached and prepared.

The Arbitrator also finds that the testimony of Pettioner's wife, Ms. Stokes, neither supports nor rebuts the disputed issue of causation.

G: <u>What were Petitioner's earnings?</u>

Petitioner offered a wage statement documenting Petitioner's earnings for the weeks he was employed by Respondent (PX # 7). Petitioner testified regarding the wage statement and that testimony, along with documentation in Petitioner's personnel file (Rx #3) clearly demonstrate that Petitioner was hired as a part time employee to work less than 32 hours weeks. His actual wages reflect that status. His wages cannot be assessed as if he were a full time 40 hour a week employee as Petitioner seems to assert.

Respondent's calculation of an average weekly wage of $269.24 is supported by the evidence and accepted by this Arbitrator.

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

Consistent with the findings and conclusions above, the Arbitrator concludes that only the original North Shore Emergency Department treatment from October 15, 2015 was reasonable and necessary to treat the left eye abrasion sustained by Petitioner in his workplace accident on October 15, 2005. Petitioner offered records from that facility but no medical bills were offered regarding those services. It is unknown whether the bills were paid at some point. Consequently, no medical bills are awarded in this matter.

K: What temporary benefits are in dispute? *TTD*

As only the North Shore Emergency Department medical services have been found to be related, there would be no award of temporary total disability benefits as Petitioner was only authorized off of work for the balance of the date of accident.

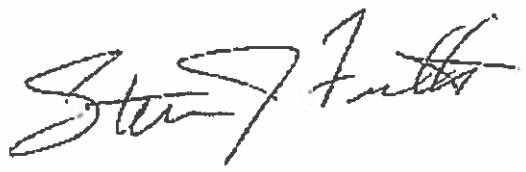
L: What is the nature and extent of the injury?

The Arbitrator finds that Petitioner proved that he sustained a left eye corneal abrasion as a result of the workplace accident of October 15, 2015. The Arbitrator further finds that Petitioner failed to prove that he sustained an injury to his right eye as a result of the workplace accident on October 15, 2005.

The left eye injury required no treatment beyond that in the Emergency Room. Nevertheless, Petitioner did sustain a corneal abrasion and is awarded a 6% loss use of the left eye which would be reasonable under the circumstances and facts of this case. Respondent shall pay Petitioner $161.54 per week for 9.72 weeks, all of which had accrued by the date of the Arbitration hearing.

M: Should penalties be imposed upon Respondent?

In light of all the evidence the Arbitrator finds that Respondent was neither frivolous nor vexatious in responding to Petitioner's claim for benefits. Therefore, there is no basis for an award of penalties or attorney's fees in this matter. The petition for same is denied.



February 4, 2016

Steven J. Fruth, 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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Miller,
Petitioner,

vs. No. 08 WC 15977

Fastrak Technologies, Inc., and
Illinois State Treasurer, Custodian of
Injured Workers Benefit Fund,
Respondents.

17IWCC0561

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, alleging a material increase in his disability and seeking additional medical, temporary total disability and permanent partial disability benefits for his condition since the Arbitrator's June 25, 2012 decision. At the time of trial, Respondent-Employer, Fastrak Technologies, Inc. ("Fastrak"), was uninsured and had gone out of business. In his decision, the Arbitrator ordered Fastrak to pay Petitioner 7.5% loss under §8(d)2, plus $14,590.36 in medical expenses. The Arbitrator also entered the award against co-Respondent, Illinois State Treasurer as Custodian of the Injured Workers' Benefit Fund ("IWBF"), "to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner."

Petitioner filed a Review of the Arbitration decision on August 23, 2012. On May 23, 2013, this Commission affirmed and adopted the Arbitrator's decision. Because Fastrak did not pay the award, IWBF paid it.

17IWCC0561

On November 28, 2012, Petitioner filed a §8(a) Petition for Review naming both Fastrak and IWBF as Respondents. On October 30, 2014, Petitioner amended his §8(a) Petition by adding a claim for benefits under §19(h). Following multiple continuances, a hearing was eventually held before Commissioner Luskin in Chicago on January 11, 2017. That hearing was continued to February 23, 2017 for additional evidence before proofs were closed on that date. As was the case at arbitration, no one from Fastrak appeared at these hearings. Petitioner now seeks, since the June 25, 2012 arbitration hearing: $30,326.39 in medical benefits; 7-3/7 weeks of TTD (September 25, 2012 to November 15, 2012), and 50% loss under §8(d)2 for increased disability.

At the time of the original accident, the Petitioner was employed by Fastrak as a welder and metal worker. On February 25, 2008, while working on a ladder, he received an electrical shock which caused him to jump off and fall, landing on his tailbone and neck. He received conservative treatment, mostly to his lower back, but he also received cervical injections and treatment to his right leg. Prior to this accident, Petitioner had undergone unrelated cervical spine surgery in 2004. He also underwent an L4-L5 microdiscectomy in May 2007, nine months before his accident.

At the §19(h)/8(a) review hearing, Petitioner testified that since the arbitration hearing he has continued to receive further treatment to his low back and neck. On August 9, 2012, he received a lumbar injection from Dr. Vo for low back and right leg pain. Following a lumbar MRI on September 25, 2012, Petitioner underwent an L5-S1 laminectomy for a herniated disc, performed by Dr. Nathaniel Brooks. In October 2013, Petitioner saw Dr. Sara Holz, a spine rehabilitation specialist, who administered cervical trigger point injections. In July 2014, he saw pain management doctor Nalini Sehgal, who administered more facet and trigger point injections. In August 2014, Petitioner saw Dr. Frederick Gahl who referred him to Dr. Marie Walker. He received more therapy, low back trigger-point injections and had to wear a sacroiliac belt. In January 2015, Dr. Holz recommended bilateral SI joint injections and additional therapy. In 2016, Petitioner underwent more injections and MRI's.

Petitioner currently lives alone in a 3-story fixer-upper house which he maintains. Since his accident, he has remodeled his bathroom which required installing drywall, painting and doing some plumbing. Petitioner admitted that shortly before the January 11, 2017 hearing, he was working on his roof to fix a leak. He does laundry, mows his lawn and uses a computer for email and paying bills. He owns a car which he drives to go shopping and to doctors' appointments. He has completed 2 years of college, has a welding certificate and has worked as a skydiving instructor.

Dr. Jeffrey Coe testified on behalf of Petitioner that he conducted three independent medical examinations of Petitioner: on February 5, 2008 (in connection with Petitioner's prior accident), April 6, 2011 and April 7, 2015. He testified that most of Petitioner's treatment between 2013 through 2015 – physical therapy, blocks and work restrictions – was for pain control. Dr. Coe opined that Petitioner's current condition was causally related to his work activities and his L4-L5 fusion, and that Petitioner had reached MMI by April 2015, though he still needed treatment. On cross-examination, Dr. Coe admitted he is not an orthopedic surgeon or neurosurgeon and he does not perform spine surgeries. Petitioner had cervical and lumbar spine problems which required surgery before his February 2008 injury. Dr. Coe agreed Petitioner's September 2, 2011 EMG and an earlier one each showed nothing impinging upon or

17IWCC0561

irritating Petitioner's lumbar nerve roots. In his April 7, 2015 report, Dr. Coe acknowledged that Petitioner was treated for a "new onset" of post-traumatic neck, left arm, low back and right leg pain, after his September 2012 discectomy. Dr. Coe opined that Petitioner has a permanent disability to the person-as-a-whole and requires a 10-pound lifting restriction.

Susan Entenberg, a vocational rehabilitation counselor, testified on Petitioner's behalf that she evaluated him via videoconference on June 15, 2015. Petitioner told her he could walk and climb stairs without problem; stand for 2 hours at a time; bend from the waist, and sit for one-half hour. Ms. Entenberg opined that Petitioner: could not perform his prior job as a welder fitter; was a good candidate for vocational rehabilitation, and could earn $9.00 to $12.00 per hour at an entry-level light duty job such as a packer or assembler. Ms. Entenberg admitted, however, that she had not reviewed any of Petitioner's treating records since his accident and was unaware of the restrictions Petitioner's treating doctors had given him. She acknowledged Petitioner occasionally lifted weights greater than recommended by Dr. Coe, and that he was the one who made the decision to stop looking for work. She acknowledged that Dr. Coe did not restrict Petitioner from sitting, standing or driving a car. Ms. Entenberg failed to mention in her report that Dr. Brooks had released Petitioner to a trial of full duty work. She agreed Petitioner did not need a training program, and in her opinion, was currently employable.

Respondent IWBF first seeks dismissal of Petitioner's §19(h)/8(a) Petition due to alleged lack of notice and due process: not to itself, but to the underlying employer, Fastrak. It is not clear whether Respondent IWBF has standing at this juncture to object to alleged lack of notice and due process to another Respondent, Fastrak, especially given the prior history at the original hearing. Regardless, IWBF does not dispute that Fastrak was uninsured on Petitioner's date of accident, or that Fastrak's corporate entity was involuntarily dissolved by the state on December 11, 2009. Prior to arbitration, Petitioner unsuccessfully attempted personal service of notice of the hearing date upon Fastrak, which by that point had ceased operations as a business. Respondent IWBF previously acknowledged its role and responsibility in this matter by paying the Arbitration award rendered in this matter. No practical purpose would be served by requiring Petitioner herein to re-attempt service or notice on Fastrak, which would in all likelihood prove futile.

Irrespective of this argument, the Commission finds Petitioner has not proven that since arbitration, he suffered a causally related material increase in his disability pursuant to §19(h), or entitlement to further benefits under §8(a) of the Act. The evidence supports a finding that Petitioner attained maximum medical improvement for his work injuries prior to the arbitration hearing. Dr. Coe testified to this at his September 2011 deposition, opining that Petitioner, "had long reached maximum medical improvement." The Commission finds Dr. Coe's subsequent reversal of that opinion unpersuasive. The fact that Petitioner worked as a welder for a year and a half after his accident, up to 12 hours a day, 6 days a week, further supports the conclusion that he had achieved MMI and returned to his pre-accident baseline prior to the June 25, 2012 arbitration hearing. The Commission finds significant the fact that none of the following treating physicians offered any opinions that Petitioner's post-arbitration treatment was causally related to his work accident: Drs. Gahl, Vo, Alsaraf, Rohrbacher, Brooks, Deladisma, Schroeder, Leu and Holz.

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The Commission finds inaccurate Dr. Coe's conclusion that the history of accident which Petitioner gave him was "generally consistent" with the history Petitioner provided to his initial treaters. Petitioner told Dr. Coe he fell off an 8-foot ladder and struck his head, neck and tailbone. The emergency room records, on the other hand, report Petitioner's history of falling from only 2 or 3 rungs, and contained no history of him striking his tailbone or back. In the emergency room, Petitioner expressly denied experiencing back pain.

In finding Dr. Coe's causation opinions unpersuasive, the Commission notes Dr. Coe admitted Petitioner's low back symptoms persisted since his initial L4-L5 fusion, which predated Petitioner's accident. Dr. Coe admitted Petitioner's September 2, 2011 EMG showed no impingement or irritation of Petitioner's lumbar nerve roots at that time. At Dr. Coe's September 23, 2011 deposition, he expressly denied performing an examination of Petitioner's neck or lower extremity on February 5, 2008. Dr. Coe contradicted this testimony at his March 28, 2016 deposition, when he claimed that he did examine Petitioner's neck and lower extremity at the February 2008 visit.

Dr. Brooks, Petitioner's treating surgeon, reported on September 11, 2012 that Petitioner's lumbar MRI taken the week before showed new findings not present on Petitioner's prior MRI study: a new L5-S1 disc herniation off to the left side with severe central and lateral recess stenosis. A 2009 MRI similarly documented that Petitioner's lumbar spinal canal was the congenitally narrowed. Dr. Brooks found Petitioner's congenital lumbar stenosis significant enough to impinge on any of his nerve roots. The September 2012 surgery Dr. Brooks performed was done to correct that problem. The Commission finds Petitioner's post-arbitration treatment and symptoms were not related to his accident, but rather, to his congenitally narrowed lumbar spinal canal and the new L5-S1 disc findings first demonstrated on the September 2012 MRI, some 4 years after his work accident.

The Commission also finds Petitioner's credibility questionable. He testified he was given a 10-lb. lifting restriction from his treaters, yet Dr. Brooks' records reveal he released him with a 25-lb. restriction in November 2012 and released him to full duty in March 2013. Petitioner denied the histories in his initial treaters' records were accurate. Contrary to what Petitioner told Dr. Coe – that his back pain began after his February 25, 2008 accident – Petitioner told Dr. Brooks he wasn't sure what caused his back problems, speculating it could have been his 2006 lifting injury, his 2008 fall, his work as a welder or his 600 parachute jumps.

Many of Petitioner's post-arbitration symptoms which he attempts to attribute to his February 25, 2008 accident are traceable to other times and events. Petitioner told Dr. Gahl on August 6, 2014 that he had neck pain since 2004. Petitioner told Dr. Walker that his back pain and numbness began after his 2007 lifting accident, not after the subject 2008 accident. He told Dr. Vo on August 1, 2012 that his pains were exacerbated in the past few weeks. He reported to Dr. Deladisma on February 8, 2016 that his neck pain was a new problem which started between one and four weeks earlier. In November 2016 Petitioner told Drs. Schroeder and Leu that he strained his right calf muscle and right Achilles tendon in October 2016 while doing work on a roof. He told his physical therapist at a February 19, 2013 evaluation that his right leg pain and numbness dated back to his 2007 microdiscectomy surgery.

Although Petitioner has undergone lumbar surgery since arbitration, he has neither proven that surgery was related to the injury at issue, nor that he sustained a material change in his disability. Petitioner is as physically active now as he was at arbitration: he drives a car, remodels his house, and even climbs onto his roof to do repairs. His current restrictions, need for pain management treatment, and complaints of back and leg pain were all present at time of arbitration. None of those factors have materially changed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h) and §8(a) Petitions are denied.

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

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

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

DATED: SEP 12 2017

o-07/26/17
jdl/mcp
68

Joshua D. Luskin

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ruben Cantu,
Petitioner,

v.

NO: 08 WC 27289

A&M Napa Auto Parts,
Respondent.

17IWCC0565

DECISION AND OPINION ON REVIEW

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

Credit

The March 13, 2015 Request for Hearing reflects the parties stipulated Petitioner was temporarily and totally disabled from December 22, 2007 through August 31, 2012, and Respondent was entitled to a credit of $77,587.00 for payment of TTD benefits. ArbX1. The Commission notes identical stipulations were made as part of the 2013 §19(b) hearing and both the TTD award and Respondent's credit were incorporated in Arbitrator Cronin's May 5, 2014 order and decision. ArbX2. As Respondent's $77,587.00 credit was awarded in the prior decision, the Arbitrator's finding of a $77,587.00 credit is duplicative and is hereby vacated.

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Findings of Fact

Petitioner was the only witness to testify at the March 13, 2015 hearing. He described the December 22, 2007 work accident, stating he slipped on stairs while carrying auto supplies, then summarized his course of treatment: Petitioner was initially seen at LaGrange Medical Center; he thereafter underwent chiropractic treatment at Midwest Chiropractic until he was referred to orthopedist Dr. Mitchell Goldflies. Dr. Goldflies obtained an MRI of the lumbar spine and subsequently referred Petitioner to pain management specialist Dr. Diesfeld as well as to Dr. Malek, a spine surgeon. Dr. Diesfeld administered nerve blocks, which Petitioner testified were ineffective. Dr. Malek's treatment consisted of nerve blocks as well as work up with a discogram, after which he recommended lumbar fusion. Around this time, it was determined Petitioner sustained an inguinal hernia during the work accident; this was surgically repaired by Dr. Diniotis. T.9-16. A May 6, 2011 FCE placed Petitioner at Sedentary strength category, able to lift 10 pounds and carry three (3) pounds. PX17. The Commission notes this was the same treatment addressed in the July 22, 2013 §19(b) hearing.

Petitioner testified his hernia symptoms did not improve after his surgery, and he has since been diagnosed with nerve entrapment. T. 16 Although prospective medical was not identified as a disputed issue at the March 13, 2015 hearing, Petitioner testified additional surgery has been recommended for the hernia and he wishes to have that surgery as well as the lumbar fusion surgery. T. 17. Petitioner testified he last saw Dr. Goldflies approximately a year before the hearing. T. 23. No updated medical records were offered into evidence. T. 43.

As to how the December 22, 2007 accident has affected his life, Petitioner testified, "I'm not as active. I don't play sports with my nephews, with respect to the intimacy with my wife." T. 23. Prior to the accident, "I was more active. I could go for walks, ride bikes. I don't do that anymore." T. 23. Petitioner did not testify as to any current symptoms or pain complaints.

Petitioner was queried about his job search efforts since the prior hearing. Petitioner stated he has continued to look for work without success but did not produce any job logs or other records to document his job search activities. T. 22, 36-38. He agreed that when he had worked with the vocational rehabilitation specialist, she had impressed upon him the importance of maintaining an organized job search. T. 37. He testified he has "Gone to different places, applied, asked around, applied different places." T. 36. When asked what his typical day involves, he responded, "Different things different days…I take my wife to work. I pick her up. I do some of the things that I have to do…Well, sometimes I might have to like go to the bank, might have to go to the insurance company, you know, go to the post office." T. 39. Besides errands, "I have been looking for a job also. I've been going to different places filling out applications." T. 40.

Conclusions of Law

There are two anatomical aspects to this claim: the hernia and the lumbar spine. With respect to the hernia, Petitioner was diagnosed with a right inguinal hernia and Dr. Diniotis

performed repair surgery on June 28, 2010. The record indicates Petitioner did not have a good surgical result; rather, he has nerve entrapment and additional surgery was recommended in the past. Due to Petitioner's body habitus and his failure to lose the weight necessary for surgery to proceed, however, that procedure was never performed. Although Petitioner testified the surgery is still recommended, he offered no current medical recommendation to that effect.

As to the lumbar spine, Petitioner was diagnosed with a disc herniation at L5-S1. Although once considered a surgical candidate, there is no such surgical recommendation currently, and in fact that seems to have been rescinded in 2011. The May 6, 2011 FCE imposes restrictions of sedentary strength category with no lifting over 10 pounds and no carrying over three pounds. PX17.

Under the Act, a claimant has the burden of proving the extent and permanency of his injury by a preponderance of the evidence. *Chicago Park District v. Industrial Commission*, 263 Ill. App. 3d 835, 843, 635 N.E.2d 770 (1994). Here, Petitioner's evidence of disability is limited to medical treatment rendered prior to the 2013 Section 19(b) hearing and his testimony regarding his ongoing unsuccessful search for employment. The Commission notes Petitioner failed to provide evidence substantiating his job search efforts despite the prior Section 19(b) decision finding Petitioner was noncompliant with vocational rehabilitation and failed to cooperate in the job search. The Commission finds Petitioner's uncorroborated testimony regarding his ongoing job search efforts not to be credible.

The Commission additionally highlights the reports and 2013 testimony of vocational experts Kim Hoyt and Peter Schneider. Ms. Hoyt's initial assessment documents Petitioner has a varied vocational history with experience as a delivery driver, cashier, retail clerk, security officer, fast food clerk, and warehouse worker. ArbX4, RX8G. Ms. Hoyt testified Petitioner has numerous skills, including prior experience in law enforcement and retail, and is bilingual, and these skills transfer to a variety of positions. ArbX4, 7/22/13 Trans p.120. Similarly, Mr. Schneider, who handled Petitioner's case for a short time and also reviewed Ms. Hoyt's file, opined Petitioner could have found employment if he cooperated with vocational rehabilitation. ArbX4, 9/17/13 Trans p.39.

The Commission further emphasizes the lack of evidence establishing Petitioner's current physical condition. Petitioner testified he saw Dr. Goldflies in 2014 yet did not offer those records into evidence. Moreover, while it is true the May 6, 2011 FCE reflects substantial physical limitations, the Commission finds it significant Dr. Goldflies testified the restrictions were not solely reflective of Petitioner's lumbar and hernia conditions but instead were due in part to Petitioner's deconditioning: "So I'm sure if he had a personal trainer and a focused exercise program, we could probably get him in much better shape and maybe upgrade him a little bit as far as his lifting capacity…I think his testing level, the level he tests as now is less because he's just really in bad physical shape." PX5B, p.26-27.

Based on our review of the evidence, the Commission reduces the permanent partial disability award to 25% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's credit of $77,587.00 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $252.00 per week for a period of 125 weeks, as provided in Section 8(d)2 of the Act, for the reason the injuries sustained caused 25% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,600.00. 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: SEP 18 2017

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 7/26/17

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

Received 7/27/15

CANTU, RUBEN
Employee/Petitioner

Case# 08WC027289

A & M NAPA AUTO PARTS
Employer/Respondent

17IWCC0565

On 7/17/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3259 McCREADY GARCIA & LEET PC
EDWIN REYES
10008 S WESTERN AVE
CHICAGO, IL 60643

2542 BRYCE DOWNEY & LENKOV
RICHARD LENKOV
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ruben Cantu
Employee/Petitioner

v.

A & M Napa Auto Parts
Employer/Respondent

Case # 08 WC 027289

Consolidated cases:

17IWCC0565

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago**, on **3-13-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 12-22-07, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ 21,840.00; the average weekly wage was $ 420.00.

On the date of accident, Petitioner was 39 years of age, *married* with 0 dependent children.

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

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

Respondent shall be given a credit of $77,587.00 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $77,587.00.

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

ORDER

THE ARBITRATOR FINDS THAT PETITIONER SUFFERED THE PERMANENT PARTIAL LOSS OF A MAN AS A WHOLE TO THE EXTENT OF 50 % THEREOF.

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

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

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

Signature of Arbitrator

07-18-15
Date

ICArbDec p. 2

JUL 17 2015

008128.0336

ILLINOIS WORKERS' COMPENSATION COMMISSION

RUBEN CANTU,	)	
	)	
Petitioner,	)	
	)	No. 08 WC 027289
v.	)	
	)	
A & M NAPA AUTO PARTS,	)	
	)	
Respondent,	)	

ARBITRATOR'S DECISION

This case previously was tried before Arbitrator Brian Cronin, pursuant to Section 19(b), on 07-22-13, 09-17-13 and 11-22-13. The disputed issues included causal connection, medical expenses, temporary total disability benefits, prospective medical treatment and penalties.

In a 05-05-14 decision, Arbitrator Cronin found:

1. Petitioner failed to prove that he was entitled to maintenance benefits as he was non-compliant with vocational rehabilitation;

2. Petitioner failed to prove that he was entitled to prospective medical treatment;

3. Petitioner failed to prove that he was entitled to penalties and attorney fees;

4. Respondent shall be liable for unpaid medical expenses except those balances that were written off and subject to Section 8.2 of the Act;

5. Respondent shall receive credit for all prior payments.

On 03-13-15, this case proceeded to trial before Arbitrator Carlson. The disputed issues included causal connection, medical expenses and nature and extent. The Arbitrator adopts and incorporates the findings of Arbitrator Cronin's 5-5-14 decision into the present decision.

I. STATEMENT OF FACTS

The Petitioner fell down stairs at work while carrying auto supplies. He injured his low back, thoracic spine and abdomen (hernia). Later, he was terminated from employment while on light duty.

The thoracic MRI showed small central disc protrusions at T6-7, T7-8, and T9-10.

The lumbar MRI showed desiccation of the L5-S1 disc; diffuse bulging at L5-S1.

A lower extremity EMG showed mild irritability of the left extensor halluces longus and left L5-S1 paravertebral muscles.

Petitioner underwent three epidural steroid injections and eventually, low back surgery (fusion) was prescribed, but never performed as the Petitioner was unable to quit smoking and lose enough weight. Petitioner did undergo hernia surgery with mesh insertion. He now suffers a nerve entrapment injury as result of the hernia surgery. A mass excision was never performed.

The Petitioner was released to permanent sedentary duty work by his treating physician on October 17, 2012. Respondent's Section 12 examiner agreed that sedentary work was appropriate. Maximum lifting is limited to 10 pounds and carrying of three pounds.

The Petitioner has never returned to gainful employment nor did he comply with vocational rehabilitation. He has not quit smoking. He has not list weight.

There is no current prescription for hernia surgery or lumbar surgery.

At the time of the occurrence, Petitioner was 39 years old, not a high school graduate, nor a GED holder.

2) Petitioner's Testimony on 3-13-15

Petitioner testified that was married with no children. His primary language is English and he also speaks Spanish. His highest level of education was a junior in high school. He does not have a GED. His employment history included unskilled manual labor jobs (T 7-8).

Petitioner testified that on 12-22-07, he had been employed by Respondent for four to five months. He was working full time, earning $10.50 per hour. He did not receive any special training and described his position with Respondent as demanding. He enjoyed working for Respondent (T 9-10).

Petitioner testified that while working on 12-22-07, he slipped and fell down stairs while carrying auto supplies. He noticed pain in his back and his arms were scratched. The accident was witnessed by Chuck Martin and Craig Dekarzik. He notified his boss, George Zarski, about the accident. Mr. Zarski sent Petitioner to LaGrange Medical Center for treatment (T 10-12).

Petitioner testified that he was treated at LaGrange Medical Center for complaints of low back pain. Treatment included physical therapy and x-rays. He returned to light duty work and continued on light duty for about five months until he was terminated on 6-8-08 (T 12-13).

Follow up care was provided by Midwest Chiropractic. Midwest Chiropractic recommended that Petitioner be evaluated by Dr. Goldflies, an orthopedic surgeon. The doctor recommended a lumbar MRI. Petitioner was referred to Dr. Diesfeld for pain management and to Dr. Malek for low back treatment (T 13-15).

Petitioner testified that Dr. Diesfeld administered two nerve block injections without improvement of symptoms. Dr. Malek recommended a lumbar fusion (T 15).

Petitioner was also diagnosed with an inguinal hernia by Dr. Diniotis and underwent surgery. His symptoms did not improve following surgery due to entrapped nerves. Further hernia surgery has been recommended but not authorized (T 16-17).

Dr. Malek recommended low back surgery that has not been authorized (T 17).

Petitioner testified that he wanted to proceed with both surgeries. It was recommended that hernia surgery be performed first (T 17-18).

At the request of Dr. Goldflies, Petitioner underwent a functional capacity evaluation on 5-6-11 and 5-11-11 (T 18).

Petitioner underwent independent medical evaluations for his low back, by Dr. Salahi, on 4-24-08, 10-1-09, 8-24-10, 10-10-11 and 5-20-12. He underwent an independent medical evaluation for his hernia by Dr. Deziel. Neither doctor made a recommendation regarding treatment (T 18-20).

Petitioner underwent vocational rehabilitation with Kim Hoyt at the request of Respondent. Ms. Hoyt assisted Petitioner in preparing a resume. Petitioner testified that he cooperated with vocational rehabilitation but was unable to find a job (T 20, 22). Temporary total disability benefits were terminated on 9-2-12. Petitioner has continued to look for a job but has not located employment. His wife works and supports the family (T 22).

Petitioner testified that as a result of the 12-22-07 accident, he is not as active. He no longer plays sports with his nephews and encounters intimacy problems with his wife. He no longer goes for walks or bike rides (T 22-23).

Petitioner wants to return to work. He wants to resume medical treatment and wants to undergo low back and hernia surgery. His last examination with Dr. Goldflies was over one year earlier (T 23-24).

On cross-examination, Petitioner testified that he was truthful at the previous hearing and at the present hearing and agreed that there was no change in his answers (T 25)

Petitioner agreed that he previously testified that he was unable to undergo hernia or back surgery until he lost weight, that he was unable to undergo back surgery until he quit smoking (T 25-26).

Petitioner testified that he is not currently smoking. He also testified that he cooperated with vocational rehabilitation despite the findings of Arbitrator Cronin that he refused to meet with a vocational rehabilitation expert, failed to fix his car and refused to use public transportation to conduct a job search (T 27-29).

Petitioner testified that "I wasn't sent anywhere" with regard vocational rehabilitation and that he conducted a job search, was willing to use public transportation and was compliant at a Moraine

Valley job fair. He agreed that Arbitrator Cronin found that he was unwilling to use public transportation. Petitioner also agreed that he expressed concerns to potential employers but denied that he refused to attend four job fairs (T 29-32).

He testified that he was cooperative but that he did not attend four job fairs because they were tot far on the bus and he was not working (T 34).

Petitioner agreed that he was instructed by the vocational rehabilitation expert to complete job logs but that he has not done so despite his testimony that he continues to look for employment. He does not recall what his weight was when he previously testified and has not seen a doctor for over one year. His days include driving his wife to work and "sometimes going to the bank, insurance company or post office. He has also gone different places to fill out applications (T 38-40).

Petitioner is currently taking Naproxen 500 for an unrelated medical condition (T 40).

II. FINDINGS

With regard to issue (F) Is Petitioner's current condition of ill-being causally related to the injury? and (L) What is the nature and extent of the injury?, the Arbitrator finds:

At the 03-13-15 hearing, the parties agreed that the entire record and Arbitrator Cronin's decision from the earlier 19(b) proceedings would be entered into the record and used in reaching a decision in the present case.

The Arbitrator adopts the following summary of medical treatment, as contained in the 05-05-14 decision of Arbitrator Cronin, as no additional medical evidence was introduced into evidence at the 03-13-15 hearing other than a 05-06-11 Liberty Physical Therapy functional capacity evaluation that released Petitioner to sedentary work (P Ex 17):

> Petitioner testified that he injured his low back and arms when he slipped and fell down stairs while working on 12/22/07. Initial treatment was provided at LaGrange Medical Center on 12/24/07. Petitioner was diagnosed with a back muscle strain and a strain of both forearms. He was placed on light duty. On 01/28/07, Petitioner was released to return to work without restrictions.
>
> Follow up treatment was provided by Midwest Chiropractic. In addition, Petitioner was treated by Dr. Goldflies beginning on 01/31/08. Petitioner underwent the following:
>
> 02/06/08 Thoracic MRI
>
> - Multilevel degenerative disc changes from T6 through T12 with relative sparring of T10-11 intervertebral dis;
> - Small central disc protrusions at T6-7, T 7-8 and T9-10;
> - No evidence of any cord abnormalities.

02/06/08 Lumbar MRI

- Desiccation of L5-S1 disc;
- Diffuse bulging superimposed on small disc protrusion at L5-S1;
- Mild congenital narrowing at L5-S1;
- Early degenerative changes in the facet joints at L5-S1.

02/19/08 lower extremity EMG/NCV

- Mild irritability of the left extensor hallucis longus and left L5-S1 paravertebral muscles.

Dr. Goldflies diagnosis was left L5-S1 radiculopathy, disc protrusions at C6 through T10 with degeneration and a left L5-S1 disc herniation. On 03/08/08, Petitioner was released to light duty. On 06/08/08, Petitioner was referred to Dr. Malek.

Petitioner underwent three lumbar epidural steroid injections by Dr. Diesfeld on 03/06/08, 03/20/08 and 04/01/08.

Petitioner was evaluated by Dr. Malek on 06/13/08. Petitioner failed to improve following two bilateral L5-S1 transforaminal epidural injections. On 11/21/08, Dr. Malek recommended an L5-S1 fusion.

On 12/08/08, Petitioner was evaluated by Dr. Diniotis. The diagnosis was a right inguinal hernia. On 06/28/10, Petitioner underwent a right inguinal hernia repair with mesh (P Ex 10).

Petitioner testified that he is in need of further hernia surgery. He also testified that he wanted to undergo the lumbar surgery recommended by Dr. Malek. On cross examination, Petitioner admitted that he cannot undergo hernia surgery until he loses weight and cannot undergo low back surgery until he has the hernia surgery and stops smoking. Petitioner testified that he only stopped smoking three months prior to the 07/22/13 hearing. Petitioner initially testified that he has lost some weight and later testified that he has always been about the same weight.

On 11/08/11, Dr. Goldflies testified regarding spinal surgery and indicated that he would defer to his surgeon but "I'm not sure that the spinal surgery at this point would resolve his symptoms." Dr. Goldflies further testified that Petitioner could return to work with restrictions (P Ex 5B, pp 15, 17). Dr. Goldflies again released Petitioner to sedentary work on 10/17/12 (P Ex 5B).

At Respondent's request, Petitioner underwent an independent medical evaluation by Dr. Salehi on 04/24/10 and 10/01/09. In a subsequent 10/10/11 report following review of updated medical record, Dr. Salehi indicated that absent surgery, Petitioner was at MMI. The doctor also indicated that Petitioner's work restrictions should be based upon a 05/06/11 FCE that placed Petitioner at a sedentary work capacity with maximum lifting of 10 pounds and carrying of 3 pounds (R Ex 4).

In a 5/20/12 report, Dr. Salehi indicated "I agree with Dr. Goldflies impression that he is not a good surgical candidate but for the following reasons: 1. He smokes increasing chances of fusion non-union and surgical complications, 2. His elevated BMI of 41 increasing chances of instrumentation failure and, 3. His symptoms have been present for now nearly five years making his success rate for pain relief less." (R Ex 5).

On 03-13-15, Petitioner testified that he has had one doctor visit, about one year earlier, since he last testified on 07-22-13.

Although he testified that he wants to undergo hernia and low back surgeries that were previously recommended, he presented no current medical evidence to demonstrate that surgery is still indicated or necessary. To the contrary, the most recent medical information is the 05-20-12 Dr. Salehi report in which the doctor indicated that he agreed with Dr. Goldflies that Petitioner was not a good surgical candidate. On 10-10-11, Dr. Salehi indicated that absent surgery, Petitioner is at maximum medical improvement.

In addition, Petitioner agreed that he was unable to undergo the previously recommended surgery several years earlier as he needed to lose weight and stop smoking. At trial, Petitioner testified that he did not recall what his weight was at the time of the prior hearing and did not present any evidence that he had lost weight at the present hearing. He testified that he is not currently smoking.

Although Petitioner testified that he continues to look for employment, he admitted that he had no job logs or evidence of a job search despite the vocational rehabilitation expert's instructions that records needed to be kept.

Petitioner testified that as a result of the 12-22-07 accident, he is not as active and encounters intimacy problems with his wife. He testified that his days include driving his wife to work and occasionally going to the bank, insurance company or post office.

In his 05-05-14 decision, Arbitrator Cronin found that Petitioner's testimony that he cooperated with Respondent's vocational rehabilitation efforts was not credible and concluded that Petitioner "...demonstrated noncompliance and lack of good faith effort to locate employment," Maintenance benefits, prospective medical care and penalties sought by Petitioner were denied.

Despite the testimony and evidence presented by Kimberly Hoyt and Peter Schneider that Petitioner was noncompliant with vocational rehabilitation and the prior finding of Arbitrator Cronin, Petitioner again testified that he had cooperated with vocational rehabilitation and denied that he had undermined the vocational rehabilitation process.

Despite the above, it agreed that the Petitioner is an unskilled worker with significant sedentary work restrictions.

Based upon the foregoing, the Arbitrator finds that as a result of the accident of 12-22-07, Petitioner sustained the permanent partial loss of use of a man as a whole to the extent of 50% thereof.

With regard to issue (J) Has Respondent paid all appropriate charges for all reasonable and necessary medical services?, the Arbitrator Finds:

Petitioner failed to present any evidence of unpaid medical bills at the present hearing. For this reason, the Arbitrator finds that Petitioner filed to prove that he is entitled to additional unpaid medical expenses as a result of the 12-22-07 accident.

III. CONCLUSION

Based upon the foregoing, the Arbitrator finds that Petitioner sustained the permanent partial loss of use of a man as a whole to the extent of 50% thereof.

Petitioner failed to prove that he is entitled to additional medical expenses as no additional medical bills were presented at trial.

Arbitrator Kurt Carlson

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Walter Kohut,

Petitioner,

vs.

NO: 08 WC 40069

17IWCC0551

Bakers Square,

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 and being advised of the facts and law, affirms the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the following modification:

Consistent with *Will County Forest Preserve v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 11077WC, the arbitrator's award of Permanent Partial Disability for the 40% loss of use of the right arm is modified to an award based on 20.25% of the loss of use of the man as a whole. This modification does not change Petitioner's overall award.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated July 16, 2015, is modified as stated herein.

17IWCC0551

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

DATED: SEP 7 - 2017
o:7/18/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOHUT, WALTER
Employee/Petitioner

Case# **08WC040069**

BAKERS SQUARE
Employer/Respondent

17IWCC0551

On 7/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST 7TH FL
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

17IWCC0551

WALTER KOHUT
Employee/Petitioner

Case #08 WC 40069

v.

BAKERS SQUARE
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 June 23, 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 August 21, 2008, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- 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 $17,160.00; the average weekly wage was $330.00.
- At the time of injury, the petitioner was 29 years of age, single with no children under 18.
- The parties agreed that the respondent paid $19,140.00 in temporary total disability benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 45 weeks, from August 21, 2008, through July 1, 2009, which is the period of temporary total disability for which compensation is payable. The respondent is entitled to an offset of $19,140.00 in temporary total disability benefits paid to the petitioner.
- The respondent shall pay the petitioner the sum of $206.67/week for a further period of 101.2 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 40% loss of use of his right arm.

- The respondent shall pay the petitioner compensation that has accrued from August 21, 2008, through June 23, 2015, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his cervical and lumbar spine through December 31, 2008, and his right shoulder through April 16, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his cervical and lumbar spine after December 31, 2008, his right knee and ankle and his depression was not reasonable or necessary and is denied. The medical costs for the petitioner's medical care that was not provided by Drs. Primus and Thometz and their referrals are denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

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

Robert E. Williams

Signature of Arbitrator

July 16, 2015

Date

JUL 16 2015

FINDINGS OF FACTS:

The petitioner, a cook with the respondent for approximately three weeks, sustained injuries on August 21, 2008, when he slipped on an avocado slice and fell backwards while breaking his fall with his right hand. The petitioner continued working until 5:00 pm and later sought medical care. The records of his initial medical care are not in evidence. On August 28th, the petitioner saw Dr. Primus for right shoulder pain and reported that the precipitating cause was a fall on the 21st. He reported symptoms of neck pain and lower back pain with numbness and tingling distally. X-rays of his shoulder were negative. The doctor's assessment was shoulder pain for which he advised the petitioner to avoid throwing, any overhead activities and any weightbearing with his right arm. The petitioner reported improvement on September 2nd especially in his lower back and neck but continued elbow and shoulder pain. On September 6th, Dr. Primus noted that the official report of the right shoulder MRI confirmed his findings of an abnormal signal of the anterior labrum, rotator cuff tendonitis and acromioclavicular joint arthrosis. He also noted that there was no Hill-Sachs or SLAP lesions. The doctor's assessments were shoulder and upper arm sprains and strain, a superior glenoid labrum lesion and an anterior labrum tear - Bamkart's lesion. A diagnostic arthroscopy of the petitioner's right shoulder was recommended on September 17th. The petitioner reported paresthesia and weakness on October 7th and an EMG/NCS was ordered to evaluate for a brachial injury. A cervical spine MRI on November 13th showed mild degenerative changes but no central canal or neuroforaminal stenosis. A chest and right shoulder x-ray the same day revealed no definitive evidence for a right brachioplexus injury.

At the request of respondent, Dr. Salehi evaluated the petitioner on November 18th. Dr. Salehi opined that during the physical examination the petitioner exhibited significant positive Waddell signs and, in light of his normal cervical MRI, unjustified significant cervical spine limitations. The doctor further opined that the petitioner would have reached MMI approximately six weeks post injury and was capable of performing his pre-injury job as regard to his cervical and lumbar spine.

An independent medical evaluation was performed at the request of respondent by Dr. Marra at Loyola University Medical Center on January 6, 2009. Dr. Marra opined that the petitioner was a candidate for a right shoulder arthroscopic repair of his anterior-inferior labral tear.

On March 24, 2009, Dr. Primus performed a subacromial decompression, arthroscopic SLAP lesion repair, suprascapular nerve block and insertion of a pain pump. Dr. Primus noted objective findings of an intact glenohumeral joint, no rotator cuff tear or irritation, fraying along the superior labrum with partial detachment of the biceps anchors, moderate synovitis about the superior aspect of the joint, significant thickened bursitis in the subacrominal space, a moderate-sized spur and mild irritation of the rotator cuff. The diagnosis was a right shoulder impingement and superior labral lesion. The petitioner received physical therapy and on May 26, 2009, Dr. Primus released him to sedentary work with ten-pound restrictions and planned full-duty release in three months. His pain medications were discontinued and physical therapy was continued.

Accomondated work consistent with Dr. Primus's release was offered the petitioner on July 1, 2009, beginning on July 6, 2009. The petitioner did not accept the job offer. On August 12, 2009, the petitioner sought care at a Cook County Health

Systems for neck, back, right knee and right ankle pain. X-rays of his right knee and shoulder were normal.

The petitioner saw Dr. Thometz on August 26, 2009, for neck pain with posterior radiating pain into his head, diffuse right shoulder pain with radiating pain into his neck and intermittent right hand numbness, tingling and weakness. Dr. Thometz opined that the petitioner was not capable of regular work. A cervical MRI on October 22, 2009, did not reveal any significant change in his mild multilevel disc degeneration or any significant central or meuroforaminal stenosis. A right shoulder MR arthrogram on October 30, 2009, showed mild fraying along the anterior distal bursal surface of the supraspinatus, subscapularis tendinosis but no labral tears. Dr. Thometz recommended more physical therapy on November 4, 2009.

Dr. Marra opined after an independent medical evaluation on January 26, 2010, that the petitioner had a profound loss of motion in his shoulder, both active and passive, and that the latest MRI did not show any tearing of the rotator cuff or labrum. Dr. Marra stated that the petitioner could return to work with lifting restrictions of five pounds.

On March 3, 2010, the petitioner returned to the Cook County Health Systems for neck pain of three-day duration with headaches and increased neck pain with movement. The assessment was cellulitis and swelling of the right side of his neck. Cervical spine, chest, right shoulder and right knee x-rays were normal. A CT scan of his head/brain on March 2, 2010, was normal. CT scans of his facial bones and the soft tissue of his neck on October 24, 2010, was compatible with cellulitis along his right neck and jaw line. Dr.

Thometz noted on April 21, 2010, that the petitioner was given a subacromial injection and therapy was continued.

An EMG on July 15, 2010, was normal. Dr. Cole evaluated the petitioner on November 15, 2010, and opined that the October 2009 MR arthrogram revealed a bursa-sided partial thickness tear of the supraspinatus and an intact rotator cuff, that the petitioner's condition was consistent with a neurologic injury and further interventions for his shoulder would not provide him any relief. Dr. Cole felt that the petitioner could work with sedentary work restrictions. Dr. Thometz noted no significant change with the petitioner's complaints at follow-ups through May 18, 2011.

On June 1, 2011, the petitioner returned to Cook County Health Systems primarily for right shoulder and right knee pain. It was noted that right shoulder, knee and ankle x-rays were normal and cervical and lumbar CT scans showed straightening of his upper cervical lordosis, levoscoliosis of the lumbar vertebrae and bulging discs most prominent at L5-S1 without evidence of foramina narrowing. He reported the same difficulties with his shoulder to Dr. Thometz on June 29 and August 24, 2011.

Lumbar and right hand x-rays on September 26, 2011, were negative. The petitioner received care at Cook County Health Systems for right leg, right arm, bilateral shoulders, neck and back pain on March 21, 2012, and followed up on April 3rd, 10th, 17th, and 24th. The last diagnosis was nonallopathic lesions of his lumbar and sacral regions. The petitioner received care at Ingalls Memorial Hospital on June 5, 2012, for generalized pain and low back pain. His upper extremity examination was normal. The diagnosis was myalgia. He received physical therapy for his right shoulder at Cook County Health Systems periodically from October 16, 2012, through January 15, 2013. A

cervical MRI on March 29, 2013, revealed mild degenerative changes at C2/3, C3/4, C4/5 and C5/6 and a slight narrowing of the left neural foramen between C3/4 and C5/6. He followed up at the health facility on January 22, 2013, and April 2, 2013.

After a follow-up evaluation on July 25, 2013, Dr. Marra indicated that the petitioner's treatment for his shoulder has been reasonable and necessary and he recommended a right shoulder MR arthrogram to rule out any major structural abnormalities. The petitioner returned several times to the County health facility for help with depression from August 9, 2013, through November 20, 2013.

An upper extremity MR arthrogram on December 5, 2013, was reported as showing contrast material extending from the insertion of the biceps anchor posteriorly through the superior labrum to the 2 o'clock position compatible with a large SLAP tear of the glenoid labrum. Dr. Thometz opined on December 11, 2013, that the MR arthrogram showed abnormalities in the superior labrum suggestive of a superior labral tear. On April 16, 2014, Dr. Marra opined that the MRI scans did not show evidence of a SLAP tear or a recurrent rotator cuff tear and no structural lesions that could account for the petitioner's complaints. He opined that the petitioner did not need any further treatment and that he could return to work at the medium physical demand level. He disagreed with the radiologist's report because the only image of contrast extending over the rim of the glenoid was a normal anatomic variant at the sublabral foramen.

Lumbar and cervical MRIs on June 19, 2014, revealed minimal central canal stenosis at L3/4 and L4/5, and mild reversal of normal cervical lordosis and minimal central disc protrusion at C7-T1. Dr. Thometz recommended that the petitioner undergo arthroscopic evaluation and treatment on June 25, 2014.

The petitioner started care with Dr. Garbis at Loyola on March 20, 2015, for his right shoulder. Dr. Garbis recommended arthroscopy with debridement and biceps tenodesis. The petitioner reported no change in his shoulder pain to Dr. Thometz on March 25, 2015. Dr. Thometz recommended an arthroscopic evaluation and, possibly, a biceps tenodesis and a labral repair.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right shoulder is partially related to the work injury. The petitioner failed to prove that his current condition of ill-being with his neck, back, right knee and right ankle and that the labral tear diagnosed in the sublabral foramen area of his right shoulder is causally related to the work injury.

The medical evidence does not support the petitioner's contention of right knee and ankle injuries. He did not report or receive treatment for right knee or ankle symptoms the year prior to seeking treatment at Cook County Health Systems on August 29, 2009. On September 2, 2008, the petitioner reported overall improvement, especially in his lower back and neck. The cervical MRI on November 13, 2008, showed mild degenerative changes only. There was no central canal or neuroforaminal stenosis. And, Dr. Salehi opined on November 18, 2008, that the petitioner exhibited significant positive Waddell signs and unjustified significant cervical spine limitations. He felt that the petitioner should have been at maximum medical improvement for his cervical and lumbar spine strains apporoximately six weeks after the injuries.

Dr. Marra opined that SLAP lesions are diagnosed from the 11 o'clock to the 1 o'clock region, not at two o'clock because that is outside the region where the biceps

tendon inserts into the shoulder and is the sublabral foramen region. Dr. Marra also noted that the radiologist indicated the SLAP tear was not located in the posterior superior quadrant, the area of the SLAP repair and the placement of the suture anchor or in the proper quadrant where SLAP tears are diagnosed but in the anterior superior quadrant that falls outside of the area of a SLAP tear. Dr. Marra further opined that a tear in the 2 o'clock position is not the location of the anchor placement and therefore, it would be a new tear. Dr. Thometz's opinions are not consistent with the surgical report on March 24, 2009, and the MR arthrogram on December 5, 2013.

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

On May 26, 2009, Dr. Primus released the petitioner to sedentary work with a ten-pound restriction and a planned full-duty release in three months. The respondent offered accomondated work to the petitioner on July 1, 2009, and April 19, 2010. The petitioner received but declined the job offers based on Dr. Thometz's restrictions.

The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 45 weeks, from August 21, 2008, through July 1, 2009, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

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

The medical care rendered the petitioner for his cervical and lumbar spine through December 31, 2008, and his right shoulder through the date of Dr. Marra's opinion regarding the MR arthrogram on April 16, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his cervical and lumbar spine after

December 31, 2008, his right knee and ankle and his depression was not reasonable or necessary and is denied. Dr. Thometz was the petitioner's second choice of physicians. The medical costs for the petitioner's medical care that was not provided by Drs. Primus and Thometz and their written referrals are denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that he is obviously incapable of employment or that he cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. The petitioner can perform some form of employment without seriously endangering his health or life. He declined job offers and has not searched for employment.

The petitioner feels he is unable to work or lift as he did prior to his right shoulder injury. He has right shoulder pain, numbness, tingling and weakness. When going out, the petitioner uses a sling for his right arm.

The respondent shall pay the petitioner the sum of $206.67/week for a further period of 101.2 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 40% loss of use of his right arm.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that he is entitled to §19(l) and §19(k) penalties and fees. The evidence was insufficient to establish that the respondent's delay in the payment of temporary total disability benefits was without a good and just cause or their conduct was vexatious and unreasonable. There was a genuine dispute regarding the issue

of causal connection of the petitioner's claim for benefits for his right shoulder, knee and ankle, neck and lumbar injuries. The petitioner's request for penalties and fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA S. FERRIS,

Petitioner,

vs.

NO: 09 WC 2226
10 WC 13757

SARAH BUSH LINCOLN HEALTH SYSTEMS,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan pursuant to Respondent's "Motion to Amend Settlement Contract" which was filed with the Illinois Workers' Compensation Commission on August 10, 2017.

That on May 28, 2016 Arbitrator Edward Lee approved a Settlement Contract Lump Sum Petition and Order in these consolidated claims which was signed by the parties.

That the parties have prepared and filed an "Amendment to The Workers' Compensation Contract to Comply with Medicare Requirements", a copy of which is attached hereto and made a part hereof, which is signed and dated by Petitioner and her attorneys on August 9, 2017.

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, parties may reserve the right to amend an approved 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.

The Commission has reviewed said stipulation, and finds that the subsequent amendment conforms with the regulatory requirements and does not abridge the substantive rights of the parties.

Therefore, it is the Order of the Commission:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Edward Lee on May 28, 2016 is hereby modified by the terms of the agreed stipulation of the parties, copies of which are attached hereto and made a part hereof, so as to conform with the requirements of Medicare and CMS; and,

2. That based upon the Respondent's funding of an MSA in accord with the terms of the Settlement Contract, the Petitioner's rights under Section 8(a) of the Act are hereby closed.

3. That the heretofore approved Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Lee on May 28, 2016, remains in full force and effect, and shall be read in concert with this Agreed Stipulation referenced which are attached hereto and made part of this Order.

DATED: SEP 6 - 2017
MJB/msb
8-23-17
44

Michael J. Brennan

AMENDED

ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death _____

Linda Ferris
Employee/Petitioner

Case # 09 WC 2226 & 10 WC 13757

v.

Sarah Bush Lincoln Health
Employer/Respondent

Setting: Urbana – Arb. Lee

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Linda Ferris
Employee's name

12773 E. County Road, Lerna, IL 62440
Street address City, State, Zip code

Sarah Bush Lincoln Health
Employer's name

1000 Health Center Drive, Mattoon, IL 61938
Street address City, State, Zip code

State Employee? Yes ☐ No ☒ Male ☐ Female ☒ Married ☒ Single ☐

Dependents under age 18 1 Birthdate 5/15/1976 Average weekly wage $ 934.83

Date of accident July 16, 2007 & July 14, 2009

How did the accident occur? During the course of employment - motor vehicle accident & lifting a CPM machine.

What part of the body was affected? Person as a whole.

What is the nature of the injury? Disk bulge at C5-C6, C6-C7, C5-6 anterior cervical fusion, cervical radiculopathy and right cubital tunnel syndrome which medical evidence finds is not causally connected.

The employer was notified of the accident orally ☒ in writing ☒ Return-to-work date: Various

Location of accident Coles County, Illinois Did the employee return to his or her regular job? Yes ☐ No ☒
If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

Petitioner is doing her own vocational job search

TEMPORARY TOTAL DISABILITY BENEFITS: 7/23/2007 – 8/31/2014, at a rate of $677.93 per week, and 9/1/2014 – present, at a rate of $623.22 per week.

MEDICAL EXPENSES: The employer has ☐ has not ☒ paid all medical bills. List unpaid bills in the space below.
Respondent has paid all reasonable and related medical expenses.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ -0- as compensation for the permanent disability caused by this injury.
An arbitrator or commissioner of the Commission previously made an award on this case on Not applicable regarding
TTD $ _____ Permanent disability $ _____ Medical expenses $ _____ Other $ _____

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.
For consideration stated below the parties hereto, hereby compromise and adjust any and all claims for benefits under either the Workers' Compensation Act or the Workers' Occupational Diseases Act, (other than Respondent's lien rights under Section 5) including claims for the cost of first aid, medical, surgical and hospital services and claims for compensation and other benefits on account of any and all injuries, disabilities, death, disablements and diseases, either known or unknown, arising out of the herein described alleged accident or disablement, providing however, that it is distinctly understood by the parties that this Settlement Contract shall be null and void if not approved by the Illinois Workers' Compensation Commission. This is a compromise settlement and is mutually understood and intended to be a purchase of peace, to avoid litigation, and the Respondent expressly disclaims any liability whatsoever under either of the aforementioned Acts. Review hereof under Section 19(h) of the Workers' Compensation Act is hereby expressly waived. This case is settled as a disputed claim. $168,270.00, representing 60% loss of use of the person as a whole. Petitioner's Section 8(a) rights shall remain open until a Medicare Set-Aside can be approved and funded. Upon the approval and funding of the MSA, Petitioner's Section 8(a) rights shall be terminated. The Respondent reserves the right to fund an MSA with an annuity, or to leave Petitioner's Section 8(a) rights open. Additionally, Petitioner agrees to comply with and complete any necessary paperwork required to fund an MSA with an annuity. If the Respondent does elect to fund an MSA with an annuity, any funds remaining in the Petitioner's MSA account shall revert back to the Respondent, upon the Petitioner's death. If Medicare has made any conditional payments in association with this claim, and those payments have not been satisfied, Respondent shall be responsible for the conditional payments relating to the disk bulge at C5-C6, C6-C7, C5-6 anterior radiculopathy, but will not be responsible for any payments made in association with the right cubital tunnel syndrome, which is completely and totally disputed. Petitioner agrees that Medicare has a right to recover any conditional payments from the settlement funds which were not resolved at the time of the settlement and may have a right to recovery of the entire settlement amount. Petitioner accepts that risk and agrees to hold harmless, indemnify, and defend Respondent/Insurer for any Medicare or Medicare Advantage plan conditional payment reimbursement demanded and Petitioner waives her rights to Private Cause of Action against the Respondent/Insurer under the Medicare Secondary Payer Act (MSP) pursuant to *42 USC §1395y(b)(3)(A)*. After the payment of attorney fees in the amount of $33,654.00 and out-of-pocket litigation expenses in the sum of $1,719.10, the Petitioner's net recovery from the consideration is $132,896.90, representing a compromise of a weekly permanency benefit over the period of the Petitioner's life expectancy, which is hereby found to be 43 years. The net sum for the weekly permanency benefit results in monthly payments over the Petitioners' life expectancy of $257.55. Parties agree that her upper extremity alleged condition of ill-being is not work related based upon medical evidence and that the injury was limited to the cervical spine for which no additional medical care is being recommended. The settlement of this Workers' Compensation case does not release the currently pending case in the Court of Claims.

Total amount of settlement	$ 168,270.00
Deduction: Attorney's fees	$ 33,654.00
Deduction: Medical reports, X-rays	$ ____
Deduction: Other (explain)	$ 1,719.10 (see attached)
Amount employee will receive	$ 132,896.90

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.*
I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Linda Ferris — Signature of petitioner
Linda Ferris — Name of petitioner (please print)
217-549-8084 — Telephone number
5/18/16 — Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney
5-22-16 — Date
Fred Johnson — Attorney's name and IC code # (please print)
Heller, Holmes & Associates, P.C. — Firm name
1101 Broadway, P.O. Box 889 — Street address
Mattoon, Illinois 61938-0889 — City, State, Zip code
217-235-0743 — Telephone number
____ — E-mail address

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agent
5/16/16 — Date
Robert E Maciorowski #481 — Attorney's name and IC code # or agent (please print)
Maciorowski, Sackmann & Ulrich, LLP — Firm name
105 W. Adams, Suite 2200 — Street address
Chicago, IL 60603 — City, State, Zip code
312-627-0600 — Telephone number
rmacior@msulaw.com — E-mail address
Illinois Risk Management Services — Name of respondent's insurance or service company (please print)

APPROVED
ILLINOIS WORKERS' COMPENSATION COMMISSION
PURSUANT TO THE AUTHORITY GRANTED TO THE COMMISSION BY SECTION 19(b) OF THE
Workers' Compensation Act and Section 8(a) of the
Occupational Diseases Act
MAY 28 2016
Edward N. Lee, Arbitrator

Illinois Workers' Compensation Commission
Having considered the terms of this contract, in accordance with Section 9 of the Act, by my stamp
I hereby approve this contract, order the respondent to promptly pay to or keep on file until entered of
settlement stated above, and dismiss this case.

DEDUCTIONS: Medical reports, x-rays

Hutti Chiropractic (03/10/2015)	$ 20.00
Bonutti Clinic (03/10/2015)	$ 20.00
St. Mary's Hospital (03/10/2015)	$ 40.00
SBLHC (03/10/2015)	$ 40.00
Southern IL Hand Center (03/10/2015)	$ 20.00
Family Medical Center (03/25/2015)	$ 20.00
Diversified Medical Records (04/07/2015)	$100.93
Dr. James Coyle (04/13/2015)	$ 46.89
iod Inc. (05/21/2015)	$ 20.00
Glover Court Reporting (05/26/2015)	$338.85
Dep of Dr. Gregory Deters (06/01/2015)	$500.00
TOTAL	$1,166.67

DEDUCTIONS: Other

Expenses of Ronald Tulin (Original attorney-now retired)	$ 552.43

L. Linda S. Ferris acknowledges and accepts the increased risk that Medicare may deem the Set-Aside described herein to be insufficient due to errors in the course of self administration.

M. *Account Management:* The petitioner, Linda S. Ferris agrees to follow Medicare CMS Rules, and Guidelines for the use of her Medicare Set Aside Account, and in making distributions from her Medicare Set Aside Account. If Medicare CMS finds that any money had been spent inappropriately, from the Linda S. Ferris Medicare Set Aside Account, then the petitioner Linda S. Ferris will reimburse the Linda S. Ferris Medicare Set Aside Account if so directed by Medicare CMS, or petitioner Linda S. Ferris will comply with any other action required by Medicare CMS or comply with any recovery sought by Medicare CMS, including past, present and future liens.

N. *Past liens, if asserted by CMS* Should Medicare require that it be reimbursed for any past medical expenses which it has paid for the petitioner's medical treatment which is related to the injury described herein, the petitioner Linda S. Ferris agrees to pay all such money and be solely responsible for the same.

O. *Medical expenses not covered by Medicare Set-aside account* In reaching this agreement, the parties have considered that many common medical expenses are not payable or reimbursable under Medicare.

P. *Fee Schedule* The Petitioner Linda S. Ferris should apply the Illinois Workers' Compensation fee schedule and follow Medicare CMS Rules, Guidelines and procedures as to the amounts to be paid from the Medicare Set Aside Account for each and every service to be performed and for which payment shall be made from the Linda S. Ferris Medicare Set Aside Account.

Q. *Releases of Information* The petitioner Linda S. Ferris agrees that the respondent or its medicare set aside analysts and annuity providers and assignees may communicate with Medicare CMS about this Medicare Set Aside Account and may communicate with Medicare for the purpose of MMSEA 111 reporting.

R. *Addendum* The Respondent may file an addendum to this contract with the Illinois Workers Compensation Commission to further set forth the Medicare Set Aside Terms and Provisions.

I, petitioner, Linda S. Ferris have read and understood the above-listed terms and conditions. I agree to abide by these terms and conditions in order to protect my ability to obtain Medicare medical, hospital, surgical and prescription coverage for my work-related injury medical expenses when and if the Linda S. Ferris Medicare and

prescription Set-Aside Accounts are depleted. I understand that if I fail to abide by the above-listed terms and conditions, I may not be eligible for Medicare coverage for my work-related injury medical, hospital, surgical, or prescription expenses.

Linda S. Ferris 8/9/17

Linda S. Ferris Date

CONSIDERATION OF MEDICARE'S INTERESTS IN THIS WORKERS' COMPENSATION CLAIM SETTLEMENT

Pursuant to 42 U.S.C. 1395y, 42 C.F.R. 411.20-411.47, the Medicare Intermediary Manual and certain Memorandums or FAQ's issued by CMS; the parties acknowledge their duty to adequately consider Medicare's interest in this workers' compensation settlement by not shifting the health care burden of this claim to Medicare. The parties have complied with their duties under the law in the following manner.

A Lump-sum compromise settlement is a settlement that "forecloses the possibility of future payments of workers' compensation benefits." *See* 42 C.F.R. 411.46. The MIM 3407.7 and "provides less in total compensation than the individual would have received if the claim has not been compromised." *See* MIM 3407.7 (E) and MCM 2370.1 for definition of "lump-sum compromise settlement" as it is used in MIM 3407.7 and MCM 2307.7. This settlement clearly fits within the definition of a lump-sum compromise settlement.

The law provides that if a lump-sum compromise payment forecloses the possibility of future payments of workers' compensation benefits, then medical expenses incurred after the date of settlement are payable under Medicare. *See* 42 C.F.R. 411.46(d) (1). The guidance provided by CMS in its July 2001 Memo from Parashar B. Patel to All Associate Regional Administrators provides that Medicare Set-Asides arrangements are only used in commutation settlements and not compromise settlements: See July 2001 Memo from Parashar B. Patel to All Associate Regional Administrators.

Even if the law does not require a set-aside, the parties have considered Medicare's interest by creating the Linda S. Ferris Set-Aside Account.

ILLINOIS WORKERS COMPENSATION COMMISSION

LINDA S FERRIS

V

09 WC 2226
10 WC 13757

SARAH BUSH LINCOLN HEALTH SYTEMS

AMENDMENT TO THE WORKERS COMPENSATION SETTLEMENT CONTRACT TO COMPLY WITH MEDICARE REQUIRMENTS

Terms of Structured Settlement for the Medicare Set Aside Account

The Petitioner and Respondent by agreement submit this amendment to the settlement contract to comply with Medicare Requirements as permitted by the Rules of the Illinois Workers Compensation Commission, 50 Illinois Administrative Code 9070.40 (e)

In performance of the Illinois Workers Compensation Settlement Contract approved by Arbitrator Lee on May 28, 2016, a medicare set aside annuity has been approved by Medicare CMS and the respondent is funding the Medicare Set Aside Account through this annuity. The petitioner's rights under section 8(a) of the Illinois Workers Compensation Act are terminated by the respondent's funding the annuity provided herein.

Linda S. Ferris, Petitioner

Heller, Holmes, & Associates, P.C.

By _____
Fred Johnson
Attorneys for Petitioner

Maciorowski, Sackmann and Ulrich LLP

By _____
Robert T Newman
Attorneys for the Respondent

MEDICARE SET ASIDE ACCOUNT FOR LINDA S. FERRIS
Part I
Terms of Structured Settlement for the Medicare Set Aside Account

Employee/Claimant Name	Claimant Social Security Number	Claimant Date of Birth
Linda S. Ferris	***_**_****	May 15, 1976
Claimant Residence Address		
12773 E. County Rd. 210 N.		
City	State	ZIP
Lerna	IL	62440-2424
Respondent Employer	Respondent Third Party Workers Compensation Administrator	
Sarah Bush Lincoln Health Systems	Illinois Risk Management Services	
Date of Accident/Loss (*MM DD YYYY*)		
July 16, 2007		

ANNUITY ISSUER:
PACIFIC LIFE
INSURANCE COMPANY

ASSIGNEE: PACIFIC
LIFE AND ANNUITY
SERVICES INC

Respondent Sarah Bush Lincoln Health Systems through its Third Party Workers Compensation Administrator, Illinois Risk Management Services, Inc or its successor agrees to pay or cause to be paid the following payment and future Periodic Payments which constitute damages on account of personal injuries arising from an occurrence within the meaning of Section 104(a)(1) of the Internal Revenue Code:

1. Initial "Seed" money for the Medicare Set Aside Account to be paid in a lump sum of $8,134.00

2. The following Periodic Payments will be made to fund the Medicare Set-Aside Arrangement account: annual payments of $3,950.00 beginning on September 7, 2018 for the next 35 years provided the claimant Linda S. Ferris survive at the time each payment shall be due.

All said payments shall be received under workmen's compensation acts as compensation for personal injuries or sickness, within the meaning of Section 104(a)(1) of the Internal Revenue Code of 1986, as amended.

The Claimant Linda S. Ferris (the term claimant refers to Linda S. Ferris) is hereby notified that a portion of any money spent to purchase an annuity or other asset to fund a structured settlement may be used by the issuer of such annuity or other funding asset to pay commissions or other fees.

Consent to Qualified Assignment

The Claimant acknowledges and agrees that the Respondent Employer or its Third Party Administrator (the Assignor) may make a "qualified assignment" within the meaning of Section 130(c) of the Internal Revenue Code of 1986, as amended, to the Assignee of the obligation to make the future Periodic Payments described in paragraph (2) above; to be designated by the Respondent; the assignee shall be Pacific Life and Annuity Services, Inc. The claimant hereby assents to the assignment and agrees (a) claimant's rights to the periodic payments and against the Assignee shall be no greater than those of a general creditor and (b) that the Assignee is not required to set aside specific assets to secure the future periodic payments, and (c) Assignee's obligation for payment of the Periodic Payments shall be no greater than that of the Respondent or its Third Party Administrator immediately preceding the assignment of the Periodic Payments obligation.

Any such assignment, if made, shall be accepted by the Claimant without right of rejection and shall completely release and discharge the Respondent and the Third Party Administrator from any and all obligations to make the Periodic Payments. The claimant recognizes and acknowledges that in the event of such an assignment, the Respondent and Third Party Administrator shall have no further obligation to make any of the Periodic Payments. The Claimant shall execute the qualified assignment to confirm such Claimant's acceptance of the assignment and such Claimant's release and discharge of the Respondent and Third Party Administrator.

Discharge of Obligation

The obligation of the Respondent or the Third Party Administrator or the Assignee to make each Periodic Payment to the Payee designated to receive such payment shall automatically be discharged upon the mailing of a valid check in the amount of such payment to the address of such payee most recently designated or upon completion of an electronic funds transfer in the amount of such payment to the deposit account of such Payee most recently designated.

Right To Purchase An Annuity

The Respondent or Third Party Administrator or, in the event of a qualified assignment, the Assignee, may fund the obligation to make the Periodic Payments through the purchase of a "qualified funding asset" within the meaning of section 130 (d) of the Internal Revenue Code, in the form of an annuity policy from the Annuity Issuer designated by the Respondent. The Assignee shall be the sole owner of any such annuity contract and shall have all rights of ownership and control of such annuity contract. The Respondent or the Third Party Administrator or the Assignee, as applicable, may have the Annuity Issuer mail payments directly to the Payee or deliver payments by electronic funds transfer to an insured deposit account in the Payee's name at an FDIC-insured institution in the United States. The Payee shall at all times keep the Annuity Issuer apprised of such Payee's current street address and telephone number and, if such Payee receives payments by electronic funds transfer, the name, address, bank identifier number (BIN) and telephone number of the Payee's depository institution and the account number of the Payee's account at such institution.

Periodic Payments to the Payee may be delayed if (i) such Payee fails to provide the Annuity Issuer with current address or banking information.

No Modification of Payment Rights May be Effected by the Claimant

The Claimant acknowledges and agrees that neither the Periodic Payments nor any rights thereto or interest therein (collectively, "Payment Rights") can be (i) accelerated, deferred, increased, decreased or varied in any respect by such Claimant or any other Payee; nor (ii) sold, assigned, pledged, hypothecated, mortgaged, anticipated or otherwise transferred or encumbered, either directly or indirectly, by such Claimant or any other Payee. No Claimant or other Payee shall have the power to effect, directly or indirectly, any such sale, assignment, pledge, hypothecation, mortgage, anticipation, transfer or encumbrance. Any purported sale, assignment, pledge, hypothecation, mortgage, anticipation, transfer or encumbrance of Payment Rights by any Claimant or other Payee shall be wholly void.

Confirmation of the Claimant's Date of Birth

The claimant understands and agrees that the payments provided herein provide income based on her lifetime, and the payee must submit evidence confirming her date of birth and said payment amounts are subject to adjustment if the date of birth is other than what is reflected herein.

Payment methods

The payments above shall be mailed to the claimant's address or until Annuity issuer is instructed otherwise in writing by the Payee. The Payee may elect to have payment made through electronic wire transfer by requesting the appropriate forms from the annuity issuer or its agent. Neither annuity issuer nor assignee is responsible for payment delays caused by electronic failure or postal service error and no interest shall be applied to such delayed payments. In the event of late, lost or missing payments, replacement checks will be issued.

Addendum to the Settlement Contract

The parties may file with the Illinois Workers Compensation Commission, an addendum to this contract to further specify the provisions and annuity issuer for the annuity described above.

Legal and Tax Advice; Comprehension of Agreement

In entering into this Terms of Structured Settlement Agreement, claimant Linda S. Ferris represents that she has relied solely upon the legal and tax advice of her own attorneys and other advisers, who are the attorneys and advisers of claimant's choice, that the terms of this Terms of Structured Settlement Agreement have been completely read and explained to claimant by such attorneys and that such terms are fully understood and voluntarily accepted by the claimant.

Linda S Ferris

Petitioner/Claimant:

8/9/17

Month Date year

TERMS AND CONDITIONS FOR BENEFICIARY SELF ADMINISTERED MEDICARE SET ASIDE ACCOUNT FOR LINDA S. FERRIS

Part II

Medicare Set Aside Provisions

Medicare beneficiary, Linda S. Ferris, sustained injuries at work as described as C5-6 and C6-7 Cervical disc injury. As a result of the accident, Ms. Ferris filed a Illinois Workers' compensation claim for the accidental injury. Ms. Ferris has negotiated a settlement of her worker's compensation claims. It is anticipated that Ms. Ferris will require future medical treatment and medications for her injuries at work.

In this document, the term "petitioner" or "claimant" means Linda S. Ferris and the term "respondent" means the Employer, Sarah Bush Lincoln Health Systems and its Workers' Compensation insurers and administrators.

Federal regulations provide that the liability for work-related injury lifetime medical expenses may not be shifted to Medicare from the responsible party. Accordingly, a portion of Medicare beneficiary's workers' compensation settlement must be allocated to pay for the beneficiary's future work-related injury or illness medical expenses. Federal regulations also provide that Medicare will not pay any medical expenses for the work-related injury or illness, after a workers' compensation settlement is received, until the amount of the lump sum settlement allocated to future medical expenses is exhausted.

A lump-sum compromise settlement is a settlement that "forecloses the possibility of future payments of workers' compensation benefits." *See* 42 C F R 411 46. The MIM 3407.7 and MCM 23707 further provide that lump-sum compromise settlement is a "settlement which provides less in total compensation than the individual would have received if the claim has not been compromised." *See* MIM 3407.1(E) and MCM 2307.7. This settlement clearly fits within the definition of a lump-sum compromise settlement.

Consequently, in order to comply with the applicable federal regulations and to reasonably consider Medicare's interests, Ms.Ferris will use the initial payment of $8,134.00 plus the annual payments of $3,950.00 to be paid for 35 years so long as the petitioner is living, to fund a Medicare set aside account.

This account will be known as the "Linda S. Ferris Medicare set aside account." If Ms. Ferris adheres to the following terms and conditions in administering the Linda S. Ferris Medicare set aside account, then, the Centers for Medicare & Medicaid Services, (CMS), Medicare could or might pay for any Medicare covered medical treatment Ms. Ferris receives as a result of her alleged work injuries, or prescriptions, after she has spent all the accrued Medicare set aside funds to that date

on services that are for cure or relief of the occupational injury, but would otherwise be covered by Medicare. If Ms. Ferris fails to adhere to any of the following terms and conditions, CMS may regard such failure as a failure to reasonably consider Medicare's interests and may deny Medicare coverage for all medical treatments due to Ms. Ferris' alleged work-related injury. The terms and conditions for the administration of Ms. Ferris' Medicare set aside account are:

A. *Work-related Injury Defined*-Ms. Ferris' "Work-related injury" is described as cervical disc injury.

B. *Set-Aside Accounting Funding*-The Linda S. Ferris Medicare Set-Aside Account shall be funded with an initial lump sum payment, being $8,134.00 to be followed by annual payments of $3,950.00 per year for 35 years so long as Linda S. Ferris shall be living at the time each annual payment shall become due. This case does not meet the threshold for Medicare CMS review. The respondent will purchase an annuity to fully perform and discharge the respondent's obligation to pay the medicare set aside account as explained in Part I of these Terms and Conditions.

C. *Set-Aside Account*-The Medicare Set-Aside funds shall be placed in an interest bearing account, denominated "Linda S. Ferris Medicare Set-Aside Account," that is insured by the Federal Deposit Insurance Corporation. A copy of the documents establishing the Linda S. Ferris Medicare Set-Aside Account shall be sent to CMS within 30 days of the workers' compensation settlement award being disbursed to Ms. Ferris.

D. *Distribution of the Set-Aside Account Funds*-The funds in the Linda S. Ferris Medicare and prescription Set-Aside Account shall be used solely for medical expenses and prescriptions incurred by Ms. Ferris for those medical needs related to or resulting from his work-related injuries, which would otherwise be reimbursable or paid for by Medicare. Funds in the Linda S. Ferris Medicare Set-Aside Account shall not be used to pay for medical services not covered by Medicare. Federal statutes and regulations set forth the medical services and equipment that are covered by Medicare. For a reference aide, Ms. Ferris should obtain a copy of the booklet, "Medicare & You," from a local Social Security office for a list of services not covered by Medicare. If Ms. Ferris has any questions concerning what Medicare covers, she may call 1-800-Medicare.

E. *Set-Aside Account Interest Income*-All interest earned on the Linda S. Ferris Medicare Set-Aside Account will be allowed to accrue in the account and will be used solely for medical expenses, that would otherwise be covered by Medicare, due to the injury that Ms. Ferris sustained at work, except that an amount may be withdrawn to pay income taxes on the interest earned by the medicare set aside account.

F. *Reimbursement to Medicare*-In the event CMS determines that Medicare has paid benefits prior to the depletion of funds in the Linda S. Ferris Medicare Set-Aside Account then Medicare shall have the right to seek and receive reimbursement of any such conditional payments or overpayments from the Linda S. Ferris Medicare Set-Aside Account to the extent that there are funds remaining in the account at that time.

G. *Accounting Records*-Ms. Ferris shall maintain accurate records of distributions and expenditures from the Linda S. Ferris Medicare Set-Aside Account. Her records should indicate the date of service, the diagnosis, the service or prescription received, who received payment and the date of the payment. Ms. Ferris shall also retain a receipt or other evidence of each and every payment made from the Linda S. Ferris Medicare Set-Aside Account.

H. *Annual & Final Accountings*-Ms. Ferris shall submit an annual accounting to CMS and the appropriate fiscal intermediary for each calendar year if and when and as directed by medicare CMS. Ms. Ferris shall notify CMS and the appropriate fiscal intermediary when the Linda S. Ferris Medicare Set-Aside and Accounts are depleted and shall submit a final accounting within 60 days of the funds being depleted. The annual and final accounting will include the information set forth in paragraph G and a copy of the receipt or other evidence of every payment made from Linda S. Ferris Medicare Set-Aside Account.

I. *Delivery of Notices & Accountings*-All required accountings and notices shall be send via certified mail to CMS or follow the direction of Medicare CMS.

J. *Distributions Following Death of Beneficiary*-In the event that Ms.Ferris dies before the funds in the Linda S. Ferris Medicare Set-Aside Accounts are depleted, the account will continue to exist for 180 days from the date of her death to enable any outstanding bills for work-related injury medical expenses that would otherwise be covered by Medicare to be paid. After the 180 days has elapsed any funds remaining in the Linda S. Ferris Medicare Set-Aside Account shall be paid to the respondent.

K. *Misappropriated Set-Aside Account Funds*-If, after the Linda S. Ferris Medicare Set-Aside Account are depleted, the final accounting reveals that funds in the account were used to pay for items other than medical expenses for medical needs or prescriptions related to or resulting from Ms. Ferris' work-related injury, which would otherwise be covered by Medicare, CMS will withhold Medicare coverage for work-related injury medical and prescription expenses in an amount equal to the misappropriated funds. Alternatively if ordered or directed by Medicare CMS, Petitioner agrees to reimburse the Linda S. Ferris Medicare set aside account for any misappropriated funds.

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

LEONARDO MONREAL,

Petitioner,

vs.

NO: 09 WC 14084

LITTLE CAESARS PIZZA,

17IWCC0544

Respondent.

DECISION AND OPINION ON REVIEW

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

Specifically, the Commission writes to clarify the Arbitrator's Decision relative to the medical expenses. The Arbitrator noted that Respondent made payments to Marque Medicos and its affiliates for medical expenses incurred through mid-April 2009; the Arbitrator denied all other treatment after April 16, 2009, finding it excessive. Nevertheless, the Arbitrator did find that Petitioner sustained an L5-S1 disc protrusion as a result of the January 19, 2009 work accident; and, therefore, found the second and third epidural steroid injections, administered on April 29, 2009 and July 6, 2009, reasonable and necessary.

In his Decision, however, the Arbitrator specifically ordered, "Respondent shall pay Petitioner the costs associated with the second and third epidural injections only (dates of service of April 29, 2009 and July 6, 2009)," and no other medical treatment.

17IWCC0544

The Commission hereby modifies the Arbitrator's Decision to state that Respondent shall pay reasonable and necessary medical expenses from January 19, 2009 through April 16, 2009, as there is no dispute in this regard. Respondent's own Section 12 examiner, Dr. Gunnar Andersson, opined that treatment through his Section 12 examination of April 16, 2009 had been reasonable. (RX1). Respondent shall also pay Petitioner the costs associated with the second and third epidural injections (dates of service of April 29, 2009 and July 6, 2009) as ordered by the Arbitrator. The Commission affirms and adopts the remainder of the Arbitrator's Decision dated May 28, 2015.

Section 8(a) of the Act states:

> The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury . . . 820 ILCS 305/8(a).

The Arbitrator and this Commission find that Petitioner's condition involved more than a lumbar strain, and his symptoms temporarily improved following the three series of injections to the lumbar spine. (T.14; PX1). Thus, the Commission finds that the second and third epidural steroid injections, administered on April 29, 2009 and July 6, 2009, were reasonable and necessary pursuant to Section 8(a) of the Act.

However, the record does not support the extensive physical therapy or chiropractic visits after April 16, 2009. Dr. Lawrence Humberstone performed a retrospective records review on July 9, 2010. He found that six visits of manipulation and passive modalities and six visits of physical therapy exercises were reasonable based on the Official Disability Guidelines (ODG). Dr. Humberston opined that any further treatment was not reasonable or necessary as no special circumstances were clearly identified. "I cannot determine that the chiropractic physiotherapy was having any impact on the patient's treatment, outcome, or diagnosis." (RX2). Petitioner's own treating chiropractor, Dr. Fernando Perez, opined that if Petitioner had not had a resolution of his symptoms or at least an improvement of his symptoms in the eight-and-a-half months of treatment, then that treatment was not warranted. (T.60). In consideration of the opinions of Drs. Andersson, Humberstone, and Perez, the Commission finds that the physical therapy and chiropractic visits after April 16, 2009 were not reasonable or necessary.

The Commission further notes that Petitioner testified that he received pain medication through Prescription Partners. (T.12; T.15). However, by April 16, 2009, Petitioner told the Section 12 examiner, Dr. Andersson, that he was no longer taking any medications. (RX1).

17IWCC0544

Based on the totality of the evidence, the Commission modifies the Arbitrator's Decision to specifically state that Respondent shall pay reasonable and necessary medical expenses from January 19, 2009 through April 16, 2009. Respondent shall also pay Petitioner the costs associated with the second and third epidural injections (dates of service of April 29, 2009 and July 6, 2009) – all of said payments are subject to the fee schedule. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed May 28, 2015, is hereby modified as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $176.26 per week for a period of 11 3/7 weeks, commencing January 22, 2009 through March 12, 2009, and March 20, 2009 through April 18, 2009, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $176.26 per week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 7.5% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses from January 19, 2009 through April 16, 2009, as well as the costs associated with the second and third epidural injections (dates of service of April 29, 2009 and July 6, 2009), pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §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 $46,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: SEP 7 - 2017

Michael J. Brennan

MJB/pm
O: 8-22-17
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONREAL, LEONARDO
Employee/Petitioner

Case# **09WC014084**

LITTLE CEASARS PIZZA
Employer/Respondent

17IWCC0544

On 5/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0800 BLUMENFELD & ASSOCIATES
BARRY E BLUMENFELD
3424 W 35TH ST SUITE 202
CHICAGO, IL 60623

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

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

5-28-15
Date

MAY 28 2015

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARDO MONREAL

Petitioner,

v.

LITTLE CAESARS PIZZA

Respondent.

CASE NO. 09 WC 14084

17IWCC0544

MEMORANDUM OF ARBITRATOR'S DECISION

INTRODUCTION

The Petitioner moved to amend the date of accident from January 22, 2009 to January 19, 2009 in the Application for Adjustment of Claim. The Respondent had no objection.

The Arbitrator granted Petitioner's oral motion to amend and admitted into evidence as Petitioner's Exhibit 7 the Amended Application for Adjustment of Claim 12/8/14.

FINDINGS OF FACT

The Petitioner testified that he currently resides at 450 Overby Road, Brandon, Mississippi. However, in January of 2009 he lived in the Chicago area and was employed by Little Caesars Pizza. At that time, he was a crew member whose duties included both prepping food as well as stocking food in the restaurant.

On January 19, 2009, the Petitioner was stocking bales of flour. Each bale weighed between 30 and 35 pounds and measured two feet by one foot. The Petitioner estimated that he moved approximately 40 to 45 bales that day. He had to kneel down to pick up each bale. On that date, the Petitioner testified, while attempting to rise from a kneeling position with the bale in hand, he heard a snap and felt pain in the lower right side of his back. He testified he had could not stand up with that last bale and

could not put pressure on his left foot.

On January 22, 2009, he sought treatment at Marque Medicos. The staff prescribed medication and took x-rays of the Petitioner's lumbar spine.

Radiologist John A. Aikenhead, D.C., DACBR, provided the following interpretation of the x-ray images:

> "AP and lateral views of the lumbar spine demonstrate a left lumbar tilt with an anterior translation in lumbar weight bearing. The visualized osseous structures demonstrate no evidence of fracture, dislocation, osseous or joint pathology. The soft tissue structures appear unremarkable.
>
> IMPRESSIONS:
> 1) Biomechanical alterations are noted and described."

The Petitioner was seen at Marque Medicos and its affiliates through December 10, 2009. (PX 2)

On February 10, 2009, the Petitioner underwent an MRI of the lumbar spine and on February 20, 2009, he underwent an EMG/NCV study of his lower extremities.

Radiologist George Kuritza, M.D., offered the following impression of the MR images of the Petitioner's lumbar spine:

"At the L5-S1 level there is a 3-4 mm. subligamentous posterior disc protrusion/herniation elevating the posterior longitudinal ligament and indenting the ventral surface of the thecal sac, without significant spinal stenosis or significant neuroforaminal narrowing." (PX 1)

Francis J. McCaffery IV, M.S., D.C., a Diplomat of the Internal Board of Chiropractic Neurology and Certified Electrodiagnostic Examiner, offered the following impression/conclusion of the EMG/NCV study:

> "(1) There is electrodiagnostic evidence of acute denervation of the right L5-S1 nerve roots via the findings on needle examination.
>
> (2) There is no evidence of a peripheral entrapment or polyneuropathy at this time." (PX 1)

Due to continued complaints of pain, the Petitioner was referred to Dr. Spirtovic for injections. He received the first injection on March 23, 2009, the second one on April

29, 2009 and the third and final one on July 6, 2009. Despite receiving the injections, the Petitioner testified that he still had the same pain and discomfort in his right lower extremity.

Petitioner continued to receive physical therapy and other modalities, as well pain medication, from Marque Medicos. Marque Medicos kept the Petitioner at a light-duty work status.

On December 10, 2009, Marque Medicos gave the Petitioner his final work status/restrictions. Such restrictions consisted of no lifting of more than 35 lbs., no continuous standing or sitting, and limited walking, climbing, standing, bending, stooping, squatting, kneeling, pushing, pulling and twisting. The final diagnosis was disc herniation, healed, and lumbago, resolved. (PX 1)

The Petitioner testified that he worked for the Respondent through April or May of 2014. He did not stay at the same store, but went to different stores. He prepped food and took pizzas out of the oven.

Presently, the Petitioner is working at a Mexican restaurant in Mississippi. He works both as a busboy and waiter. He works between 50 and 60 hours a week. He estimates the weight of a tray that he carries is between 10 and 20 pounds. He is trained to take only two plates at a time, as there is a very narrow pathway between the kitchen and the dining room. Such narrowness only allows the waiters to carry only so much food at a time. On cross-examination, the Petitioner stated that when he works as a busboy, he does not have to carry tubs of dirty dishes very far since there is a cart on which he can place the dirty dishes.

The Petitioner testified that while in the Chicago area, he also worked at a thrift store putting prices on clothes. The name of the store was Unique Boutique and it was located at 51st and Kedzie.

The Petitioner testified that during the course of his treatment at Marque Medicos, he tried the best he could but found that the pain was still there and that he felt the same. In fact, upon being discharged he still had pain and discomfort in his low back. He tries not to overexert himself and notices that he gets tired after 3-4 hours of work. He notices problems such as a pinch in his back if he sits most of the day.

The Petitioner testified that he received his physical therapy and epidural steroid injections at a location other than Marque Medicos. He went to an affiliated facility. His physical therapy included exercises, specifically, stretching. He then proceeded to do more aggressive exercises. At the end of the day, the Marque Medicos staff would have him lie on his belly and would place a cold pack on his back to make him feel better.

On cross-examination, the Petitioner testified that after a few months, he knew the exercises by heart. There was always someone at Marque Medicos to monitor his exercises. The Petitioner testified that, at times, he performed the same exercises at home. He estimated that each time he was seen at Marque Medicos, it was for a 2-1/2 – 3 hour session.

The Petitioner denied any outside physical activities other than work. On the date of accident, the Petitioner was 22 years old. He testified he used to ride a bike and play quarterback. He testified that he is not able to do these activities now. He confirmed that he sat outside the hearing room all morning and early afternoon before entering the hearing room for his trial. He had returned to Illinois on a plane with connecting flights. He estimated that the total flying time was six to seven hours.

The Petitioner presented two additional witnesses at hearing: Fernando Perez, D.C., and Nataliya Kuchiy. Mr. Perez is a chiropractic physician affiliated with Marque Medicos. His offices are at 3121 West 26th Street in Chicago. Ms. Kuchiy is with Premier Billing Services. They are the billing entity for Marque Medicos, but are a separate entity. She is the Director of Revenue at Premier Billing Services.

Chiropractor Perez testified with regard to the Petitioner's medical treatment at Marque Medicos. He oversaw the treatment shortly after the Petitioner began receiving care at this facility. He could not comment directly on the care that the Petitioner initially received other than to say he had reviewed those medical records. The Petitioner's care consisted of physical therapy, which included exercises, and therapeutic modalities. Each visit lasted approximately one hour and the Petitioner would receive hot or cold packs for approximately 15 minutes thereafter. The Petitioner was first seen on January 22, 2009 and was last seen on October 6, 2009. He was seen approximately three times per week. The doctor noted that the Petitioner did improve, but that his condition waxed and waned. When Petitioner's activity level would increase, his pain would also increase. The chiropractor testified that the Petitioner's pain followed the S1 dermatome into his heel. On direct examination, Chiropractor Perez testified that the Petitioner's treatment at Marque Medicos was both reasonable and necessary to relieve the Petitioner from the effects of his work-related injury. On cross-examination, Chiropractor Perez testified that if the Petitioner's condition stayed the same after all the treatment was rendered, such treatment would not be justified. Chiropractor Perez testified that he was not aware of the fact that the Petitioner testified that his pain never got any better.

Ms. Kuchiy testified that as Director of Revenue, she has four professional coders that work under her. All four have been certified by the American Academy of Professional Coders. She oversees the work that they do. Ms. Kuchiy testified that she prepares everything on an Excel spreadsheet and then plugs in the codes. She testified that the billing for services rendered to the Petitioner by Marque Medicos and its affiliates, as outlined in Petitioner's Exhibit No. 2, would be reimbursed under the

Illinois Workers' Compensation Fee Schedule at the amount outlined in their document. On cross-examination, when asked if she did the actual work of reviewing each of the entries and the appropriate amount to be reimbursed under the Fee Schedule, she stated that she did not do the initial work - - someone else did it for her.

The Respondent did not call any witnesses but submitted into evidence the report of Dr. Gunnar Andersson (RX 1) and the report from a chiropractic peer review prepared by Lawrence Humberstone, D.C. (RX 2)

On April 16, 2009, at the request of the Respondent and pursuant to Section 12 of the Act, Petitioner presented for an examination by Gunnar B. Andersson, M.D. Dr. Andersson is an orthopedic spine surgeon. Dr. Andersson's history reflects, in pertinent part, the following:

> "In March of 2009, he underwent an epidural injection by Dr. Spirovic. He states that the epidural helped. He states that his pain is now 4-5/10. *** The patient describes pain in the right low back. He had previously had right leg pain but this resolved in physical therapy. He describes his pain as intermittent stabbing pain with intermittent numbness and tingling in the right buttock. His pain increases with walking more than 3-4 hours, sitting several hours, and it increases with standing for a few hours. He has no increased pain with bending or lifting and he is able to sleep through the night. He denies any loss of bowel or bladder control or change in function. He currently remains off work and is in physical therapy. He is not currently taking any medications. He denies any history of low back pain or problems. He denies any significant medical or surgical history. He takes no other medications. He smokes socially. He has no known drug allergies.

Upon examining the Petitioner, Dr. Andersson wrote:

> "Physical examination: On physical examination the patient is 5'9" tall and weighs 165 pounds. There is no significant weight change. He presents with a normal gait and can walk unassisted. He has a normal lumbar lordotic back posture with no significant tenderness. Range of motion in the lumbar spine in normal in flexion, extension and lateral bending. Straight leg raising is negative. Patellar and Achilles reflexes are 2+ and symmetrical. There are no motor or sensory changes in the lower extremities. Hip motions are normal and non-organic physical signs are negative." (RX 1)

Dr. Andersson reviewed the February 20, 2009 MRI films of the Petitioner's lumbar spine and interpreted them as showing degenerative changes at L4-5 and L5-S1, and at L5-S1, a small central annular tear and a disc protrusion, but no frank herniation. (RX 1)

Dr. Andersson concluded that the Petitioner strained his back when he lifted the heavy flour sacks, that there is nothing to suggest that there is a more severe underlying problem, that the Petitioner's physical examination is completely normal and that the Petitioner has no leg pain and his back pain is much improved. Dr. Andersson further opined that the treatment has been reasonable, but at this point he does not need any further treatment. The doctor released the Petitioner to return to full-duty work without restrictions. (RX 1)

CONCLUSIONS OF LAW

Causation:

The Arbitrator finds the diagnostic opinions of Chiropractor Perez, the diagnostic tests and the Petitioner's post-accident, ongoing complaints to be more persuasive than the opinions of Dr. Andersson.

Dr. Andersson found that the Petitioner's physical examination was completely normal. Yet, Chiropractor Perez testified that at the time he was treating the Petitioner, his back condition waxed and waned. He noted that the Petitioner's pain in 2009 followed the S1 dermatome into his heel.

Dr. Andersson noted that the epidural injection that the Petitioner received three weeks earlier had helped him.

Dr. Andersson interpreted the MR images as showing degenerative changes at L4-L5 and L5-S1. Yet, Dr. Kuritza, an M.D. who specializes in radiology, made no mention of any degenerative changes in his assessment of the lumbar MRI of this 22-year-old man. Furthermore, John A. Aikenhead interpreted the visualized osseous structures (on the x-rays) as demonstrating no evidence of fracture, dislocation, osseous or joint pathology. The soft tissue structures appear unremarkable. (Emphasis added.)

Dr. Andersson conceded that the lumbar MRI showed a small central annular tear and disc protrusion.

Additionally, there was electrodiagnostic evidence of acute denervation of the right L5-S1 nerve roots via the findings on needle examination.

When Petitioner saw Dr. Andersson for the April 16, 2009 examination, he described the pain as intermittent stabbing pain in the low back with intermittent numbness and tingling into the right buttock.

Presently, the Petitioner testified, he tries not to overexert himself. He gets tired after 3-4 hours of work. Instead of getting better, the Petitioner testified, he finds that

his back condition has affected his life.

There is no evidence that the Petitioner sustained an intervening accident to his low back.

The Petitioner had no prior problems with, or pre-existing conditions of, his low back.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Indus. Comm'n, 93 Ill. 2d 63-64 (1982)

Based on the foregoing, the Arbitrator finds that the Petitioner's current condition of ill-being of a disc protrusion at L5-S1 is causally related to the accident of January 19, 2009.

Medical Expenses:

The Petitioner submitted medical bills from Marque Medicos of $16,325.84, from Medicos Pain and Surgical Specialist of $31,102.68, and from Prescription Partners of $2,098.13. In regard to medical expenses incurred in this matter, the Arbitrator first notes that the Respondent already paid $21,515.16 to Marque Medicos and its affiliates for medical expenses incurred through mid-April of 2009.

Dr. Andersson diagnosed the Petitioner with a lumbar strain. Chiropractor Humberstone determined, based on the Official Disability Guidelines, that only 6 visits for chiropractic care and 12 visits for physiotherapy would have been appropriate for a lumbar strain.

However, based on the evidence presented, the Arbitrator has found that as a result of the January 19, 2009 accident, the Petitioner sustained an L5-S1 disc protrusion.

The Arbitrator notes that the Petitioner told Dr. Andersson that his leg pain resolved in physical therapy. Additionally, the Petitioner told Dr. Anderson that the first epidural steroid injection helped him.

Therefore, the Arbitrator awards the Petitioner the costs associated with the reasonable and necessary second and third epidural injections only (dates of service of April 29, 2009 and July 6, 2009), pursuant to Section 8(a) and subject to Section 8.2 of the Act. The Arbitrator denies all other treatment after April 16, 2009 and finds it excessive. The Respondent is entitled to a credit for medical bills previously paid.

Nature and Extent of the Injury:

17IWCC0544

The Arbitrator has found that the Petitioner suffered a disc protrusion at L5-S1 as a result of the January 19, 2009 accident. The Petitioner was 22 years old at the time of injury. He underwent physical therapy and chiropractic care and received a series of 3 epidural steroid injections in his low back. He took pain medication. On December 10, 2009, the doctors at Marque Medicos released the Petitioner to return to work with restrictions that included a 35 lb. lifting restriction.

The Petitioner currently works 50 to 60 hours a week as a busboy and waiter at a restaurant in Mississippi. He testified that he does not lift anymore than 10-20 pounds at this job.

The Petitioner testified that he is very cautious with his back now and does not want to overexert himself. He notices that he gets tired after 3-4 hours of work. He also notices that he experiences a pinch in his back if he sits most of the day. The Petitioner testified that because of his back, he no longer plays any sports and he does not go to the gym.

Based on the foregoing, the Arbitrator finds that as a result of his accident of January 19, 2009, the Petitioner sustained a loss of use, man as a whole, to the extent of 7 -1/2%, pursuant to Section 8(d)2 of the Act.

Brian T. Cronin 5/28/15

Brian Cronin
Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bryan Grant,
Petitioner,

vs. No: 09 WC 15481

17IWCC0577

City of Peoria,
Respondent.

DECISION AND OPINION ON REMAND FROM THE APPELLATE COURT

This matter returns to the Commission pursuant to the September 26, 2016 Order of the Workers' Compensation Commission Division of the Appellate Court for the Third District of Illinois under its case number 3-15-0658WC. In the Rule 23 Order, the Appellate Court reversed the August 24, 2015 judgment of the circuit court which had confirmed the Commission's decision awarding benefits to Petitioner; vacated the Commission's decision; and remanded this matter to the Commission with directions regarding the rebuttable presumption of section 1(d) of the Workers' Occupational Diseases Act (Act) (820 ILCS 301/1 *et seq.* (West 2010)).

By way of background, Petitioner, Bryan Clark, 51, was a firefighter for Respondent, City of Peoria, for about 19 years at the time he was diagnosed with renal cell carcinoma, his alleged work-related accident (or occupational disease), in his right kidney in August 2008. He underwent total right kidney removal and made a good recovery, requiring no chemotherapy or radiation, and was released to full duty in October 2008.

At the arbitration hearing, the disputed issues were accident, causation, and the associated issues of medical services and temporary total disability. Petitioner testified that, while suppressing fires (including structural, rubbish, dumpster, car, and grass fires), he wore a self-contained breathing apparatus (SCBA) that provided breathable air and protected the wearer from breathing in contaminants. However, as Petitioner testified, during the later stages of a fire suppression operation – the "overhaul and salvage" stage, when the main fire has been extinguished and the fire scene is being checked for "hot spots" and smoldering – firefighters would remove their protective SCBA equipment because much of the heat and smoke had dissipated and it was easier to communicate and see without it. It should be noted that Chief Kent Tomlin acknowledged that firefighters chose to remove the contraption also due to its weight and their own exhaustion after fighting a fire. Petitioner testified that he was regularly exposed to various substances, including smoke, toxins, carcinogens, asbestos, and diesel fumes.

Regarding the cause of his kidney cancer, both parties presented knowledgeable, expert testimony at the arbitration hearing. For Petitioner, Dr. Peter Orris opined that, even though Petitioner's obesity and hypertension were probable contributory factors, his exposure to carcinogens in the performance of his duties also contributed to and caused his condition. For Respondent, Dr. Scott Eggener explained that the great majority of all renal cancer is idiopathic – there is no etiology or explanation as to why the cancer developed – and that the evidence of any link between kidney cancer and firefighting work is inconsistent and often conflicting. Dr. Eggener opined that there was no definitive association or causation evident for firefighters being at an increased risk of developing kidney cancer. Both experts explained and cited to medical literature in support of their opinions.

The arbitrator issued a decision on December 23, 2013, finding that Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with the City, and failed to prove that his condition of ill-being was causally related to his alleged work-related accident. Petitioner sought review of the arbitrator's decision before the Commission. On December 26, 2014, the Commission reversed the arbitrator. The Commission opined that, while both parties offered "extremely persuasive expert testimony," the Commission ultimately "view[ed] the evidence differently" from the arbitrator, and thus found that Petitioner proved by a preponderance of the evidence that he sustained a compensable accident. In coming to its decision, the Commission explained that Petitioner suffered from kidney cancer and that, as a firefighter of some 19 years, he was entitled to the benefit of the presumption set forth in section1(d) of the Act. This section provides, in pertinent part:

> "Any condition or impairment of health of an employee employed as a firefighter ... 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 ... employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment."

17IWCC0577

820 ILCS 310/1(d). As mentioned already, the circuit court confirmed the Commission's decision and the City then sought review with the Appellate Court. The City contended that the Commission erred insofar as language in its decision suggested that the Commission misapprehended the role of the statutory presumption by treating it as evidence; that is, the Commission considered the section 1(d) presumption as evidence favorable to Petitioner and in doing so misplaced the burden of proof. The Appellate Court agreed, and therefore issued a "limited remand" to ensure that the Commission has applied the correct principles of law. The Appellate Court wrote that it sought "[assurance] on appeal that the Commission did not improperly shift the burden [of proof] to the City by treating the presumption in section 1(d) as evidence." (Order para. 36).

In accordance with the Appellate Court's Order, the Commission explicitly finds that the City satisfied its burden of producing evidence sufficient to rebut the presumption of section 1(d); this evidence is the expert medical causation testimony of Dr. Eggener, Respondent's independent medical examiner. The Commission further finds, upon weighing the evidence anew – and giving no evidentiary weight to the presumption in section 1(d) -- that Petitioner has proven both accident and causal connection by a preponderance of the evidence. In particular, the Commission finds that, as compelling as Dr. Eggener's expert testimony was, the expert testimony of Dr. Orris was more persuasive.

IT IS THEREFORE ORDERED BY THE COMMISSION that the December 23, 2013 decision of the arbitrator is reversed. The Commission finds Petitioner sustained an accident on August 19, 2008 that arose out of and in the course of his employment, and Petitioner proved by a preponderance of the evidence that his current condition of ill-being is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 911.02 per week for a period of 6 and 5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Workers' Compensation Act and §7 of the Occupational Diseases Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses contained in Petitioner's Exhibit 9, pursuant to §§8(a) and 8.2 of the Workers' Compensation Act and §7 of the Occupational Diseases Act.

IT IS FURTHER ORDERED BY THE COMISSION that Respondent pay to Petitioner the sum of $ 664.72 per week for a period of 100 weeks, for the reason that the injuries sustained caused the loss of use of 20% of the person as a whole, pursuant to §8(b)(2) of the Workers' Compensation Act and §7 of the Occupational Diseases Act.

17IWCC0577

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest, if any, pursuant to §19(n) of the Workers' Compensation Act and §7 of the Occupational Diseases Act.

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

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

DATED: SEP 25 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-08/02/17
jdl/ac
68

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

Martha O'Connor,

Petitioner,

vs.

NO: 09WC 21001

Mather Lifeways,

17IWCC0589

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

The Petition for Review filed by Petitioner on consolidated case 11WC 39679 was settled and approved by Commissioner Michael J. Brennan on September 20, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 23, 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.

17IWCC0589

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,575.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 27 2017
MJB/bm
o-9/18/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

O'CONNOR, MARTHA
Employee/Petitioner

Case# **09WC021001**

11WC039679

MATHER LIFEWAYS
Employer/Respondent

17IWCC0589

On 3/23/2017, 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 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON LAW FIRM
DENNIS M LYNCH
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1596 MEACHUM & STARCK
JAMES JANNISCH
225 W WASHINGTON ST SUITE 500
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

Martha O'Connor
Employee/Petitioner

v.

Mather Lifeways
Employer/Respondent

Case # 09 WC 21001

Consolidated cases: 11 WC 39679

17IWCC0589

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **2-16-2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4-15-2008**, 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 **$22,230.00**; the average weekly wage was **$427.50**.

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $256.50/week for 150 weeks, because the injuries sustained caused the 30% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Molly C Mason

Signature of Arbitrator

3/23/17
Date

MAR 23 2017

Martha O'Connor v. Mather Lifeways
09 WC 21001 and 11 WC 39679 (consolidated)

17IWCC0589

Summary of Disputed Issues in Both Cases

The parties agree Petitioner, a retirement home employee, was injured on April 15, 2008 and May 8, 2009. Different carriers insured Respondent on these dates. Causation and nature and extent are at issue in each case. Arb Exh 1.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified she began working for Respondent in July 1995. T. 11-12. Initially, she held a job in the social work department at Respondent's Evanston location. She met with patients and pushed patients' wheelchairs. T. 12. Later she worked as a companion at various Respondent facilities, accompanying patients to doctors' appointments. T. 12-13.

Petitioner testified that all of the patients she assisted were elderly. Some were able to get around using walkers or canes but they would sometimes lean on her. T. 13-14.

Petitioner testified that, as of the April 2008 accident, she was responsible for lifting items such as bandages or extra clothing that patients brought to appointments. She was also sometimes required to move and lift patients when co-workers were not available to help. T. 14.

Petitioner testified she felt fine when she reported to work on April 15, 2008. Her low back was not hurting at that time. T. 15.

A bill in PX B reflects that Petitioner saw Dr. Sclamberg of the Illinois Bone and Joint Institute on February 6, 2007 and underwent spinal X-rays the same day. PX B, p. 8. [Dr. Sclamberg's records are not in evidence.] Records in RX 1 reflect that Petitioner sought treatment in June 2007 for a work-related left gluteal injury that happened on May 14, 2007. Dr. Campbell's note of June 21, 2007 reflects that Petitioner reported sitting on a foreign object while assisting an elderly patient. The doctor noted the presence of a semi-raised lesion in the left gluteal region. At a subsequent visit, on March 27, 2008, he noted that Petitioner complained of non-radiating left gluteal pain of several weeks' duration. He also noted that Petitioner's job involved lifting patients but that Petitioner had recently discontinued performing low back exercises. He indicated that Petitioner reported taking Ibuprofen for pain. On examination, he noted negative straight raising and point tenderness in the deep gluteal area in the region of the greater sciatic notch. He diagnosed "sciatic notch inflammation" and prescribed local heat, Ibuprofen and rest. He noted that Petitioner did not want to see a chiropractor but was willing to see an acupuncturist. He recommended she return in four weeks. RX 1, p. 18.

Petitioner testified that, on **April 15, 2008**, she was at a doctor's office, trying to help an obese patient get out of a wheelchair in order to use the bathroom on an emergent basis, when the patient's weight shifted back onto her. Petitioner testified she experienced low back pain at that time. T. 15-16. She reported the accident to Respondent the same day. [Notice is not in dispute.]

Petitioner testified she initially underwent treatment with Dr. Campbell, her personal care physician.

Dr. Campbell's note of June 2, 2008 reflects that Petitioner complained of "lower back pain that travels down the left leg, present for some time." The doctor also noted that Petitioner "mentioned reporting [this pain] to workman's comp and thought it was sciatica." He went on to state that Petitioner also reported the problem to "the HMO director to see if some of the testing would be covered by her current insurance." He indicated that Petitioner was having difficulty swimming every other day, as had been her custom in the past. He noted that Petitioner "sees an acupuncturist but that has not provided much relief and wants to see a chiropractor." [No records from an acupuncturist are in evidence.] On examination, he noted some slight tenderness with pressure over the lower lumbar spine and positive straight leg raising at about 30 degrees on the left.

Dr. Campbell diagnosed lumbar radiculopathy. He recommended lumbar spine X-rays and a DEXA bone density exam. He recommended that Petitioner lose weight and exercise as tolerated. He directed Petitioner to return in one month. RX 1, p. 17.

The lumbar spine X-rays, performed on June 2, 2008, showed no acute fracture and intervertebral disc space narrowing, most prominent at the L5-S1 level, "compatible with osteoarthritic degenerative changes."

The bone density exam, performed on June 30, 2008, was normal. RX 1, pp. 17, 55.

Petitioner testified that Dr. Campbell referred her to Dr. Shapiro, an orthopedic surgeon.

On August 15, 2008, Peggy Garcia of Liberty Mutual's St. Louis Claims Service Center sent a note to Dr. Shapiro via facsimile authorizing the doctor "to evaluate and treat Martha O'Connor for a work-related injury to her low back that occurred on 4-15-08." PX B, pp. 79, 81.

Petitioner first saw Dr. Shapiro on August 20, 2008. The doctor's note of that date reflects that Petitioner was referred to him "by workmen's compensation." The doctor noted that Petitioner reported injuring her back at work in the spring of 2007 and April 2008. The doctor indicated that Petitioner complained of significant back pain as well as pain radiating into her left leg. He described Petitioner's gait and motor strength as normal. He noted positive straight leg raising on the left. He reviewed lumbar spine X-rays which Petitioner brought to the appointment. He described the L5-S1 disc space as moderately arthritic. He

recommended a lumbar spine MRI. T. 17. PX B, pp. 20-21. A Liberty Mutual utilization review employee sent Dr. Shapiro a letter on August 29, 2008, approving the MRI. PX B, p. 53.

The MRI, performed without contrast on September 2, 2008, showed a moderate sized, broad-based left lateral recess disc herniation at L5-S1 causing marked left lateral recess compromise. PX B, pp. 59-60.

On September 9, 2008, Dr. Shapiro reviewed the MRI results with Petitioner and discussed treatment options. He noted that Petitioner was "extremely uncomfortable" and wanted to undergo surgery. PX B, p. 19.

On October 1, 2008, Dr. Shapiro operated on Petitioner's lumbar spine, performing a left L5-S1 microdiscectomy. PX B, pp. 57-58. T. 17.

At the first post-operative visit, on October 8, 2008, Dr. Shapiro noted that Petitioner reported "feeling better than she did prior to surgery with some residual leg discomfort." He recommended that Petitioner stay off work and start physical therapy. PX B, p. 18.

Petitioner underwent an initial physical therapy evaluation on October 15, 2008. The therapist recorded a history of work accidents in the spring of 2007 and a subsequent unspecified date. The therapist noted that Petitioner complained of low back pain as well as pain in her left ankle, left buttock and left hip. PX B, pp. 54-55.

On November 4, 2008, Dr. Shapiro released Petitioner to work four hours a day, three days a week, with no lifting over 20 pounds and the ability to change positions as needed. The doctor noted that Petitioner "does not feel able to push a wheelchair at all." He indicated the restrictions were to remain in effect for two weeks, at which time Petitioner would be re-evaluated. He also wrote notes clearing Petitioner "to return to work at her side job" and indicating Petitioner could undergo acupuncture. PX B, pp. 36-38. T. 18.

On November 18, 2008, Petitioner returned to Dr. Shapiro and indicated she was making progress but needed two more weeks before resuming full-time work. The doctor noted Petitioner was accompanied by a nurse case manager. He kept Petitioner at four hours a day, three days a week, with no heavy lifting or pushing wheelchairs. He directed Petitioner to return in two weeks. PX B, p. 17.

On November 26, 2008, Dr. Campbell noted the recent surgery, indicating that Petitioner felt she could not continue her normal work due to recurrent back discomfort. On examination, he noted some direct gluteal pain with deep pressure and negative straight leg raising. He recommended therapy, Ibuprofen and follow-up with Dr. Shapiro. RX 1, p. 16.

On December 2, 2008, Dr. Shapiro continued the restrictions for two more weeks, noting that Petitioner still did not feel ready to return to full-time work. He again noted the presence of a nurse case manager. PX B, p. 16.

At the next visit, on December 14, 2008, Dr. Shapiro noted that Petitioner felt "somewhat better." He released her to unrestricted work. He anticipated she would reach maximum medical improvement in two more weeks, after undergoing additional therapy. He indicated he did not need to see her again. PX B, p. 15.

Petitioner was discharged from physical therapy on December 23, 2008. On that date, the therapist indicated Petitioner reported being able to work the previous day without significant pain and being able to walk two miles at a track. PX B, p. 49.

Petitioner underwent a therapy evaluation on January 19, 2009, with the therapist noting "poor awareness of proper form" and recommending back school and aquatic therapy. PX B, p. 46.

Petitioner returned to Dr. Shapiro on January 27, 2009, with the doctor noting "gradual improvement in her back and leg." The doctor gave Petitioner a note for continued restrictions at work. PX B, p. 14.

On February 16, 2009, Petitioner's therapist noted progress and indicated Petitioner was able to swim more than forty laps. The therapist recommended three or four more sessions, noting Petitioner still had occasional leg pain. PX B, pp. 43, 45.

On February 24, 2009, Dr. Shapiro gave Petitioner a note indicating she could not push a wheelchair until the next visit, in approximately one month. PX B, p. 13.

Petitioner finished aquatic therapy on March 4, 2009. On that date, her therapist indicated she had met her goals but "still may experience intermittent discomfort or pain." PX B, p. 39.

On March 25, 2009, Dr. Shapiro indicated Petitioner could work full days but could not push wheelchairs or lift more than 30 pounds. He described the restrictions as permanent and released Petitioner from care on a PRN basis. PX B, p. 12.

Petitioner testified that, as of **May 8, 2009**, she was working in Respondent's companion care department, visiting people and taking them to appointments. She testified she was still subject to restrictions as of that date. As she was walking at work, she slipped on a wet area of flooring and "felt something in [her] back." She could not recall whether she fell to the ground but she experienced low back pain again. T. 20. She reported the accident to a supervisor that day. [Notice is not in dispute.] She followed up with Drs. Campbell and Shapiro. T. 20.

On May 26, 2009, Petitioner returned to Dr. Shapiro and reported slipping on a wet floor in the employee cafeteria. Petitioner indicated she "landed on left knee, twisted and ended up on her left hip." Petitioner complained of left gluteal and low back pain. PX B, p. 12. The doctor noted that Petitioner had improved since the accident but was still experiencing

some back discomfort. He also noted an abrasion on the anterior aspect of Petitioner's left knee. He recommended "continued conservative care and following up on a PRN basis." PX B, p. 11.

On January 25, 2010, one of Dr. Campbell's residents noted that Petitioner refused a check-up and complained of low back and left thigh pain. The resident indicated there was "no preceding trauma." He noted positive straight leg raising on examination. He recommended physical therapy. RX 1, p. 12.

On January 30, 2010, Dr. Campbell issued a note referring Petitioner to Dr. Bathla for pain management "for herniated disc and lumbar radiculopathy." PX E, p. 73. No accompanying office note is in evidence.

On February 9, 2010, Petitioner underwent another lumbar spine MRI at Dr. Campbell's recommendation. The interpreting radiologist noted a left paracentral protrusion of disc material into the left lateral recess at L5-S1 with apparent compression of the left S1 nerve root. PX D, pp. 8-9.

Petitioner saw Dr. Bathla at Sports and Spine on February 11, 2010, with the doctor recording the following history:

> "50-year-old female with history of low back pain. Pain started about 3 weeks ago. She describes no trauma or unusual events. Pain initially started as a slight low back pain. Eventually, the pain started to radiate down the left lower extremity."

On low back examination, Dr. Bathla noted a full range of motion, negative facet loading signs bilaterally and negative straight leg raising bilaterally. He described Petitioner's gait as normal. He suggested an epidural steroid injection and administered this injection the same day. PX E, pp. 60-61.

On February 19, 2010, Petitioner saw Dr. Lazar, a neurosurgeon. The doctor wrote to Dr. Campbell on that date, acknowledging the referral. In his letter, he indicated Petitioner reported being able to return to her regular job after the October 2008 microdiscectomy but, in January 2010, "developed severe back and left sciatic pain similar to what she had previously." He also noted that Petitioner had recently undergone an injection, and was scheduled for a second, but was "far from well." He interpreted the MRI as showing a "very large disc recurrence at L5-S1 on the left severely compressing the S1 nerve root." He described straight leg raising as "markedly positive on the left at fifteen degrees." He indicated Petitioner would require another microdiscectomy due to the recurrent disc if the second injection did not help. PX D, p. 3. He imposed restrictions of no lifting over 25 pounds and no excessive bending, stooping or lifting until February 26, 2010. PX D, p. 7.

On February 25, 2010, Dr. Bathla administered a second epidural steroid injection.

On March 9, 2010, Dr. Lazar noted "remarkable improvement" since the second injection. He indicated that Petitioner reported experiencing only minimal left hip pain at times and mild lateral leg discomfort. On re-examination, he noted that straight leg raising was mildly positive on the left with some tingling in the foot. He recommended a course of non-steroidal anti-inflammatory medication and indicated he would recommend a third injection if the medication did not help. He further indicated Petitioner would require surgery if her pain worsened. He directed Petitioner to return in four weeks. PX D, p. 6.

On April 27, 2010, Dr. Lazar described Petitioner as being "almost well." He noted that she complained of occasional left hip discomfort but "nothing like she had previously." He noted no abnormalities on re-examination and indicated Petitioner "does not need surgical intervention at this time." He described Petitioner as "swimming on a regular basis." He indicated Petitioner would require surgery to remove the recurrent disc if her symptoms recurred. PX D, p. 4.

On April 29, 2010, Dr. Campbell noted that Petitioner's back had improved and that the two injections were moderately beneficial. RX 1, p. 6.

Petitioner testified that Respondent laid her off in approximately November 2010.

On March 22, 2011, Dr. Campbell noted that Petitioner had "just returned from [a] three and one-half week excursion [to] Europe." The doctor's note contains no mention of back or leg complaints. RX 1, p. 5.

On October 4, 2011, Dr. Campbell saw Petitioner due to a "recurrent onset of acute back pain with left lumbar radiculopathy." He indicated that Petitioner described her back as "going out again" after doing "some simple lifting." On examination, the doctor noted no direct tenderness with pressure and negative straight leg raising. He recommended a follow-up visit in three months and suggested that Petitioner contact Dr. Bathla or Dr. Rao for consideration of an epidural injection. RX 1, p. 4.

Petitioner testified she saw Dr. Templin on February 5, 2016, at her attorney's request. T. 27. Dr. Templin interviewed and examined her. T. 27-28.

Dr. Templin testified by way of evidence deposition on May 20, 2016. PX F. Dr. Templin testified he obtained board certification in orthopedic surgery in 2009. He underwent fellowship training in spinal surgery in 2007. He is currently affiliated with Hinsdale Orthopaedic Associates. PX F at 4-5.

Dr. Templin testified he examined Petitioner on February 5, 2016, at the request of her attorney. He reviewed records from St. Francis and Evanston Hospitals, Illinois Bone & Joint and Drs. Shapiro, Bathla and Lazar in connection with this examination.

Dr. Templin testified that Petitioner reported being injured in the spring of 2008, undergoing surgery for a herniated disc in October 2008, resuming restricted duty thereafter and "aggravating things in May 2009 after a slip and fall." Petitioner rated her low back pain at 4-5/10. She did not report significant leg pain. PX F at 8-9.

Dr. Templin testified he views Petitioner's restrictions as appropriate, due to the original herniated disc and recurrent herniation. He attributes the need for those restrictions to the accident of April 15, 2008. PX F at 10. He does not believe Petitioner currently requires medical treatment. PX F at 10. Petitioner's current condition is also related, "to some degree," to the May 2009 work accident. Petitioner's recurrent herniation was a sequelae of the initial herniation from 2008. "Whenever you have a herniated disc, whether you have surgery or not, there's a void in the annulus or the outer fibers of the disc so there's always a risk of a recurrent herniation." The removal of a herniated disc carries with it about a 10 to 15% risk down the road of a recurrent herniation. PX F at 10-11.

Dr. Templin testified that Petitioner's treatment was reasonable and necessary, as well as related to her work accidents. As of his examination, Petitioner was neurologically intact. PX F at 12.

Under cross-examination by Respondent's counsel in the first case, Dr. Templin testified that about 15 to 20 percent of his patients have work injuries. PX F at 13. He performs one to two independent medical examinations per month. PX F at 13. About half of the examinations he performs are for injured workers. PX F at 14. In terms of diagnostic studies, he saw only the 2010 lumbar spine MRI report. He did not review any films. PX F at 14-15. The actual images might prompt him to change his opinions. He did not take any X-rays of Petitioner. PX F at 15-16. The recurrent disc herniation occurred after the 2009 slip and fall. It is the initial disc herniation, rather than the surgery, that creates a risk of recurrent herniation. A recurrent disc herniation can occur with everyday activities, a slip and fall, bending or twisting. Some people "just wake up with" a recurrent herniation. PX F at 17. Petitioner could have experienced a recurrence due to everyday activities but "it is the initial herniation that predisposes her to having a recurrent disc herniation." PX F at 17-18.

Under cross-examination by Respondent's counsel in the second case, Dr. Templin acknowledged that, in May 2009, Dr. Shapiro noted Petitioner was feeling much better and released Petitioner from care on a PRN basis. PX F at 19. Petitioner next sought care in February 2010, nine months later. It is difficult to say but most likely the May 2009 work fall was a temporary minor aggravation of a pre-existing condition. PX F at 19.

On redirect, Dr. Templin indicated it would not be helpful for him to review a pre-operative MRI since the surgery fixed the nerve compression, not the disc defect. PX F at 20. The MRI would simply confirm the presence of the herniated disc. PX F at 20. He reviewed Dr. Shapiro's operative report and the 2010 MRI report. He believes he had sufficient information to arrive at the opinions he has offered. PX F at 20-21.

Under re-cross by Respondent's counsel in the first case, Dr. Templin testified the original and recurrent disc herniations do not really look the same on MRI. A recurrent herniation typically has an outline of scar tissue that can be seen. PX F at 21.

At Respondent's request, Petitioner saw Dr. Sadek, an occupational medicine physician, for purposes of a Section 12 examination on August 16, 2016. In his report of August 22, 2016, Dr. Sadek indicated he reviewed records from Dr. Shapiro, physical therapy notes, imaging reports, pain clinic reports and procedure reports in connection with the examination.

Dr. Sadek's report sets forth a history of the 2008 work accident.

The doctor noted that Petitioner complained of intermittent mild to moderate low back pain and occasional left leg pain. He indicated Petitioner reported performing elder care through agencies five days a week but avoiding doing anything heavy.

Dr. Sadek described Petitioner as cooperative and moving about "freely without distress or discomfort." On lumbar spine examination, he noted minimal paraspinal tenderness, no spasm, negative straight leg raising bilaterally, flexion of 70/90 with mild discomfort, extension of 10/40 with moderate discomfort and lateral rotation of 35/45 bilaterally.

Dr. Sadek opined that the accident of April 15, 2008 caused a herniated disc at L5-S1 on the left side. He related Petitioner's current symptoms to this accident. He attributed Petitioner's restrictions of no pushing wheelchairs and no lifting over 30 pounds to this accident. He believed Petitioner to have reached maximum medical improvement from this accident but indicated that "a recurrence of her injury in 2009 caused the recurrence of her herniated lumbar disc" and brought about the need for additional care, including injections. He opined that Petitioner's "mild but recurrent low back pain . . . will remain a constant pain for the foreseeable future." PX G.

Petitioner testified that, since being laid off in November 2010, she has taken various continuing education courses in her field and has worked intermittently as a companion through several agencies. She testified she has declined agency assignments because she is "not able to push or pull" due to her back. During some periods, she has been off work altogether. During other periods, she worked outside of her nursing home/companion care field. For example, she worked in the fish department at a Mariano's store. During this stint, she required help with lifting. T. 23-24. She had to stand for long periods, without a mat, and this caused symptoms. T. 24.

Petitioner testified she is currently working for two agencies: Seniors Helping Seniors and Visiting Angels. T. 24. At the first agency, she cooks and performs light housework for elderly people in their homes and takes them to appointments. At the second agency, she lived with and assisted an elderly woman who was losing her vision.

Petitioner testified she has had to decline some agency assignments because they involve extended driving and/or lifting. Before the accidents, she was able to drive for a long period in order to attend a continuing education course or perform a job assignment. She stopped performing a job that required her to drive 300 miles per week because this affected her back. T. 27. She would like to find an in-house position such as the one she held at Respondent but there do not seem to be any openings. T. 25. Her restrictions prevent her from being able to push a wheelchair and this is required in many nursing homes. T. 26.

Petitioner testified her left leg is sore. It is difficult for her to go through a revolving door because of having to push weight. She is able to bicycle and use a vacuum but not without difficulty. Biking used to be her favorite hobby. T. 33. It is difficult for her to lift groceries. She used to take yoga classes but cannot do this any longer. She is unable to ice skate, ski, sled or toboggan. She can do basic hiking so long as she avoids wearing a backpack or walking on uneven terrain. T. 31. She attended an aquatics class for people with arthritis. She applies a topical herbal remedy called "China gel" to her back. T. 31-32. She also takes vitamins and herbs and follows a special diet that promotes muscle strength. T. 32. She has also tried acupuncture and heating pads. T. 31.

Under cross-examination, Petitioner reiterated she started out in social work and then became a companion. She was never Respondent's admissions coordinator. T. 35. She continued performing home exercises between January 2009 and the second accident of May 8, 2009. She believes she also continued seeing a doctor at least three times during that period. T. 36. By the end of January 2009, she was back to full-time work. Dr. Shapiro imposed restrictions in March 2009. She does not recall undergoing a functional capacity evaluation before he did this. T. 37-38. Respondent accommodated the restrictions by providing her with paperwork and office assignments. T. 39-40. She continued performing this accommodated duty until Respondent terminated her in November 2010. T. 39. She recalls Dr. Shapiro telling her in December 2008 that she would reach maximum medical improvement in a couple of weeks and would likely not require restrictions. It was a couple of months later that he imposed restrictions, after she asked him to address her ongoing discomfort. T. 40. She has not undergone any functional capacity evaluations since March 2009. T. 40. After she left Respondent, she worked on a very part-time basis for two elderly clients who were recommended to her by Respondent. Eventually, those clients died. T. 41-42. She had to undergo testing in order to be hired by the agencies she now works for but she cannot recall whether she underwent pre-employment examinations. T. 42-44. She makes those agencies aware of the activities she can and cannot perform. T. 43-45. She has her own personal restrictions as well as formal, physician-based restrictions. T. 46. A doctor imposed a sitting-related restriction in the past but she cannot recall which doctor did this. T. 47. She does not have any formal driving-related restriction. She last underwent care for her back in 2011. T. 48. She does not recall telling a physical therapist on May 18, 2009 that she was sore due to working in her yard the day before. T. 50. In February 2010, she told Dr. Lazar her back complaints had returned the previous month. She would not say she was asymptomatic during any period between her May 2009 work fall and February 2010. T. 52. She recalls seeing Dr. Bethla. She told him the truth. She does not recall telling him her back pain started three

weeks earlier. Her back pain was ongoing. T. 53. She told him she did not sustain any traumas or unusual events. T. 53. She perhaps told Dr. Lazar she was swimming regularly when she last saw him in April 2020. She is physically able to swim. T. 55. She perhaps told Dr. Campbell in March 2011 she had just returned from a 3 ½-week vacation to Europe. She initially flew to Ireland and also visited Europe. She traveled via car, bus and train while on this vacation. T. 56. She does not recall telling Dr. Campbell, post-trip, that she had no back complaints.

On redirect, Petitioner testified she has good and bad days, in terms of back pain. T. 61. Regardless, she tries to address her back pain at each of her visits to Dr. Campbell. T. 61. Both Dr. Templin and Dr. Sadek agreed with the restrictions Dr. Shapiro imposed in May 2009. T. 62. She tries to inform prospective employers of her limitations. Those limitations have hindered her ability to work. T. 63.

Under re-cross, Petitioner testified she is unable to accept agency assignments that require pushing or pulling. A large percentage of elder care assignments involve those activities. T. 63-64.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working individual who enjoys elder care. She was, however, argumentative at times. She acknowledged that some of her current "restrictions" are self-imposed. Her direct examination testimony concerning her back-related limitations is at odds with some of the entries in her 2010 and 2011 medical records. For example, she testified she has difficulty sitting for extended periods but her records show she was able to travel around Ireland and Europe for 3 ½ weeks in March 2011.

Arbitrator's Conclusions of Law Relative to Both Cases

<u>Did Petitioner establish causal connection in both cases?</u>

In 09 WC 21001, the Arbitrator finds that Petitioner established a causal connection between her undisputed work accident of April 15, 2008 and her current lumbar spine condition of ill-being. In so finding, the Arbitrator relies on the treatment records, including the lumbar spine MRI report of September 2, 2008, and the opinions voiced by Drs. Templin and Sadek. While there is evidence indicating Petitioner underwent care for left gluteal and sciatic notch pain in 2007 and early 2008, the pain is described as non-radiating and there is no evidence indicating any doctor prescribed a lumbar spine MRI at that time. Additionally, Petitioner denied having any lower back pain when she reported to work on April 15, 2008. The Arbitrator further finds a causal relationship between the April 15, 2008 accident and the need for the permanent restrictions Dr. Shapiro imposed in March 2009. In so finding, the Arbitrator relies on the opinions expressed by Drs. Templin and Sadek. The Arbitrator further finds that the April 15, 2008 work accident was the cause of both the original disc herniation, which Dr. Shapiro treated surgically in October 2008, and the recurrent herniation diagnosed via repeat MRI in 2010. In so finding, the Arbitrator relies on Dr. Templin's opinions. The doctor explained

that the original disc herniation set the stage for a recurrence. On this particular point, the Arbitrator finds Dr. Templin more persuasive than Dr. Sadek. Dr. Sadek opined that the May 2009 accident caused the recurrent herniation but he did not express any awareness of the gap in care after Petitioner's May 26, 2009 visit to Dr. Shapiro. Nor did he seem to be aware of the history Petitioner provided when she resumed treatment in late January 2010.

In 11 WC 39679, the Arbitrator finds that the undisputed work fall of May 8, 2009 led to the need for Petitioner's visit to Dr. Shapiro on May 26, 2009 but was not a cause of the recurrent disc herniation diagnosed via repeat MRI in February 2010. The Arbitrator adopts Dr. Templin's ultimate opinion that the May 2009 fall was "most likely" a temporary aggravation. PX F at 19.

What is the nature and extent of the injury?

Based on the foregoing causation analysis, the Arbitrator awards permanency only in the first case, 09 WC 21001. This case is pre-amendatory, since the accident occurred before September 1, 2011.

The Arbitrator has previously found that the April 15, 2008 accident caused both the initial disc herniation, which led to a microdiscectomy and permanent restrictions, and the recurrent herniation, diagnosed in 2010. Petitioner responded to injections and other conservative care in 2010 but Dr. Lazar did not rule out the possibility that the recurrent herniation would one day have to be repaired.

This is not a classic "loss of trade" case since Petitioner is still pursuing her chosen elder care career. However, Petitioner credibly testified that her permanent restrictions, which Respondent's examiner endorsed, prevent her from qualifying for some work opportunities within her field. In particular, the restriction preventing her from pushing wheelchairs limits the job assignments she can accept.

The Arbitrator, having considered the foregoing and having compared Petitioner's testimony concerning her limitations with her most recent records, finds, in 09 WC 21001, that Petitioner is permanently partially disabled to the extent of 30% loss of use of the person as a whole, equivalent to 150 weeks of compensation under Section 8(d)2 of the Act. The Arbitrator awards no permanency benefits in 11 WC 39679.

STATE OF ILLINOIS)
) SS:
COUNTY OF LAKE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Evelyn Magpantay,

Petitioner,

vs. NO: 10 WC 2436

Vista Health Systems,

Respondent.

ORDER

A "Motion to Recall Pursuant to Section 19(f) of the Act" having been filed by Petitioner herein, and due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on August 24, 2017 in Chicago, Illinois, the parties failing to appear at that time. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, denies and dismisses said motion, for the reasons set forth below.

§19(f) provides that "[t]he decision of the Commission acting within its powers, according to the provisions of paragraph (e) of this Section shall, in the absence of fraud, be conclusive unless reviewed as in this paragraph hereinafter provided. However, the Arbitrator or the Commission may on his or its own motion, or on the motion of either party, correct any clerical error or errors in computation within 15 days after the date of receipt of any award by such Arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision…"

In a Decision and Opinion on Review dated June 26, 2017 (17 IWCC 0383), the Commission modified the Decision of the Arbitrator to find a date of MMI of January 26, 2011 with respect to Petitioner's psychological injuries. As a result, the Commission found that Petitioner was temporarily totally disabled from December 19, 2009 through January 26, 2011, for a period of 57-5/7 weeks and denied medical expenses incurred subsequent to MMI (January 26, 2011). In addition, the Commission modified the Arbitrator's award to find that as a result of the accident Petitioner sustained permanent

partial disability to the extent of 20% person-as-a-whole pursuant to §8(d)2 of the Act. All other aspects of the Arbitrator's decision were otherwise affirmed and adopted.

Petitioner contends that the Commission "... erroneously fails to identify which providers and which bills dates of service prior to January 26, 2011 were 'reasonable or necessary' and would be required to [be] paid under the fee schedule by the Respondent." (Petitioner's motion, p.1).

The motion in question was set before Commissioner Tyrrell on his review call on August 24, 2017. Both parties failed to appear. As a consequence, the motion is hereby dismissed.

However, even if one were to consider Petitioner's motion, the Commission finds that the clamed error is neither "clerical" nor "computational" as required by §19(f) of the Act but instead deals with a substantive issue of the case – namely, the amount of medical expenses due and owing. As a result, the Commission would be without authority to recall the decision even if the parties thought enough of Petitioner's motion to appear.

Therefore, based on the above, and the parties' failure to appear, the Commission denies and dismisses Petitioner's "Motion to Recall Pursuant to Section 19(f) of the Act."

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's "Motion to Recall Pursuant to Section 19(f) of the Act" is hereby denied and dismissed.

DATED: SEP 7 - 2017

Thomas J. Tyrrell

r-08/24/17
TJT/pmo
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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)
☐ PTD/Fatal denied
☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID CROSSEN,

Petitioner,

vs.

No: 10 WC 47868

BECHTEL CONSTRUCTION,

Respondents.

ORDER

This matter comes before the Commission on the Petition for Attorney Fees pursuant to Section 16 of the Workers' Compensation Act filed by John V. Boshardy & Associates. A hearing was held on July 12, 2017 before Commissioner Simpson in Collinsville. John V. Boshardy on behalf of the petitioning firm, Bob Perica on behalf of The Perica Law Firm PC, and Scott Kelemetc on behalf of Respondent were present and a record was taken.

At the hearing, Mr. Boshardy represented that he had secured temporary total disability benefits for Petitioner, for which he did receive a fee, and he informed Petitioner what he had to get from his doctors to establish his permanent partial disability. Mr. Boshardy alleged 96 hours of work on the file and sought fees in the amount of $19,200.00, based on his hourly rate of $200 per hour. He also submitted numerous documents that he alleged corroborated the amount of work he put into the file. The record also establishes that on May 25, 2017 the claim was settled in the amount of $500,000 with attorney fee of $100,000 to The Perica Law Firm.

Petitioner was called to testify at the hearing by Mr. Perica. He agreed that he hired Mr. Boshardy in December 2010. He represented Petitioner for about two years. He testified that in many of his conversations with Mr. Boshardy's associate, Mr. Ricci, Mr. Ricci could not retrieve items from his computer which resulted in "a lot of wasted time on the phone;" it was "one of [his] big aggravations." He terminated representation by Mr. Boshardy's firm because he was told there was nothing more that could be done for him and that basically he should return to work. He felt Mr. Ricci was incompetent. Petitioner never appeared at any hearing. He received one year of temporary total disability benefits. Petitioner estimated that about 1/3 of time he was on the phone with Mr. Boshardy's office was wasted due to the problems with their computers.

On cross examination, Petitioner agreed that he spoke to Mr. Boshardy personally on more than a few occasions. Petitioner did not remember ever talking to him on the phone but did remember meeting with him in person twice. He also agreed that he was told repeatedly that he was to get documents from his doctors about his work status. They also discussed temporary total disability benefits. He did not have any hearing on the Section 19(b) hearings Mr. Perica scheduled. When asked whether he was told that he needed permanent restrictions to get permanent partial disability benefits, Petitioner answered: "I was under the impression there was nothing more you could do and that *** I should go back to work. The only thing I understood on that, there was nothing more that you could do about the situation."

Correspondence between the lawyers indicate that throughout the representation by Mr. Boshardy's firm and in the initial phase of the representation by Mr. Perica's firm, the lawyers were under the impression that the claim was a simple hernia claim. Initially, Mr. Perica offered Mr. Boshardy 1/3 of the fees he eventually realized from the claim. However, the claim became more complicated as Petitioner's condition apparently worsened considerably after treatment. Petitioner's worsened condition lead to the large settlement noted above, in which Mr. Perica's firm was awarded the aforesaid $100,000 in fees. Thereafter, Mr. Perica informed Mr. Boshardy that he was "not able to pay [him] 1/3" of his actual fees. Instead he offered Mr. Boshardy $1,328.40, representing 1/3 of the fee that would be expected in a settlement/award in a simple hernia case. The record also indicates that during the representation of Mr. Boshardy's firm, Petitioner received temporary total disability benefits from which Mr. Boshardy received his fee of $2,767.53.

The Commission notes that if the petitioning firm is entitled to any fees it would be on the basis of the *quantum meruit* value of its services. Generally, in establishing appropriate attorney fees under the doctrine of *quantum meruit*, the Commission looks to the skill and standing of the discharged attorney, the nature, novelty, and complexity of the underlying case, the hours devoted to the case, and the customary hourly charges for such services in the workers' compensation legal community. The Commission notes that Mr. Boshardy has an excellent reputation in the workers' compensation legal community and finds his hourly fee of $200 to be reasonable.

Mr. Boshardy alleged his firm put in 96 hours on the file. In his presentation to the Commission, he specified 55 hours in telephone communication with the client, 16 hours in preparing correspondence, 5 hours in document review, and 1.25 hours for preparing subpoenas. He also submitted various pleadings that his office prepared, but did not specify exactly how much time he spent preparing those documents. Even though Mr. Boshardy did not specify how many hours he spent on the pleadings, the Commission is prepared to accept his representation as an attorney, and "officer of the court" that a total of 96 hours was spent working on the file.

As noted above, Petitioner testified that about 1/3 of the time he spent on the telephone with Mr. Boshardy's associate was a waste of time due to difficulty accessing Mr. Boshardy's computer system. That testimony was not specifically rebutted. Mr. Boshardy specified that 55 hours were spent on telephonic conversations with Petitioner. Based on Petitioner's testimony, the Commission will allow compensation for 2/3 of the 55 hours, or rounded off to 36.5 hours. In addition, Mr. Boshardy already received a fee of $2,767.53 for payment of temporary total disability benefits, which we reduce from the total fee award.

Based on the above reasoning, the Commission finds that Mr. Boshardy's firm is entitled to fees for 77.5 hours @ $200 an hour, minus $2,767.53 fee he already received. The Commission calculates the total fees at $12,732.47, and accordingly the Commission awards that amount in fees to John V. Boshardy & Associates

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petition of the firm John V. Boshardy & Associates for Attorney Fees Pursuant to Section 16 of the Workers' Compensation Act is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that the firm of The Perica Law Firm PC pay to the John V. Boshardy & Associates the sum of $12,732.47 for attorney fees in the underlying cases.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,800.00. 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: SEP 7 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
R-7/12/17
46

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul S. Slotkin,
Petitioner,

vs. NO: 10 WC 42081

International Profit Association,
Respondent.

17IWCC0560

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 the nature and extent of the injury and being advised of the facts and law, modifies the Decision of the Arbitrator as delineated below, but 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. Regarding the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. We first note that the Arbitrator evaluated the five factors delineated in Section 8.1b of the Act in making his determination as to permanent partial disability; however, this accident pre-dated September 1, 2011, and as such, the 8.1b analysis does not apply to this case.

We observe that the claimant possesses extensive business experience and advanced degrees (J.D., L.L.M.) and he continues to work in an intellectually rigorous field. We do not believe that any limitations the claimant has stemming from his shoulder surgeries act to significantly prevent him from continuing in his business endeavors, although he no longer works in his pre-injury job for the respondent. Nevertheless, we agree with the claimant's contentions that he faces additional inconveniences and difficulties in travel, including business travel, as well as in his personal activities. He also describes ongoing symptoms which are not inconsistent with the shoulder surgeries he underwent.

17IWCC0560

After due consideration of the medical records and the claimant's testimony, the Commission finds an award of permanent partial disability of 27.5% loss to the whole person to be consistent with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. The Arbitrator's other findings are affirmed in their entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed February 17, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $664.72 per week for a period of 137.5 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused a 27.5% loss of use of the person as a whole.

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

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

Bond for 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: SEP 1 1 2017

Joshua D. Luskin

o-08/30/17
jdl-mcp
68

Charles J. DeVriendt

DISSENT

I respectfully dissent. I believe Arbitrator Falcioni analyzed the facts thoroughly and his award was appropriate. Accordingly, while I agree with my colleagues the "five-factors" analysis under Section 8.1b was inapplicable given the date of accident, I would otherwise affirm and adopt the Arbitrator's decision.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLOTKIN, PAUL S
Employee/Petitioner

Case# **10WC042081**

INTERNATIONAL PROFIT ASSOCIATES INC
Employer/Respondent

17IWCC0560

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:

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2097 GRANT & FANNING
BLAKE T LYNCH
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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
NATURE AND EXTENT ONLY

Paul S. Slotkin
Employee/Petitioner

Case # 10WC042081

v.

International Profit Associates, Inc.
Employer/Respondent

17IWCC0560

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 cities of Waukegan and New Lenox, on April 22, 2015 and January 8, 2016. By stipulation, the parties agree:

On the date of accident, 01/29/2009, the Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between the Petitioner and Respondent.

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

Timely notice of this accident was given to the Respondent.

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

In the year preceding the injury, the Petitioner earned $139,000.16 and the average weekly wage was $2,673.08.

At the time of injury, the Petitioner was 60 years of age, married with no dependent children.

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

The parties stipulate that Petitioner is entitled to temporary total disability benefits for the period from April 20, 2009 through October 31, 2010 or 80 weeks at the rate of $1,231.41 per week (maximum rate). Respondent shall be given a credit of $98,512.80 for TTD paid for the period from April 20, 2009 through October 31,2010, for a total credit of $98,512.80 (80 weeks x $1,231.41).

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 $664.72 per week (maximum rate) for a further period of 100 weeks, as provided in Section8(d)2 of the Act, because the injuries sustained caused 20% loss of use of the whole person.

Respondent shall pay Petitioner compensation that has accrued from October 31, 2010 through January 8, 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 Dalton

Signature of Arbitrator

February 2, 2016

Date

Attachment to Arbitration Decision
Paul Slotkin v. International Profit Associates
10WC042081

FINDINGS

The Petitioner Paul Slotkin (Petitioner) was employed by the Respondent International Profit Associates (Respondent) as a senior business analyst selling consulting services, which required Petitioner to travel extensively, approximately 90% of the time. Petitioner was required to travel by air and by car in the United States and Canada, carrying with him: changes of clothing; office equipment, such as lap top computer and printer; and promotional materials in a rolling case weighing at least 35 to 40 pounds. Petitioner would be required to set up his computer and printer at each location he visited and he would visit about two locations per week.

Petitioner is right hand dominant and prior to January 29, 2009, Petitioner did not have any injuries to or medical treatment for his right shoulder and was working full duty in his job as senior business analyst.

The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment on January 29, 2009 when Petitioner slipped and fell on ice at a customer's location in Winchester, Virginia, striking his right elbow on the ground. Petitioner immediately noticed pain in his right shoulder.

On January 30, 2009 Petitioner sought medical treatment for his right arm at St. Mary Medical Center in Langhorne, Pennsylvania, near to where Petitioner lived at the time. PX 2, pg. 3. X-ray of the right shoulder raised the possibility of chip fracture of the inferolateral right scapula. PX 2, pg.8. Diagnosis was shoulder pain with suspected rotator cuff injury. PX 2, pg. 5.

On February 19, 2009, Petitioner followed up with this family physician Dr. Kravatz and Dr. Goldberg of Penn Care; diagnosis was joint pain in the shoulder and referral was made for MRI and surgical consultation. PX 1, pg. 8. MRI performed on February 20, 2009 showed: supraspinatus tendinosis with full thickness tear of the anterior leading edge and additional

partial tears; infraspinatus tendinosis with delaminating tear; and subscapularis tendinosis. PX 1, pg. 258.

On March 6, 2009, Petitioner followed up with Dr. Stephen Lowe of Makefield Orthopedics, who read the MRI, diagnosed acute rotator cuff tear, performed a subacromial injection and recommended surgical consultation with Dr. George Stollsteimer of Makefield Orthopaedics. PX 6, pg. 2.

On March 20, 2009, Petitioner followed up with Dr. Stollsteimer, who diagnosed right shoulder rotator cuff tear and recommended surgery. PX 6, pg. 5.

Until April 17, 2009, Petitioner continued working for Respondent.

On April 22, 2009, Petitioner underwent surgery by Dr. Stollsteimer at St. Mary Medical Center in Langhorne, Pennsylvania, consisting of right shoulder arthroscopy with mini-open rotator cuff repair. PX 2, pg. 25. Post-operative diagnosis was right shoulder rotator cuff tear. PX 2, pg.25. Operative report showed obvious full-thickness rotator cuff tear. PX 2, pg. 25.

After the surgery, Petitioner followed up with Dr. Stollsteimer who prescribed pain medication and physical therapy. PX 6, pg. 8.

On May 14, 2009, Petitioner began physical therapy at NovaCare in Morrisville, Pennsylvania, approximately two to three times per week. PX 3, pg. 20. On June 26, 2009, NovaCare noted ongoing significant deficit in range of motion of the right shoulder on objective examination. PX 3, pg. 82. By July 7, 2009, Dr. Stollsteimer noted that Petitioner was not making significant advancements in physical therapy and was considering surgical intervention to improve range of motion. PX 6, pg. 10.

On August 31, 2009, Petitioner underwent second surgery by Dr. Stollsteimer at St. Mary Medical Center, in Langhorne, Pennsylvania, consisting of: right shoulder examination under

anesthesia: right shoulder arthroscopy; arthroscopic capsular release; and arthroscopic lysis of adhesions. PX 2, pg. 79. Post-operative diagnosis was right shoulder adhesive capsulitis post rotator cuff repair. PX 2, pg. 79. Operative report showed adhesions anteriorly and posteriorly from the cuff up to the acromion. PX 2, pg. 80.

After the second surgery, Petitioner continued to follow up with Dr. Kravatz, who continued to prescribe pain medication for Petitioner. PX 1, pg. 323.

On September 1, 2009, Petitioner continued to undergo physical therapy at NovaCare. PX 3, g. 170. On March 2, 2010, NovaCare issued a discharge summary because Petitioner's progress in physical therapy had plateaued. PX 3, pg. 476. At that time, Petitioner demonstrated lack of range of motion in the right shoulder in flexion, abduction, and external and internal rotation. PX 3, pg. 468.

On April 16, 2010, Dr. Stollsteimer placed Petitioner at maximum medical improvement with restrictions of limited use above the shoulder and limited lifting of 20 lbs. or less above the shoul;der. PX 7, pg. 25.

On June 8, 2010, at the request of Dr. Stollsteimer, Petitioner underwent functional capacity evaluation (FCE) at NovaCare in Philadelphia. PX 5. FCE demonstrated: ability to function in the medium physical demand level; ability to occasionally lift up to 50 lbs. floor to waist, 30 lbs. waist to shoulder and 20 lbs. floor to overhead; ability to carry up to 20 lbs. unilaterally; frequent sitting and forward reaching at desk level; and frequent walking and standing. PX 5, pg. 1.

On or about October 21, 2010, the petitioner was offered a return to work by Respondent as either senior business analyst or senior area manager. RX 2. The Respondent's job description for senior business analyst states that the "work environment is dynamic, uncertain, hectic, frequently emotionally challenging coupled with physically harsh conditions, and extensive travel." RX 1, pg. 2. The job description for senior area manager involved extensive driving and lifting and carrying promotional materials.

On or about November 16, 2010, Petitioner was advised that his temporary total disability benefits were being terminated because he failed to return to work for Respondent on November 1, 2010. RX 3. Petitioner received Pennsylvania state unemployment compensation benefits after November 1, 2010.

On February 22, 2011, at the request of Dr. Kravatz, Petitioner saw pain specialist Dr. Buck of RA Pain Service, who diagnosed chronic pain and weakness secondary to shoulder injury and prescribed pain medication for Petitioner. PX 4, pg. 33. On April 6, 2011, Dr. Buck reported that Petitioner would need ongoing treatment for pain management as a result of his rotator cuff tear in the right shoulder and recommended that Petitioner not drive any long distances while taking medication. PX 4, pg. 34. Petitioner continued to see Dr. Buck through at least February 2012. PX 4, pg. 4.

In approximately July 2011, Petitioner created a company called Tudor Consulting Group through which he contracted his personal services to different accounting firms. In one year after November 1, 2010, Petitioner earned approximately $14,000 through Tudor. The work Petitioner performs for Tudor involves office work sitting at a computer, without any travel or lifting.

Petitioner now notices constant pain in his right shoulder and continues to take pain medication. Petitioner is restricted to lifting no more than 20 pounds over head. Petitioner feels physical fatigue in his right arm. Petitioner notices that his right arm is weak. Petitioner notices that he has a restricted range of motion in his right arm. Petitioner feels that the injury to his right shoulder caused him emotional distress.

CONCLUSIONS OF LAW

NATURE & EXTENT OF THE INJURY

In addition to the findings above, the Arbitrator notes the following in determining the nature and extent of the injury:

Petitioner's age at the time of the accident alleged herein was 60 years;

Petitioner testified to significant physical problems regarding his right arm and shoulder, most of which were reflected in the medical records and FCE;

No AMA report was offered in to the record;

That Petitioner was a senior business analyst at the time of the alleged accident;

That Petitioner's future earning capacity is unproven;

Based on the findings above, the Arbitrator concludes that Petitioner sustained accidental injuries that resulted in 20% loss of use of person as a whole pursuant to Section 8(d)2 of the Act. The Arbitrator bases this conclusion on the holding in Will County Forest Preserve District v. IWCC, 2012 IL App (3d) 110077WC.

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

Christopher Hastings,
Petitioner,

17IWCC0554

vs.

NO: 10 WC 43932

SOI/Pinckneyville Correctional Center,
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, prospective medical, causal connection and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2016, is hereby affirmed and adopted.

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

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

DATED: SEP 7 - 2017
o7/13/17
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

David L. Gore
David L. Gore

Stephen J. Mathis
Stephen J. Mathis

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

17IWCC0554

HASTINGS, CHRISTOPHER
Employee/Petitioner

Case# **10WC043932**

ST OF IL/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 4/14/2016, 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 0.35% 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:

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

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

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

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

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

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

APR 14 2016

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

17IWCC0554

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Christopher Hastings
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # **10** WC **43932**

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

FINDINGS

On **October 29, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$56,136.50**; the average weekly wage was **$1,079.55**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent child.

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

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

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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

Melinda M. Pace-Sullivan

Signature of Arbitrator

4/12/16

Date

APR 14 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Christopher Hastings
Employee/Petitioner

Case # 10 WC 43932

v.

Consolidated cases: N/A

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is employed by the State of Illinois Pinckneyville Correctional Center. He testified that he started with the Department of Corrections in July of 1998 and was hired at Pinckneyville as a correctional officer. He testified that he has not changed either his job title or the facility at which he works since the day he was hired. He testified that his job duties have not changed from the day he was hired to the present. He testified that when he was first hired at Pinckneyville it was not yet open, so he was sent to Sheridan for approximately one month.

Petitioner denied having any prior workers' compensation claims and further denied having any prior injuries to his elbows or hands. He denied being diabetic or having either gout or rheumatoid arthritis. He testified that his height and weight have remained the same for the last 15 years. He denied having high blood pressure and testified that he is 54 years of age.

Petitioner agreed that he had opportunity to review Respondent's exhibits, including the worker's compensation document log, the estimation of key usage, the job site analysis and the DVDs. He testified that his signature appeared on the report contained in the document log and that he completed the information on the report. He testified he picked the date of injury or illness of October 29, 2010 because that was the date on which he underwent nerve studies on his wrists and elbows. He testified that his statement that that was the date on which he first started feeling symptoms was an error. He testified that he had been having symptoms for a couple of months before he was tested, and that Dr. Blaise, his primary care physician, referred him to Dr. Alam. He denied having an attorney at the time that he saw either Dr. Blaise or Dr. Alam. He agreed that after he received the test results showing that he had positive findings, he then contacted his attorney. He testified that his attorney referred him to Dr. Brown.

Petitioner testified that he saw Dr. Brown for an initial work-up for his elbow and hand problems. He testified that he had tingling in his hands, that his elbows would hurt when he turned the keys or drove, and that his hands went numb any time he did anything with his hands. He testified that this was a gradual onset.

Petitioner testified that when he worked at Pinckneyville Correctional Center, most of his time was spent as a wing officer. He testified that a wing was a section of the cell house that housed up to 112 inmates. He testified that there were 52 cells on a wing, and that there were typically two inmates in each cell unless it was a handicapped cell in which case there would be up to four. He testified that as a wing

officer patrolling the wing, an electronic device secured the doors of each wing and that a wing key was used to open it. He testified that in the years immediately leading up to this accident, he was on the afternoon shift working 3 to 11. He testified that there was movement during that shift, and that one meal was fed during that shift. He testified that as a correctional officer he rotated and in the years leading up to his accident, he spent most of his time in segregation. He testified that in segregation, the inmates had to be fed, you had to open chuckholes, you had to give them showers and you had to keep an eye on the inmates. He testified that the doors in segregation were different than a regular wing in that you had to open the chuckhole and had to use a Folger-Adams key which was 5-6 inches long and opened the chuckholes to the cell doors so you could place the food or whatever they needed.

Petitioner testified that the chuckhole was a metal section that was approximately 12 by 6 inches on the door, and in order to open it you had to grab it with one hand and turn the key with the other and pull. He testified that he used both hands, that it was not easy to open and that many were really hard to open. He testified that they were old and worn, and that the inmates messed with them, food would get stuck in them and they would be jammed. He testified that food, feces and urine would be thrown in the chuckholes. He testified that when performing these tasks, he would have to use his wrist and whole arm, and that he had to keep turning and sometimes they would not open at all and he would have to write a report. He testified that when the chuckhole was opened, they would put in the food tray and shut it, or if giving the inmate a shower they would have to handcuff each inmate and double-lock each handcuff.

Petitioner testified that when there was a door in segregation, it would have to be opened with a cell door key that was approximately three inches long. He testified that the doors were made of solid steel. He testified that the doors in segregation had rubber strips on the bottom that were different than the regular wing doors, and that the strips were on the bottom to help keep toilet water from coming into the cell house. He testified that in segregation he cuffed and uncuffed inmates in segregation every day, and that most of the inmates were not easy to cuff. He testified that to cuff an inmate, he would first have to open the chuckhole, the inmate would back up to it and that he put the cuffs on each hand and deadlocked it. He testified that usually there were two officers cuffing and uncuffing the inmates. He testified that some of the inmates struggled, and that you typically used your arms to restrain them.

Petitioner testified that there were a few bars in the segregation unit and that they occasionally had to rap the bars. He testified that they used a mallet and were supposed to go through and rap once a day. He testified that he has rapped bars a few times, and that it felt like a vibration sensation and was numbing to the hands. He testified that there were bars in segregation in 5 on both A and C wings. He testified that during 2008 up through the end of 2010, he spent approximately 2-2.5 years as a wing officer in segregation on the afternoon shift.

Petitioner testified that a shakedown involved going into an inmate's cell, going through his property, and making sure there was no contraband. He testified that the inmates had property boxes where they kept all of their books, supplies, laundry, etc., and that the officers would have to go through them and that some of them were heavy. He testified that they would also have to lift up the mattress and TV to look underneath, and that they would use their hands and arms to lift the televisions and mattresses.

Petitioner testified that there was a locksmith on duty at Pinckneyville Correctional Center during the day shift, and that he had written a few work orders concerning the locks and the doors on the chuckholes. He testified that when he was in segregation, there were 52 cells per wing. He testified that a wing check was when you went down the wing every half hour, and that you were supposed to look through all the doors and make sure nothing was going on, no one was hanging, no one needed anything and that everything was alright. He testified that as they passed by each door, they often had to shake the door to make sure there was not something in the door so that the inmates could get out and that you had to rattle each door as you went down.

Petitioner testified that he had reviewed the videos prepared by the State of Illinois concerning the job description of a correctional officer, and he believed that the individuals on the video were going a lot slower than he actually worked and that you had to be a lot faster when you worked the wing. He testified that what he saw on the video was not showing any straining to open the chuckhole or the doors, and that it took more grip and force than what was shown. When asked to compare the frequency of the activity that he saw on the video versus what he did as a correctional officer, Petitioner responded that it seemed like it skipped around and was not constant. He testified that the video showed the R5 unit where he worked, and that he could not recall whether it showed the bars.

Petitioner testified that when the locks were stuck, he had to keep working with them to get them open. He testified that a lot of time they would eventually come open, but if they did not then he had to fill out a work order. He testified that it required force, was strenuous and required the use of both hands. He testified that this was more common in the segregation unit. He testified that the chuckhole was the equivalent of a food slot tray, and that when the chuckhole was stuck when being closed, he would have to keep slamming it until it shut. He testified that he is right-handed.

Petitioner testified that in the course of his employment at Pinckneyville, he estimated that he has opened a chuckhole and cuffed or uncuffed inmates tens of thousands of times. He testified that he has lifted property boxes and mattresses while performing shakedowns hundreds of times, and has opened cell doors tens of thousands of times. He testified that as he performed this activity, he started noticing his hands started tingling and that his his elbows were hurting. He denied having any hobbies that involved repetitive use of his arms or hands and further denied riding a motorcycle. He denied working on cars or being a mechanic. He further testified that he was never examined by Dr. Williams.

Petitioner testified that he performed a wing check every 30 minutes, and that every 30 minutes he was required to make an entry into a log book. He testified that every time you went into the wing, you had to open the door and pull on it. He testified that lockdown was when the whole institution was locked, and that the working inmates were sent back to their cell houses. He testified that they usually did a count to make sure everybody was accounted for. He testified that in 2008-2010, Pinckneyville Correctional Center was on lockdown approximately 20-25% of the time. He testified that when they were on lockdown, there was more opening of chuckholes and doors.

Petitioner testified that chuckholes were used to take care or service inmates on the regular wings on lockdown. He testified that he used the Folger key to open the chuckholes on wing doors. He testified that officers carried trash, laundry, meals and milk during lockdowns. He testified that he did not recall anything in the video or job site analysis showing the facility when it was on lockdown. He testified that not all of the handcuffs were in good working order, and that when trying to get a handcuff to work he would use his hands and arms.

Petitioner testified that when he saw Dr. Brown on December 22, 2010, he gave him splints. He testified that the splints did not help at all, so Dr. Brown said he needed surgery. He testified that it was soon after that he learned that his claim was denied. He testified that his hands have gradually gotten worse over the last three years, but that he was still performing the duties of a correctional officer. He testified that he wished to have surgery. He testified that he currently works midnights from 11 to 7. He testified that he performed activities around the house with his hands and arms such as cleaning. He testified that he has a 7 year-old daughter and that his wife is deceased.

Petitioner testified that Major Thompson appeared at the arbitration hearing, and that he worked with him a few times. He testified that Major Thompson had likely been his supervisor a couple of times over the course of 18 years. He testified that he had to qualify every year for weapons use, and that he had to qualify with a 12-gauge shotgun, a mini 23 rifle and a 38-caliber pistol. He testified that he did not

practice, but had qualified every year. He testified that when his hands hurt, he quits whatever he is doing because there is nothing he can do. He testified that he typically wakes up three or four times a night because whatever side he lays on, the whole hand or arm will go to sleep. He testified that if his hands tingle, he switches hands. He testified that he is unable to help his daughter practice her tumbling flips because he is afraid of dropping her and it makes his elbows hurt.

On cross-examination, Petitioner agreed that there were two types of segregation at Pinckneyville, that one was R5 and the other was R6 which was referred to as "little seg." He testified that he worked R5 when he said he worked 2-2.5 years. He agreed that in R5 there was a control pod, and that it was used for mass movements of inmates. He also agreed that it was used for running health lines. He agreed that mass movements would include going to dinner.

On cross-examination, Petitioner agreed that he started working at Pinckneyville in 1998, and that the 2-2.5 years he testified to referred to the timeframe of 2008-2010. He testified that for the timeframe of 1998 through 2010, he spent at least half of his time in R5 segregation and the other half would have been on a housing unit. He agreed that the housing units that were not R5 had control pods that were used to open the cell doors for mass movement. He agreed that when working on R5, there were inmate porters and that if the facility was not on lockdown, the inmate porters did some of the job duties like laundry and collecting trash. He testified, however, that they opened the chuckholes for them because they were not allowed to touch the keys. He agreed that on a regular housing unit there were inmate porters, and that the porters did some of the job duties such as laundry and taking the trash. He testified, however, that they had to open the chuckholes on a regular housing unit to get the trash out. He agreed that on R5, showers were done once a week.

On cross-examination, Petitioner testified that he no longer smoked but agreed that when he saw Dr. Brown in 2010 he smoked a pack a day. He testified that he quit smoking on January 1, 2015. When asked about the New Patient Questionnaire that he completed for Dr. Brown, Petitioner testified that he wrote that his job duties included the turning of keys for opening and closing doors. He agreed that he did not mention anything about using handcuffs, performing wing checks, using feed trays or the chuckholes. He denied having any other employment other than working for Respondent.

On cross-examination, Petitioner agreed that in the December 22, 2010 note it stated that he would use a Folger-Adams key 40-50 times an hour to open cell doors. He agreed that he did not use a Folger-Adams key to open cell doors, and that he used Folger-Adams keys to open chuckholes. He agreed that on the 11 to 7 shift there was bar rapping on R5 on the shower doors, and that he did not have to bar rap every individual cell.

On cross-examination, Petitioner testified that he had not seen Dr. Blaise's records prior to the date of arbitration. He agreed that October 15, 2010 was the first time he would have seen Dr. Blaise with the problem of numbness and tingling in his hands. He agreed that he testified that when he saw Dr. Alam on October 29th, he had had the problem for about two months. When asked about Dr. Blaise's note that indicated that the onset of wrist pain had been gradual following no specific incident and had been occurring in a persistent pattern for years, Petitioner responded that he did not know what Dr. Blaise indicated in the records. He testified that he did not recall whether he told Dr. Blaise that he had the problem for years. When asked if he recalled what he told Dr. Brown as to how long he had had the problem, Petitioner responded that he did not recall. He testified that if Dr. Brown's note stated that he had had a 3-4 year history of numbness and tingling in both of his hands associated with medial elbow pain and decreased strength, Petitioner responded then that was what he told him. He further agreed that at the time of the October 15, 2010 visit with Dr. Blaise, he described it as a hand injury while doing repetitive motions at work, that the problem was a workers' compensation claim and that his current symptoms included arm weakness while sleeping and driving.

On cross-examination when asked if Dr. Blaise referred him to see Dr. Paletta, Petitioner responded that he may have but then testified that he did not see Dr. Paletta. He denied that his attorney told him to see Dr. Paletta in 2011, but agreed that his attorney advised him to see Dr. Brown. He denied seeing any other physician for his hand problems other than Drs. Blaise and Brown.

On cross-examination, Petitioner testified that he was 5'11" tall and weighed approximately 215 pounds, and further testified that he weighed approximately 200 pounds in 2010. Petitioner admitted that he chose an accident date of October 29, 2010. When shown Respondent's Exhibit 9 on page 166, Petitioner admitted that he saw Dr. Blaise's name as well as another individual in his office, Emily Henson, on the note dated March 10, 2011. He agreed that the document referenced a date of accident of October 15, 2010, and he further agreed that this was the first visit with Dr. Blaise for his hand problems.

On cross-examination, Petitioner testified that for the bar rapping done in R5, he did this a few times in the shower cells. He agreed that there were several correctional officers that worked the shifts that he did, so sometimes they would do it and sometimes he would do it. He agreed that he previously testified that the chuckholes in R5 were not easy to open all the time, and that sometimes they would stick and he had to use a little more force to open them. He agreed that he testified that if he had a problem with one of the chuckholes, he would report it to the locksmith or fill out a work order to be submitted to the locksmith. He agreed that the locksmith would eventually repair the chuckhole.

On cross-examination, Petitioner agreed that Pinckneyville opened in 1998 and that when he started there it was a brand new facility. He agreed that the locks worked properly when it first opened. He agreed that when the facility first opened, the inmates had their own keys and that this took place for approximately five years. He further agreed that during those five years, the keying done by the correctional officers was less than it was at the time of arbitration or even back in 2010.

On redirect examination, Petitioner denied having undergone any sort of EMG/nerve conduction studies prior to October 29, 2010.

Jason Thompson was called as a witness by Petitioner at the time of arbitration. Mr. Thompson testified that he was employed by the Illinois Department of Corrections at the Jacksonville Correctional Facility, and that he was also in the National Guard. He testified that he worked at Pinckneyville Correctional Center from approximately July of 1998 until March of 2013. He agreed that he knew Petitioner, and testified that Petitioner was a correctional officer at Pinckneyville while he was a lieutenant. He testified that they tended to be on opposite shifts, but if they worked overtime they would tend to cross paths.

Mr. Thompson testified that he had knowledge of the job duties of a correctional officer at Pinckneyville, and denied having any trouble hearing Petitioner testify during the arbitration hearing. He testified that he did not think that Petitioner was being deceptive, and further indicated that there was nothing grossly incorrect or untruthful. He testified that he never had any difficulties or trouble with Petitioner as an employee.

Mr. Thompson testified that he performed the key estimation study. He agreed that at the time that his deposition was taken, he was under oath and was as honest and truthful as he was on the date of arbitration. He agreed that if asked the same questions, he would give the same answers as he did in the deposition.

On cross-examination, Mr. Thompson testified that he worked at Pinckneyville from the end of July of 1998 until March of 2013, but actually worked at the center until December 1, 2011. He testified

that from December of 2011 to March of 2013 he was at the DuQuoin Boot Camp, which was a satellite facility of Pinckneyville so he went back and forth to the actual facility. He testified that when he started at Pinckneyville, he was a correctional officer for three months and then became a lieutenant. He testified that he was familiar with the duties of a wing officer and that he was further familiar with the job duties in R5 segregation. He agreed that he supervised these positions at Pinckneyville, and that as a supervisor he would also pitch in and do some of the work of a correctional officer.

On cross-examination when asked whether he performed wing checks, Mr. Thompson responded that lieutenants had to do their own wing checks. He testified that he was mandated to check the wings twice per shift to ensure that the wing checks were being done. He testified that he was familiar with a wing check. He testified that in a normal housing unit other than R5, every 30 minutes the officer was required to check the security on all of the doors on both the upper and lower decks, check the equipment closets at the back of the wing, check the storage room on the top of the end of the wing and also check the laundry rooms. He testified that technically they were checking to see if the doors were locked, but it could be done visually. He testified that you could literally flick a finger and hear the locking mechanism hit on the bolt of the door. He testified that if there was any indication from the control pod that a door was showing that it was not secured, you would actually go down to that door and pull on it to make sure that it was secured. He testified that if the correctional officer actually pulled on the door, it did not generally take much force to check to see if the lock was working.

On cross-examination, Mr. Thompson testified that all of the housing units were controlled by a control pod, but that there was limited amount in R5 that they allowed to be controlled by the control pod. He testified that control pods opened the locks for mass movements in the regular housing and on the general population wings of R5. He agreed that there was a correctional officer in the control pod and was called the control pod officer. When asked what the control pod officer would do when one of the housing units (not R5) was going to lunch, Mr. Thompson responded that they would announce that they were getting ready for chow and to be on your doors in ten seconds. He testified that they would open up the bottom deck, which came out in a mass line. He testified that once they started to clear out, they opened up the top deck. He testified that the top deck would come out, come downstairs and they would count them out. He testified that the control pod officer hit a button which unlocked the doors.

On cross-examination, Mr. Thompson agreed that on R5 there was also a control pod. He testified that for mass movements they would use the touch screen control pod on the general population wings. He testified that when he left, R5 was broken down and had two wings that were general population and two wings that were segregation. He testified that R5 A and C wings were segregation, and that R5 B and D wings were general population when he left. He testified that from 2008 to 2010 it was not like that, and that all four wings were segregration. He testified that from 2008 to 2010, there was no mass line movement coming out of R5.

On cross-examination, Mr. Thompson agreed that in his deposition there was an error that he found pertaining to how he described the X wings of the cell house. He testified that with the X wings, there was a central control pod which acted as a hub, and that there were four "spokes" coming out of a mag wheel that looked like an X. He testified that in that X, there would be two that were general housing units in R5 after 2011. He testified that in housing units 1 through 4, there was no segregation in those units and only if receiving had mass overflow was there a segregation inmate in it.

On cross-examination when asked if there was bar rapping in R5 segregation, Mr. Thompson testified that when he was there they had a mesh screen on the doors that technically did not have to be bar rapped in R5. He testified that in little segregation, they had actual bars on the shower stalls that had to be rapped. He agreed that R6 had the shower stalls that needed to be rapped.

On cross-examination, Mr. Thompson testified that in his deposition the reference to ADA was incorrect and should have been AD, which referred to administrative directive. He agreed that he worked at other facilities such as Jacksonville, Pittsfield Work Camp, Green County Work Camp and DuQuoin. He testified that he was familiar with bar rapping at Stateville and Menard, where they had to bar rap the individual cells. He testified that the bar rapping that was done in R6 was identical to what was being done at Menard and Stateville but the amount was minuscule. He testified that the bar rapping at Pinckneyville was usually done with a broomstick in the early days, and then in approximately 2005 or 2006 they had a rubber mallet.

On cross-examination, Mr. Thompson testified that when he supervised the housing units for the majority of his career at Pinckneyville, in the general population units 1 through 4 and receiving the door locks were great. He testified that in the general housing units, it would take a correctional officer less than half a second to open a cell door with a key. He testified that with the chuckholes, 1-2% of the chuckholes would stick a little bit and took more than just a flick of the wrist to open it. He testified that with respect to the key study he performed, he directly observed housing unit 4, and that this was how he got the basis for housing units 1, 2, 3, 4 and the receiving wing because they all operated identically. He testified that he physically observed the key usage in R4 and tallied up how many keys were turned, and added a little bit of flexibility to account for the fact that some days were busier than others, and then he applied that to all the housing units. With respect to segregation, he testified that he did not really have the ability to directly observe it because he spent most of his time directly observing the housing units but he went back to the records that they kept for all of the moves that they did and added up all the movement in and out of segregation every day for a month, and then averaged that into a daily count. He testified that they kept very accurate records of who was moved in and out and who they moved internally in segregation, so it was a very precise number that he used for a monthly average. He testified that from the number of moves, he was able to calculate how many key strokes it would take to open the chuckhole, cuff the inmates, double-lock the cuffs, shut the chuckhole, open the door, bring the inmates out, close the door and go off the wing.

On redirect examination, Mr. Thompson agreed that the break-up between segregation and the regular housing units occurred in 2010. He agreed that there was a quantitative and qualitative difference between working in segregation and working in the general population, and that the inmates were in segregation for a reason.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a repetitive trauma injury with a date of accident of October 29, 2010, and that the body parts affected were that of the right and left hands as well as the right and left arms/elbows. (AX2).

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. Blaise/Medical Arts Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was referred to SI Neurology & Sleep Medicine, LLC for an EMG/Nerve Conduction Study on October 29, 2010 at the referral of Dr. Blaise. The study was interpreted as revealing (1) moderately severe bilateral ulnar neuropathy at elbow, right worse than left; (2) moderately severe bilateral carpal tunnel syndrome, right worse than left; (3) there is no evidence of cervical radiculopathy on either side. (PX3).

The medical records of Dr. Alam/SI Neurology & Sleep Medicine, LLC were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The identical EMG/Nerve Conduction study

performed on October 29, 2010 was included within the records as those contained in Petitioner's Exhibit 3. (PX4).

The medical records of Dr. David Brown/The Orthopedic Center of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on December 22, 2010 for evaluation and treatment for a problem with both of his upper extremities. It was noted that Petitioner worked at Pinckneyville since 1998, that he worked 37.5 hours per week, and that he was a right-hand dominant correctional officer at the facility. It was noted that Petitioner's job entailed turning Folger-Adams keys 50 times per hour to unlock and lock cell doors, that he would push and pull cell doors and that he had a 3-4 year history of numbness and tingling in both of his hands associated with medial elbow pain and decreased strength. It was noted that Petitioner underwent a nerve conduction study on October 29, 2010, which revealed findings consistent with moderate to severe bilateral cubital tunnel syndrome and moderate to severe bilateral carpal tunnel syndrome. It was further noted that Petitioner was a smoker. Petitioner was assessed with bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome, and he was recommended to wear wrist splints over both wrists at night and pillow splints over both elbows at night. He was also instructed to take a nonsteroidal anti-inflammatory. Dr. Brown noted that based on Petitioner's job description as a correctional officer combined with his own understanding of the job, he believed Petitioner's work activities would he considered in part an aggravating factor in the need for treatment for bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. It was noted that Petitioner could continue to work full duty with no restrictions. (PX5).

Included within the records of Dr. Brown was a New Patient Questionnaire which noted that Petitioner was referred to Dr. Brown by his attorney, Thomas Rich. With respect to the request to describe his job in detail, Petitioner noted "turning of keys, for opening and closing doors." (PX5).

The records of Dr. Brown reflect that Petitioner was seen on February 16, 2011, at which time he stated he had no improvement in his symptoms. He stated he had noticed increased pain over the volar aspect of his right wrist and increased numbness in his little and right fingers. It was noted that Petitioner had had numbness and tingling in both his hands for the past three years associated with medial elbow pain, and that his nerve conduction studies from October 2010 revealed findings consistent with moderate to severe bilateral cubital tunnel syndrome and moderate to severe bilateral carpal tunnel syndrome. It was noted that Petitioner noticed an increase in symptoms over the past seven weeks in spite of conservative treatment. The records reflect that Dr. Brown explained to Petitioner that due to the chronicity of his compression neuropathies and the fact that he had noticed no improvement over the last seven weeks and actually had increasing symptoms in spite of conservative measures, surgical decompression was an option. Petitioner was again recommended to continue to wear his elbow splints over both elbows at night and wrist splints over both wrists at night and to take a nonsteroidal anti-inflammatory. Petitioner was again allowed to work full duty, no restrictions. (PX5).

The transcript of the evidence deposition of Dr. David Brown was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Dr. Brown testified that he is a hand surgeon and is board-certified in plastic and reconstructive surgery as well as in hand surgery. He testified that two mentors in his training were Dr. Susan Mackinnon at Washington University and Dr. David Green. He testified that in his primary position as a treating physician, he saw anywhere from 120-125 patients per week. He testified that approximately 7% of his work included IMEs, second opinions, depositions and disability ratings. (PX6).

Dr. Brown testified that he has performed IMEs for Boeing in Missouri and Continental Tire in Illinois, as well as various insurance companies and defense firms in Illinois. He testified that he has also performed IMEs for the State of Illinois as well for the timeframe of summer of 2010 through spring of

2011. He testified that in the course of his practice he treats people who suffer from carpal tunnel syndrome and cubital tunnel syndrome, and that these are the most common conditions that he treats in his practice. He testified that he performs on average 8-10 carpal tunnel releases per week, and that he performs approximately 3-4 cubital tunnel releases per week. (PX6).

Dr. Brown testified that some of the more common risk factors or occupational factors that have been associated with carpal tunnel syndrome were things like vibration exposure over time, forceful gripping, forceful pinching, forceful turning, wrist flexion and wrist extension. He also testified that a cold environment has been associated with carpal tunnel syndrome as well. For the cubital tunnel syndrome condition, Dr. Brown testified that forceful turning of the forearm, elbow flexion, prolonged elbow flexion and leaning on the elbow were some of the more common risk factors. He testified that the frequency of these activities has been found to be important, and that the force involved has been found to be an independent factor so one could do these activities less frequently but with more force. He testified that the duration of exposure to these types of occupational factors has been found to be an important factor as well. (PX6).

Dr. Brown testified that with repetitive trauma, patients can be exposed to repeated micro-traumas from occupational factors over a prolonged period of time and be completely asymptomatic, but at some point they reach a threshold that as microtraumas accumulate they become symptomatic and develop the condition. He testified that was why the duration of exposure or latency was a key concept in understanding how repetitive trauma developed and worked. He testified that there was no bright line or threshold that someone had to meet before they developed the conditions, but it was known that the longer one was exposed to the occupational factors, the risk of developing the conditions increased. (PX6).

Dr. Brown testified that there were medical conditions that had been shown in the medical literature to be associated with an increased risk for developing carpal and cubital tunnel syndrome, including diabetes, arthritis, rheumatoid arthritis and lupus. He testified that the conditions were also more common in women than men, which was believed to be due to some subtle anatomical abnormalities where a woman's carpal tunnel was more prone to compression than a man's. He further testified that some of the older literature suggested that hypertension could be a factor, but more recent studies had not shown that high blood pressure was a factor. (PX6).

Dr. Brown testified that he had occasion to see Petitioner on December 22, 2010, and that Petitioner was referred to him by his attorney. He testified that Petitioner gave a history of a 3-4 year history of numbness and tingling in both of his hands with some associated medial elbow pain and decreased strength. He testified that prior to seeing him, Petitioner had seen his primary care physician and had been referred for electrodiagnostic studies which revealed findings consistent with moderate to severe bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. He testified that Petitioner explained to him that at that time he was 48 years old and had worked as a correctional officer at Pinckneyville since 1998 for approximately 12 years. He described his job as unlocking and locking cell doors 50 times per hour, and that he would also push and pull on cell doors as well as lock and unlock cuffs. (PX6).

Dr. Brown testified that the pertinent findings on the physical examination revealed a positive Tinel's sign over the left and right cubital tunnels, as well as a positive Tinel's and direct compression test over both carpal tunnels. He testified that the nerve conduction study was performed by Dr. Alam in Herrin, and that Dr. Alam was a board-certified neurologist. He testified that he reviewed the nerve conduction studies as well, and that he agreed with Dr. Alam's interpretation. He testified that Petitioner had symptoms and findings on examination as well as confirmatory electrodiagnostic studies for the diagnoses of bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome, and that he

recommended a course of conservative treatment of wearing wrist splints over both wrists at night, pillow splints worn at night to keep the elbows straight and anti-inflammatory medications. He testified that based on Petitioner's job description of unlocking and locking cell doors 50 times per hour, pushing and pulling on cell doors and being exposed to activities over the course of greater than a decade in an otherwise healthy 48-year-old man with no other medical problems, it was his opinion that those were considered at least an aggravating factor to his cubital tunnel syndrome and carpal tunnel syndrome diagnoses. He testified that by the time he had seen Petitioner he had also seen several other Pinckneyville correctional officers, so he had a basic understanding of what they were doing based on their job descriptions. He further testified that he did not find any non-occupational risk factors, as Petitioner denied a history of diabetes, hypothyroidism and arthritis. He testified that Petitioner denied being involved in any active hobbies or sports activities outside of work, and he did not recall that Petitioner was obese. (PX6).

Dr. Brown testified that he saw Petitioner one additional time approximately two months later, and that he reported no improvement and actually noticed some increased symptoms. He testified that based upon Petitioner's history of having the symptoms for 3-4 years and increased symptoms despite approximately two months of conservative treatment, confirmatory electrodiagnostic studies and two positive physical examinations, he felt that Petitioner was a candidate for decompression of the nerves. He testified that he did not believe that the surgery was scheduled as approval was being sought. He denied seeing Petitioner since that time. (PX6).

Dr. Brown testified that since his care and treatment of Petitioner, he had also reviewed some additional materials about Petitioner's job for Pinckneyville. He testified that he reviewed two jobsite analyses which were commissioned by the State of Illinois, one of which was dated December 7, 2010 and the other of which was dated February 2, 2011. He testified that he reviewed two DVDs that corresponded to those, one of which was dated December 13, 2010 and the other of which was dated January 20, 2011. He also testified that he reviewed a key estimation study which was done February 14-17, 2011. He further testified that he had post descriptions, as well as deposition testimony of a locksmith at Pinckneyville, the lieutenant that performed the key estimation study, and several other correctional officers' on-the-job duties at Pinckneyville. He further testified that he had reviewed two reports from Dr. Williams, one of which was dated April 15, 2012 and the other of which was dated December 17, 2012. He also testified that Petitioner provided supplemental information about his job, which included a page and a half of handwritten comments from Petitioner about his job duties that were provided to him by his attorney's office. (PX6).

Dr. Brown testified that he reviewed the deposition testimony from the Pinckneyville correctional officers, lieutenant and locksmith multiple times since 2011. He testified that he reviewed the deposition testimony of Jason Thompson, a lieutenant at Pinckneyville; Robert Schuckert, the locksmith at Pinckneyville since 2004; Jaelene Brian, who worked there for 13 years as a correctional officer; Jimmy Phillips, another correctional officer; and Donna Jones, who had been a correctional officer at Pinckneyville for 13 years. He agreed that the deposition transcripts were marked as Petitioner's Exhibit 2 through 6. The Arbitrator notes, however, that only the transcript of the evidentiary deposition of Jason Thompson, marked as Petitioner's Exhibit 5, was ultimately attached to Dr. Brown's deposition transcript and submitted into evidence at the time of arbitration. (PX6).

Dr. Brown testified that all of the individuals testified that the job site analysis and DVDs did not accurately show what the correctional officers did. He testified that the job site analysis did not show the officers repeatedly pulling on the heavy cell doors to make sure they were secure, nor did the job site analysis accurately depict the frequency of the activities such as opening and closing locks, turning keys, opening and closing cell doors and pulling on cell doors to make sure they were closed. He further testified that the individuals also testified that the locks and doors were difficult to open, that the locks

oftentimes got stuck and that they had to repeatedly forcefully turn the keys and locks multiple times to get them to open. He also testified that the chuckholes were also very difficult to open and close because food and other material often got stuck in the chuckhole doors, and that cuffing and uncuffing of inmates was not always simple. (PX6).

Dr. Brown testified that the individuals also testified that in 2010 and before, Pinckneyville was short-staffed and alot of the correctional officers were working double shifts, working overtime and working more than one wing at a time, and that this was not depicted anywhere in the materials. (PX6).

Dr. Brown testified that the deposition testimony was a very important source of information because they were all individuals who had worked at the facility for over a decade so they knew their jobs. He further testified that Lieutenant Thompson described that the chuckholes got stuck all the time. He testified that it gave insight on what it was like to work there as opposed to someone who was there for 3-4 hours and then generated a report about what the job was like. He testified that he relied on the deposition transcripts and the testimony in forming his opinions, and that it was part of the information that he relied on in addition to the job description obtained from Petitioner. (PX6).

Dr. Brown testified that the information provided by Petitioner's attorney suggested that Petitioner most recently worked as a segregation correctional officer and a segregation sergeant where, according to the key estimation study, most of the keying was done. He testified that Petitioner described his work as a relief sergeant, and that he worked two days as a segregation sergeant during which he would have to key 100-200 keys a night depending on the particular shift. He further testified that the other days Petitioner was a housing sergeant, where he would have to feed which involved keying. When asked what was significant about working in the segregation unit, Dr. Brown responded that viewing all of the information about the Pinckneyville facility including the information provided by the State, the key usage study and the testimony from other correctional officers, this was the part of the facility where most of the keying was done. He further testified that this was the one area where there was bar rapping in the showers, which was significant to him due to the vibrational exposure if performed frequently enough. (PX6).

Dr. Brown testified that the job site analyses were insufficient, and that he would have preferred to see a better quantification of the amount of keying performed by the correctional officer. He testified that the job site analyses did not address the issue of checking to make sure the cell doors were secure, which involved forcefully pulling on the cell doors. He further testified that the analyses mentioned handcuffing but did not talk about the frequency of the cuffing, and that some information was provided about strength demands but did not provide enough information. He testified that if the job site analyses were the only information that he had and whether he would feel comfortable rendering an opinion whether the job duties could contribute to conditions like carpal tunnel syndrome or cubital tunnel syndrome, he would like to see more information before rendering an opinion. (PX6).

Dr. Brown testified that the DVDs he reviewed were dated December 13, 2010 and contained Lieutenant Thompson demonstrating some of the activities that the correctional officers did, including opening and closing cell doors, turning a key and walking the wing. He testified that the DVD also showed Lieutenant Thompson demonstrating the process of taking an inmate to a shower. He further testified that the second DVD showed an officer talking and going on a tour, and that he was not performing activities which was not helpful. (PX6).

With respect to the key estimation study, Dr. Brown testified that the key estimation study performed by Lieutenant Thompson was helpful and suggested to him that most of the keying was done in segregation as well as with wing officers. He testified that the key estimation study was consistent with what Petitioner reported to him. He testified that the key estimation did not take into account the

increased keying that was performed when the facility was on lockdown, nor did it take into account increased keying when a correctional officer was working more than one post or working more than one wing. (PX6).

When asked if after reviewing all of the documents whether his opinion was at all changed, Dr. Brown testified that he still thought Petitioner was exposed to occupational factors of repeated forceful pinching from keying the cell doors, repeating forceful gripping from pulling and pushing on the cell doors and cuffing and uncuffing inmates at a level way beyond what someone would have encountered in normal activities of daily living, and that exposure to those activities over the course of greater than a decade in an otherwise healthy individual was at least an aggravating factor to both carpal tunnel syndrome and cubital tunnel syndrome. (PX6).

When asked if Petitioner was given a different job that required less keying or less forceful gripping or pinching and whether he would expect the carpal and cubital tunnel syndrome conditions to go away or for his symptoms to improve, Dr. Brown responded that in cases of patients with chronic nerve compressions oftentimes those changes were not reversible even if removed from activities which could be aggravating or contributing to the condition. He testified that in cases where the patients only had the symptoms for a short period of time, those were cases where he would expect that if they were removed from the occupational factors which were aggravating or contributing to it, he would expect for those individuals' symptoms to improve. He testified that nerves could become permanently damaged. (PX6).

Dr. Brown testified that he reviewed two records review reports from Dr. Williams, and that from his review there were things that they disagreed and agreed upon. He testified that some of the things on which they agreed included the risk factors for carpal and cubital tunnel syndrome. He testified that some of the things on which they disagreed included the interpretation of the nerve conduction study performed by Dr. Alam and the issue of causation. He testified that he had the opportunity to talk to Petitioner and examine him, and that Dr. Williams did not have the opportunity to do so. He testified that Dr. Williams did not have the opportunity to review the deposition testimony of the correctional officers who had worked there for more than a decade, including the locksmith who talked about the condition of the locks. He further testified that Dr. Williams did not have the opportunity to review the deposition testimony of Lieutenant Thompson or the other correctional officers that talked about all of the other activities that they had to do, and how the job site analysis did not really depict what they did. (PX6).

Dr. Brown testified that in the second report authored by Dr. Williams, he reviewed additional office notes from Dr. Blaise and Dr. Hanson, as well as pre-accident medical records in 2007 referencing low back pain precipitated by heavy weightlifting. When asked if Dr. Williams was in a better position to describe and give an opinion on what the correctional officers did on a daily basis given his participation in a 4-hour guided tour, Dr. Brown responded that Dr. Williams could tell him what it was like to cuff a correctional officer but he did not think he was in any better position to tell him what it was like to open cell doors at the facility or what it was like to cuff an inmate that was struggling. (PX6).

Dr. Brown testified that Dr. Williams did not give an alternative explanation to Petitioner's symptoms beyond reference to weightlifting. He testified that it was important when seeing someone for an IME to actually examine them and take an in-person history from them, as oftentimes you got a different history from the patient as to what their job duties were as compared as the information from the employer. He testified that it was critical to examine and interview the patient. (PX6).

Dr. Brown agreed that he has not seen Petitioner since February of 2011, so he would need to re-examine him and, if Petitioner still had symptoms consistent with a compressive neuropathy, he would likely repeat the nerve conduction studies and then make his recommendations. (PX6).

Dr. Brown testified that the bills were generated as a result of the care and treatment required due to his work injury, and that they were reasonable and customary charges for the same or similar services rendered in the medical community and in his geo-zip area. He further testified that all of his opinions had been rendered to a reasonable degree of medical certainty. (PX6).

On cross-examination, Dr. Brown agreed that he had only seen Petitioner on two occasions and that he was not aware whether Petitioner had contacted his office since February of 2011. He testified that at the last visit he felt that surgery was a reasonable option at that point. He testified that he did not believe that Petitioner had ever contacted his office after that point to request surgery. He testified that he would have performed the surgery if it had been approved, and that he was an out-of-network provider so Petitioner would have had to pay out-of-pocket for him to do the surgeries and never made the request. He testified that he has referred patients to other in-network physicians to perform surgery when the patient has requested it. (PX6).

On cross-examination, Dr. Brown agreed that he has sent patients to Dr. Paletta in the past because he was in-network for some of his patients and took most major private health insurance. He agreed that he did not review any of Dr. Blaise's records beyond those referenced in Dr. Williams' reports. He agreed that Petitioner never contacted him for a referral. He testified that if Petitioner's case was deemed not to be compensable, then he would be more than happy to perform Petitioner's surgery if he had out-of-network benefits and if Petitioner wanted to pay the extra out-of-pocket cost. (PX6).

On cross-examination, Dr. Brown testified that he authored an article regarding evidence-based medicine and submitted it to the *Journal of Hand Surgery* which was ultimately published. He testified that the *Journal of Hand Surgery* was a publication which contained studies regarding problems with the hand and upper extremity. He agreed that it was a peer-reviewed journal. He testified that there were multiple occupational and non-occupational factors that have been associated with the development of carpal tunnel syndrome in multiple studies. He agreed that he was familiar with the article entitled "The Quality and Strength of Evidence for Etiology: Example of Carpal Tunnel Syndrome" written by Dr. David Ring in 2008, but testified that it was not an article that was widely considered the treatise on repetitive trauma and hand surgery. When asked if he agreed that idiopathic carpal tunnel syndrome was the most common peripheral mononeuropathy, Dr. Brown responded that he agreed that carpal tunnel syndrome was the most common peripheral mononeuropathy but he thought in most cases idiopathic meant there was no identifiable risk factor whatsoever and he thought that in most cases patients had at least one – and often more than one – factor that was associated with carpal tunnel syndrome. (PX6).

On cross-examination, Dr. Brown agreed that his first visit with Petitioner took place on December 22, 2010 and that Petitioner was referred to him by his attorney's office. He agreed that was when Petitioner filled out the New Patient Questionnaire. He agreed that Petitioner was asked in the questionnaire what his hobbies were, and that Petitioner did not list any. He testified that Petitioner indicated that he was a smoker, and that he smoked a pack a day for 4 years. When asked if there was a correlation between smoking and compression neuropathies at the elbows and wrists, Dr. Brown responded that there were anecdotal studies in the older literature that suggested there was but the most recent studies did not. (PX6).

On cross-examination, Dr. Brown agreed that Petitioner told him that he was a correctional officer but denied that he reported that he was a relief sergeant. He agreed that he was aware that there was a difference between the rank of sergeant and correctional officer. He testified that Petitioner told him that he had been working at Pinckneyville since 1998, and that he worked 37.5 hours per week. He testified that Petitioner reported to him that he turned Folger-Adams keys 50 times per hour. When asked what the Folger-Adams keys were used for at Pinckneyville, Dr. Brown responded that they were

primarily used for the chuckholes and were mostly used in segregation. He testified that what Petitioner reported to him was included in his report. (PX6).

On cross-examination, Dr. Brown agreed that a correctional officer at Pinckneyville used more than just a Folger-Adams key, and that if he used Folger-Adams keys 50 times per hour he would use other keys throughout the day. He agreed that if Petitioner used the Folger-Adams key 50 times per hour over the course of a 7.5 hour shift, Petitioner would be using the key some 375 times per day. When asked about the key estimation study, Dr. Brown agreed that the 335 figure was not referring to five days per week for the 3 to 11 shift for R5 segregation. He testified that the amount of key turning of 50 times per hour in addition to the other job duties was not inconsistent with the key estimation study. Dr. Brown testified that there was no bright line minimum that Petitioner could turn keys at Pinckneyville and still develop carpal and cubital tunnel syndrome, and that you had to take all factors into consideration. (PX6).

On cross-examination, Dr. Brown testified that in his December 22, 2010 note he did not specifically say that Petitioner turned keys 50 times every hour, and that he interpreted his report as that was one of the activities that Petitioner did throughout the day in addition to the other activities which would be aggravating factors. He testified that it was not reasonable to interpret his report that Petitioner was doing it every hour, because Petitioner was doing other things throughout the day such as pushing and pulling on cell doors as well as cuffing and uncuffing inmates. He testified that in the job site analysis no force measurements were given, which was not done in this case. (PX6).

On cross-examination, Dr. Brown agreed that the frequency with which the individual did the job was an important factor to consider. He testified that with respect to the number of times that Petitioner turned the Folger-Adams keys, he had information that Petitioner estimated he would turn keys 180-200 times per day and that this information was given to him the week prior to the deposition. (PX6).

On cross-examination, Dr. Brown agreed that the Folger-Adams keys were only used on chuckholes and that he was not using them on cell doors. He testified that since December of 2010 everyone had learned a lot more about keying, and that there was a typographical error in his report. He agreed that the Folger-Adams keys were used on a chuckhole, not a cell door. He testified that Petitioner did not state which segregation he worked, but that he was a segregation sergeant. He admitted that he was not aware of which segregation they did bar rapping in, but testified that bar rapping did not have an effect on his causation opinion as it was done infrequently. (PX6).

On cross-examination, Dr. Brown testified that there was a typographical error in the December 22, 2010 note that referred to cell doors, in that Folger-Adams keys were not used on cell doors but rather were used on chuckholes. He agreed that Petitioner reported that he used a key to unlock and lock cell doors as a correctional officer, and further agreed that he did not mention in his report that he had any problems opening chuckholes or that he even did that activity. He agreed that Petitioner did not report that the chuckholes were difficult to open because food was stuck in them. He further agreed that Petitioner did not tell him anything about cuffing and uncuffing of inmates as being a stressful activity because of the resistance that the inmates sometimes used. He testified that if one were doing the cuffing and uncuffing frequently enough, he thought the turning of the keys to double-lock a cuff if done on a frequent basis throughout the day over a prolonged period of time could potentially aggravate carpal tunnel syndrome. He testified that for the correctional officers on a housing wing, it would depend on how frequently the officers were cuffing and uncuffing inmates. He agreed that it was the resistance of the inmates that made it problematic. (PX6).

On cross-examination, Dr. Brown testified that if the cuffing and uncuffing were done on a frequent basis or for a prolonged period of time, he still thought it could be a risk factor even if there was

no resistance from the inmates. He testified that if the inmates were struggling and trying to get out of the cuffs, the force was increased and that made it a more important risk factor. He testified that absent the force of the inmates resisting, it could still be a risk factor if done frequently enough over a prolonged period of time. (PX6).

On cross-examination, Dr. Brown agreed that he was aware that there was a policy of job duty rotation at Pinckneyville, but testified that the depositions from the correctional officers suggested to him that many of them were not rotated. Dr. Brown agreed that he had seen the Supervisor's Report of Injury or Illness dated November 21, 2010 as prepared by Major Edwards. He testified that Petitioner's job duty as of November 21, 2010 according to Major Edwards was that of tower relief. He agreed that there was a difference between a cell house officer and a segregation officer at Pinckneyville Correctional Center. (PX6).

On cross-examination, Dr. Brown testified that there was more keying in segregation. He agreed that he reviewed the Worker's Compensation Employee's Notice of Injury prepared by Petitioner on November 16, 2010, on which Petitioner indicated he was performing repetitive turning of keys. He noted that Petitioner indicated that he was a cell house officer, and that he indicated repetitive turning of keys was what happened regarding how the injury occurred. He agreed that Petitioner did not mention any pushing and pulling on cell doors. While Dr. Brown agreed that Petitioner did not mention repeated locking and unlocking of cuffs, Dr. Brown noted that activity involved key turning. He agreed that when he saw Petitioner on December 22, 2010, he also listed the pushing and pulling on cell doors. (PX6).

On cross-examination, Dr. Brown agreed that based on his December 22, 2010 note, he could not tell how tall Petitioner was. He agreed that the only outside medical record that he had when he saw Petitioner on December 22, 2010 was the nerve conduction study of Dr. Alam. He testified that a height of 5'11" and 200 pounds placed Petitioner in the obese category. When asked if weightlifting could lead to the development of carpal and cubital tunnel syndrome, Dr. Brown responded that it depended on the frequency, duration of exposure and type of weightlifting. (PX6).

On cross-examination, Dr. Brown testified that the DVD was not helpful because it was a walking tour and did not show actual workers doing their jobs. He testified that the depositions of the correctional officers, however, were helpful because it was sworn testimony taken under oath of individuals who had worked there for greater than 10 years and described what they did on a daily basis. The Arbitrator notes, however, that no such deposition transcripts (with exception of Jason Thompson) were admitted into evidence the time of arbitration. (PX6).

On cross-examination, Dr. Brown agreed that the next time he saw Petitioner was on February 16, 2011, at which time he admitted he did not ask any more information about Petitioner's job duties on that date. Dr. Brown admitted that he was familiar with the American Academy of Orthopaedic Surgeons' *Guidelines of the Treatment of Carpal Tunnel Syndrome*, which recommended that the physician should obtain an accurate patient history as well as how long the symptoms had been present in addition to the severity and character of the symptoms. He testified that Petitioner gave a history of a 3- or 4-year history of numbness and tingling in both his hands, associated medial elbow pain and decreased strength. He testified that he did not note under the severity of character guideline as to when the symptoms occurred. He agreed that it can be important if symptoms are occurring when doing an activity, and that Petitioner related to his primary care physician that work activities aggravated his symptoms. (PX6).

On cross-examination, Dr. Brown testified that it was not significant to him if Petitioner reported that he had the symptoms while driving. When asked if driving could lead to the development of carpal and cubital tunnel syndrome, Dr. Brown responded that it was primarily for over-the-road truck drivers that did prolonged driving which required gripping of the steering wheel, vibration exposure or leaning on

the elbows as to when driving could aggravate those conditions. When asked if he had a differential diagnosis with regard to Petitioner, Dr. Brown responded that the most common causes by far for numbness and tingling in the hands associated with decreased strength and medial elbow pain were carpal tunnel syndrome and/or cubital tunnel syndrome and that if Petitioner presented with a history of neck pain, it could potentially be due to a cervical radiculopathy. (PX6).

On cross-examination, Dr. Brown agreed that the sensitivity and specificity of nerve conduction studies could not be determined with absolute certainty and the use of reference standards that were variable from study to study could give differential results. When asked if he examined Petitioner's neck, Dr. Brown responded that he did not as he was a hand surgeon. He testified that the American Academy of Orthopedic Surgeons' guidelines should not be construed that every patient that came into his office with carpal tunnel-type symptoms needed to have a neck examination. He testified that the guidelines should not be construed as including all proper methods of care or excluding methods of care reasonably directed to obtain the same results. He agreed that in this case he had no clinical suspicion of any neck problems. He testified that he was supposed to perform a neck examination only if he suspected other diagnoses such as a cervical neck problem, and that you did not do it on every patient that had carpal tunnel syndrome. (PX6).

On cross-examination, Dr. Brown agreed that with respect to the Dr. Ring study, one of the conclusions was that modern keyboarding and computer use had a strong association with carpal tunnel syndrome. He testified that the study did not say that typing did not aggravate carpal tunnel syndrome and cubital tunnel syndrome. He testified that he did not label things as either work-related or not work-related. He further testified that he tried to apply evidence-based medicine to his opinions. (PX6).

On cross-examination, Dr. Brown denied that Petitioner mentioned any overtime work to him. He testified that the timeline history that Petitioner gave started in 2001, and that there were no activities listed prior to 2001. He testified that it was his understanding that Petitioner started at Pinckneyville in 1998, and he further believed that Pinckneyville opened in 1998. He agreed that it was a reasonable assumption that in 1998 the locks might work better when they first opened than they did 10 years later. (PX6).

On cross-examination, Dr. Brown testified that he thought that Petitioner worked for 10 years and then started having symptoms because Petitioner had occupational stressors that affected carpal tunnel and cubital tunnel syndrome. He agreed that if there were damage to the median and ulnar nerves, they could regenerate depending on the severity of the damage. (PX6).

On redirect examination, Dr. Brown testified that it was important to him what activities the individual was doing as well as the frequency and duration of exposure as opposed to the individual's job title. He testified that when he sees individual as a treating physician, he is looking for a basic understanding of what the individual does at work and was not preparing reports in contemplation for litigation. (PX6).

The transcript of the video evidentiary deposition of Jason Thompson was attached to the deposition transcript of Dr. Brown and marked as Petitioner's Deposition Exhibit 5. Mr. Thompson testified that he was employed by the Illinois Department of Corrections at the Pinckneyville Correctional Center. He testified that he began working at the Department of Corrections in 1996, and that in August of 1998 he transferred to Pinckneyville. He testified that when he first started at Pinckneyville, he was actually a correctional officer. He testified that he was promoted to lieutenant approximately two months after he arrived at Pinckneyville, and had been operating as a correctional lieutenant for 13 years. (PX6/Petitioner's Deposition Exhibit 5).

Mr. Thompson testified that he accompanied Dr. Williams on his tour of the adult correctional center but did not learn that he was present until after the tour was over. He testified that he and Dr. Williams were in both R3 and R4 when being filmed. He testified that R3 and R4 were housing units 3 and 4, which were X-wing-style and held approximately 448 inmates. He testified that there were two wings with 88 cells in each, which were four-man cells. (PX6/Petitioner's Deposition Exhibit 5).

Mr. Thompson testified that he saw Dr. Williams turn one handcuff key as well and a wing key door and that Dr. Williams found the handcuffs to be a little awkward and had difficulty hitting the double-lock key portion of it. He testified that with the handcuff keys, there was the keyhole in which the key fit and was turned. He testified that on either the edge or on the opposite of the keyhole there was also a double-locking mechanism. He testified that they were double-locked so they could not be compressed any further and they were hard to jimmy, which was for safety. He testified that Dr. Williams did not go with him to the R5 unit. He denied that Dr. Williams went with him out to the yard, nor was there any visit to the areas where showers were taken in segregation. He further testified that Dr. Williams did not make any effort to open a chuckhole. (PX6/Petitioner's Deposition Exhibit 5).

Mr. Thompson testified that he saw a video prepared by Corvel for the officers, which he believed was 38 minutes long. He denied being asked to give any opinions or any presentation or any facts concerning its accuracy. He testified that he did, however, do a key use estimation for Pinckneyville which he turned in to the warden. He testified that he did not see a video for a correctional lieutenant at Pinckneyville Correctional Center, but believed he was the subject of the video. He testified that the basic difference between a correctional officer and a correctional lieutenant was that the correctional lieutenant supervised the work being done to make sure that security and procedures were being upheld. He testified that the lieutenant did not do as much key turning as the officers, and he agreed that he completed more paperwork than physical work. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that when he first met Dr. Williams on the way to his housing unit and admitted that he did not know where he had been prior to meeting up with him. He testified that he did not know who Dr. Williams was accompanied by from his facility, but testified that he was sure Dr. Williams was accompanied by someone. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson agreed that he was on his way to housing units 3 and 4 that day. He agreed that housing units 3 and 4 did not contain the segregation unit. He admitted he did not know whether Dr. Williams went to the segregation unit. He testified that after Dr. Williams left, he remained with the two ladies from CorVel where they videotaped him in R3 and R4 during chow lines. He testified that after watching him during chow lines, he walked them past R5 so they could see the outside and then passed receiving segregation. He testified that he could not recall whether Dr. Williams was with them when they went to the chow lines, but he did not think he was. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that he was unable to recall whether segregation was on the video that he saw. He testified that there were two segregations at Pinckneyville, including R5 as well as a receiving segregation, which was a single wing of segregation which was also accompanied by a receiving wing. He agreed that he performed the key estimation study, which contained an estimate for every position at the prison. He testified that it took him three days to perform the estimation, and that he did both a visual observation as well as a request for paperwork from their movement. He testified that there was no difference between R1, R2, R3 and R4, and that he also went to receiving segregation as well as healthcare. He testified that the study was based upon his observation as well as his experience, and that as a lieutenant he supervised the correctional officers and sergeants. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that most of the key-turning took place in R5 segregation. He testified that R5 would have Folger-Adams keys for the chuckholes, but housing had Folger-Adams keys for chuckholes. He testified that the chuckholes were supposed to be closed, and that they were closed on day shift for safety reasons. He testified that he was not certain how many lockdowns Pinckneyville had been on in the last year, but he believed there were either one or two institution-wide. He testified that a Level Four lockdown could occur anywhere, it just affected the number of people being locked down. He testified that in a Level One lockdown, every inmate in the prison was in his cell. He testified that in a Level Four, you could get your workers out and they could have unfettered movement on the wing as long as they were doing work. He agreed that you would cuff the workers while under a Level Four lockdown. He agreed that shakedowns would not be performed on midnights, and that every cell had to undergo a shakedown every 30 days. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, when asked out of the last five years many times there had been a Level One lockdown, Mr. Thompson responded that he was gone for almost two years in Afghanistan and returned at the end of 2009. He testified that he believed they were on a Level One lockdown for approximately one month at the beginning of 2010. He agreed that as a lieutenant, part of his job included taking work orders regarding bad locks. He testified that in the regular housing units, there were not very many during a week. He testified that in R5, there were approximately one or two per week. He testified that in the regular general population housing units, on a monthly basis he would receive perhaps two or three. He further testified that in his entire 13 years at the facility, he had seen a key snap off in a lock either three or four times. He testified that the keys broke, but they did not always snap off inside the lock. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that there were bars on the shower cells in receiving segregation. He testified that he did not believe they were required to be rapped, but testified he had seen people use a broom which made a different sound if the bar was cut. He testified that it could take anywhere from 10-20 minutes to do a thorough shakedown on an average cell. He testified that it took approximately half a second to turn the key in order to open one cell in general population. When asked how long it would take to open segregation one cell out from a double-occupied cell with a regular chuckhole, Mr. Thompson responded that it could take 3-5 minutes. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that on day shift, they always had at least three officers on the floor, acting as wing officers. He testified that on day shift, he tended to have seven officers and a property officer. He testified that wing officers also manipulated the property boxes, and that there were porters that helped with the feeds in segregation and passed trays to inmates. He testified that during a lockdown of a wing or a house when it was a Level Four Lockdown, there would be inmate porters. He further testified that dietary workers packaged the food, and then they passed it out. He testified that when there was a lockdown on the general population, trays were made of styrofoam and taken to the second floor by being carried out manually in a gray laundry cart. He further testified that typically two correctional officers carried the carts as they sometimes weighed more than 100 pounds. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that there could be 50 inmates on a transfer bus. He testified that on a normal day, they would arrive at the facility, get the bus ready and bring the bus into the institution. He testified that generally they picked up inmates from another bus so they did not have to put handcuffs on every inmate as they had already been cuffed. He testified that the inmates were placed on their bus, and that every inmate was handcuffed to a leader chain that ran down the center of their seats. He testified that they were secured to the chain with the double-lock at both the chain and on the wrist. He testified that handcuffs were taken off once the inmate was given to the officer at the switch point at Logan. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that they were required to qualify once per year for weapons training. He denied having a metal bar to bar-rap at Pinckneyville. He agreed that he used keys as a lieutenant, and admitted that he sometimes had difficulties with the keys. He testified that chuckholes stuck all the time and that food would gum up the lock. He testified that every now and then, you also had an inmate try to sabotage a unit. He testified that there were a lot of chuckholes that were sticky. He testified that they typically did not have difficulties with the key to the cell door. He testified that sometimes the pins got loose or the key was worn out and it would not completely engage the pins when you locked it. He testified that for the most part, the actual door locks had minimal problems. He testified that the cell doors were heavy but were on fairly stout hinges. He further testified that he needed more momentum to open them because they were heavy. (PX6/Petitioner's Deposition Exhibit 5).

On cross-examination, Mr. Thompson testified that there was paperwork to be completed by the correctional officers, including tracking call passes, inmates going to the health care unit, 30-minute wing checks and cleaning equipment logs. He testified that pod officers had to maintain inventories, perform spot checks and prepare chronological logs. (PX6/Petitioner's Deposition Exhibit 5).

On redirect examination, Mr. Thompson agreed that he performed a key study. He agreed that there was not a single part of the job of a correctional officer that did not involve using the arms, hands or elbows to some extent. He agreed that there were days, depending on the level of activity, where the arms and hands were in use anywhere from 5-6 hours per day, and he agreed that there were days when it was more than 6 and that there were also days when it may be less than 5. He further agreed that the activities with the hands and arms involved force and stress. (PX6/Petitioner's Deposition Exhibit 5).

The video deposition of Jason Thompson was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Worker's Compensation Employee's Notice of Injury was completed on November 16, 2010, and alleged a date of accident of October 29, 2010. When asked to detail how the injury occurred, Petitioner indicated "repetitive turning of keys." The Initial Worker's Compensation Medical Report completed by Dr. Hansen dated March 10, 2011 noted a history of repetitive turning of keys at work which caused pain and numbness in both hands and elbows. The Supervisor's Report of Injury or Illness completed on November 21, 2010 noted that the description of accident/incident was unknown, and that he was told Petitioner was having surgery on his wrist. Also included was a Demands of the Job document dated November 21, 2010 also prepared by Major Edwards, which noted average daily job demands for Petitioner. (RX1).

The Estimation of Key Usage at Pinckneyville Correctional Center was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report for the study noted that it was conducted on the 7-3 shift from Monday, February 14, 2011 through Thursday, February 17, 2011, and that Lieutenant Jason Thompson conducted the study in its entirety. The report noted that these were estimations based on visual observations, average inmate movement experienced on the post, estimated amount of staff movement during the shifts and the assumption that the institution was not on lockdown. It was further noted that several posts were "split" posts, which were manned by one staff member for approximately half of the shift and another staff member for the other half. It was noted that in these situations, the usage was determined by adding the total usage for each post and dividing by two. The Definitions provided did address the distinction between large keys, small keys, buttons and bar rapping. (RX2).

The Job Site Analysis for Correctional Officer at Pinckneyville Correctional Center was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The job site analysis was performed on

December 17, 2010, and the facility was noted to be Pinckneyville Correctional Center. It was noted that the facility consisted of 5 X-design housing units, one of which was segregation housing only, and that there were four wings (i.e., the legs of the X). It was noted that there were also Receiving and Health Care areas. It was further noted that when the site visit occurred, there were an average of 112 inmates on each wing, 448 inmates in the house as they were two per cell. (RX3).

According to the Job Site Analysis, the essential job functions included security; guard inmates; escort inmates from their cells, coordinate "movement lines" to dining rooms/dietary, classrooms, healthcare, chapels and work areas; search prisoners for forbidden articles; patrol buildings and grounds; keep a daily log or record of activities; use radios to communicate. According to the Physical Demands component of the Analysis, the Correctional Officer was required to do Occasional grasping, pinching and carrying, while being required to do Frequent wrist turning and finger manipulation. The Strength Demands were noted to be Medium, requiring lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. (RX3).

The Job Site Analysis noted that Wrist Turning was considered to be Frequent, and related to opening doors and chuckholes with keys; estimated up to 150 keys turned for day shift in housing unit; key turning in other areas could be at an occasional rate; fewer key turning exists for remaining shifts; there would be more key turns during lockdown. Grasping was considered to be Occasional and related to opening doors and chuck holes; holding keys; taking items off of belt; hold radio when not on shoulder clip. Pinching was considered to be Occasional to turn key. It was noted that the physical work demands varied depending upon shift and correctional officer position assigned. (RX3).

The Job Site Analysis DVD dated December 13, 2010 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Job Site Analysis DVD dated January 20, 2011 was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The records review of Dr. James Williams dated April 18, 2012 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The supplemental records review report of Dr. Williams dated September 17, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 7.

The transcript of the evidence deposition of Dr. James Williams taken on January 14, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. Dr. Williams testified that he is board-certified in orthopedic surgery, and that he has an added qualification for hand and upper extremity surgery having specifically trained in microsurgery and upper extremity surgery. (RX8)

Dr. Williams testified that in his practice he was familiar with carpal tunnel syndrome, treated patients with the diagnosis of carpal tunnel syndrome and operated on approximately 150 patients per year with the condition. He further testified that he was familiar with cubital tunnel syndrome, treated patients with the diagnosis of cubital tunnel syndrome and operated on approximately 100 patients per year with the condition. (RX8).

Dr. Williams testified that he was asked to perform a records review regarding Petitioner, related to which he authored reports dated April 15, 2012 (including an addendum) as well as September 17, 2014. He testified that as part of his review, he reviewed a detailed job description and medical records as well as the two job site analysis videos by CorVel for the position of a correctional officer and the key estimation study performed by Lieutenant Thompson. He testified that his understanding of Petitioner's job title at Pinckneyville was that of a correctional officer. (RX8).

Dr. Williams testified that his understanding of the job duties of a correctional officer at Pinckneyville Correctional Center included taking care of inmates, which would be anywhere from

escorting inmates, cuffing and uncuffing inmates, opening and closing cell doors with small or larger Folger-Adams keys, in segregation opening and closing chuckholes, sometimes carrying food trays and passing ice, sometimes doing shakedowns of cells involving lifting property boxes, very little bar rapping and doing yearly gun qualifications. He testified that he had taken a tour of the facility in July of 2011, and that while on the tour he was able to perform some of the job duties of a correctional officer. He testified that he opened and closed cell doors with small as well as large Folger-Adams keys, went up into a guard tower, opened and closed a chuckhole, lifted property boxes, cuffed and uncuffed an officer, lifted food trays and opened and closed padlocks. (RX8).

Dr. Williams testified that some of the environmental risk factors for the development of carpal tunnel syndrome or cubital tunnel syndrome included tasks that involved vibration; tasks involving repetitive, sustained forceful gripping and/or pinching; and activities such as riding a motorcycle, significant weightlifting, shooting guns, pulling on a bow and doing woodwork with hammers, drills, saws and grinders. He further testified that non-environmental factors included increased body mass index, female sex, advancing age, post-menopausal status, high blood pressure, diabetes, thyroid dysfunction, smoking and inflammatory arthritis. He testified that with respect to age, the largest group of individuals who developed carpal tunnel syndrome or cubital tunnel syndrome were usually age 60 or older. He further testified, however, that there were studies that indicated that people in their fourth decade of life had an increased risk, and that Petitioner fell into that category. (RX8).

Dr. Williams testified that he did not believe that the job activities of a correctional officer at Pinckneyville would cause or aggravate either carpal tunnel syndrome or cubital tunnel syndrome based on his review of the job videos, the key turning analysis, the job descriptions of a correctional officer, the activities that he witnessed and performed while at Pinckneyville on July 12, 2011 and the fact that he did not find those activities to either be sustained or repetitive forceful gripping and/or pinching and/or any significant exposure to vibration. (RX8).

Dr. Williams testified that on the Employee's Notice of Injury filled out by Petitioner, Petitioner reported that repetitive turning of keys caused him to develop his complaints. He testified that the turning of keys at Pinckneyville did not involve a significant magnitude of force. He testified that Petitioner's diagnosis was that of carpal tunnel syndrome as well as cubital tunnel syndrome, and that he did not have any reason to disagree with the diagnosis. (RX8).

Dr. Williams testified that while he was on tour of Pinckneyville he had opportunity to open the cell doors by using the key, and testified that the force required to open the door was of low magnitude and was not any activity that was sustained for any significant period of time. He testified that opening and closing chuckholes also required a low magnitude of force. He testified that his understanding of how often bar rapping was done was very infrequently. (RX8).

Dr. Williams testified that he did not feel that Petitioner's bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome were in any way causally related, aggravated or contributed to by his job duties as a correctional officer at Pinckneyville Correctional Center. He testified that in his tour he did not find any job activities that involved significant impact or vibration, nor did he see any activities that involved sustained, forceful or repetitive pinching. He testified that he relied on the specific numbers from key turning for the various shifts and various assignments of a correctional officer as set forth in the key estimation study. (RX8).

Dr. Williams testified that the Demands of the Job referenced that hands for gross manipulation were used for 0-2 hours per day, and that the use of the hands for fine manipulation was that of 0-2 hours per day. He testified that the records indicated that Dr. Brown took a history from Petitioner about what his job duties were at Pinckneyville, and that Petitioner reported that he keyed 50 times per hour for

unlocking and locking cell doors, that he would also push and pull on cell doors, and that he would lock and unlock handcuffs. Dr. Williams denied that there was anything about those job activities that Petitioner told Dr. Brown that would lead to the development of carpal or cubital tunnel syndrome while at Pinckneyville Correctional Center. (RX8).

On cross-examination, Dr. Williams agreed that he performed a records review but never actually met or examined Petitioner. He testified that he would not be able to recognize Petitioner if he saw him in person. He agreed that in the past he had performed examinations for employers including the State of Illinois in worker's compensation cases, and that he was happy to see people in his office for an examination. He testified that he did not know why he was not asked to perform an examination of Petitioner in this case. (RX8).

On cross-examination, Dr. Williams testified that it was helpful to examine and interview the patient when being asked to give a causation opinion. He testified that he did not know how many IMEs and records reviews he had performed for the State of Illinois in the past several years. He testified that he did not know how much he had earned performing them, but believed that someone had indicated that it was around $600,000. He agreed that 90% of the IMEs and records reviews that he performed were at the request of the employers. He testified that he charged $1,000 for a records review and $2,500 for an IME, and that he charged $2,000 for a deposition for two hours. (RX8).

On cross-examination, Dr. Williams agreed that it was his understanding that Petitioner had been employed at Pinckneyville since 1998 according to Dr. Brown's records, and admitted that he did not know if Petitioner had been a correctional officer for the entire time. He testified that he did not know what specific assignments Petitioner had a Pinckneyville, nor did he know if Petitioner worked in segregation at some point. He agreed that when he was on the tour, he did tour the segregation unit at Pinckneyville. (RX8).

On cross-examination, Dr. Williams agreed that most of the keying in the facility was done in the segregation unit given that the inmates had to be keyed in and out and were always in cuffs and had chuckholes to get their food. He testified that bar rapping in the segregation unit was very minor as there were only bars in the showers and that otherwise the doors were solid steel. (RX8).

On cross-examination, Dr. Williams agreed that he was provided with the records of Dr. Brown in anticipation of the September 17, 2014 report. He testified that he was not sure whether he was sent a letter accompanying the medical records but offered to search for it. He denied having reviewed Dr. Brown's deposition testimony and further denied having been given any depositions of any of the patients. He testified that he would have reviewed and considered the deposition testimony. He agreed that the more information he had the better equipped he was to give an accurate causation opinion, and that depending on the accuracy of the information he received his opinions could change. (RX8).

On cross-examination, Dr. Williams agreed that he did not have any reason to disagree with Dr. Brown's diagnosis and further agreed that he would not have any reason to disagree with his recommendation for surgery if Petitioner's symptoms persisted. He agreed that he had a very high opinion of Dr. Brown and thought that he was a good hand surgeon. (RX8).

On cross-examination, Dr. Williams testified that with respect to his reference to the data from the nerve conduction study in the April 15, 2012 report, he believed that many of the numbers seemed almost equivocal or normal. He testified that he did not disagree with the diagnoses that Dr. Alam found, but it seemed that the numbers were not that glaring. He testified that in his report, he believed he was referring to the antidromic distal latency when he made that assessment. (RX8).

On cross-examination, Dr. Williams agreed that in his first report he discussed Petitioner having had elevated blood pressure on one office visit, but testified that hypertension was a diagnosis that had to be made over several office visits so he was not extrapolating that Petitioner had hypertension. When asked if he identified any other comorbid or non-occupational risk factors that Petitioner could have had for carpal or cubital tunnel syndrome, Dr. Williams responded that Petitioner smoked a pack a day for four years. He agreed that it was fair to say that he did not attribute Petitioner's diagnoses to anything in particular in his report. (RX8).

On cross-examination, Dr. Williams agreed that the activity of bar rapping could be a risk factor for carpal or cubital tunnel syndrome if done over a significant period of time and done repetitively. He did not agree, however, that using Folger-Adams keys to open and close cell doors and chuckholes could. He agreed that two people may be doing the exact same jobs for the same amount of time but one of them may develop the conditions while one of them may not. He agreed that he has never been provided with any depositions from any State employees or Melanie Welch of CorVel. He further agreed that he did not know if Dr. Brown had reviewed them. (RX8).

On cross-examination, Dr. Williams agreed that he reviewed the job site analysis, and that according to the report a correctional officer was required to perform lifting up to 50 pounds and frequently lifting and/or carrying up to 25 pounds for up to 5.5 hours per day. When asked if that activity when performed that frequently could contribute to or cause cubital or carpal tunnel syndrome, Dr. Williams responded that it would depend on the frequency, duration, the manner in which it was carried, the position of the hands and what the object was. When asked if repeated pinching and key turning could cause increased pressure in the carpal and cubital tunnel, Dr. Williams responded that it depended on how long it took to turn the key, how frequently it was done, how often it was done and what kind of breaks there were. When asked about forceful and repeated gripping, Dr. Williams responded that it was also dependent on the frequency, duration and the amount of time spent doing it. He agreed that the activities of repetitive, forceful gripping and pinching could cause or aggravate those conditions if they were sustained and forceful. (RX8).

On cross-examination, Dr. Williams testified that his tour at Pinckneyville in July of 2011 lasted for approximately 3-3.5 hours, and he agreed that he was taken on a guided tour. He testified that he did not remember who took him on the tour, but testified that they toured the entire facility. He agreed that while he was there he did not attempt to open each and every cell door or chuckhole, and that he would not know how easy or difficult it may be to open the ones that he was not taken to. He agreed that he was aware that in the past there was a locksmith on staff at Pinckneyville, and agreed that it was possible that the reason to have a locksmith on staff would be that the locks needed repair and replacement. He agreed that he cuffed and uncuffed a correctional officer when he was at Pinckneyville, and testified that he did not have any trouble trying to do it but admitted that it was an odd task for him given that he had never done it before. He testified that he did not remember how long it took him to cuff and uncuff the officer. (RX8).

On cross-examination, Dr. Williams testified that neither when he went to Pinckneyville nor when he reviewed the videos did he see that the chuckholes had to be slammed with force with two hands in order to get them to close properly. He agreed that correctional officers needed to pull forcefully on the doors when performing wing checks to make sure that the doors were closed, but testified that the forceful pulling caused increased pressure in the carpal and cubital tunnel for only a very limited amount of time and was not sustained. He testified that it was possible if it took minutes to do one door. He agreed that they had to do that for each cell door. (RX8).

On cross-examination, Dr. Williams testified that there would be more than 100 doors if they were doing two wings. He testified that it was his understanding that the officers pulled on the doors only

at the end of the shift, but admitted that he had been told different things by different officers he had seen. He testified that he understood that the walking down and checking to make sure that the inmates were present was done every 30 minutes. He agreed that when officers were shaking down cells and moving property boxes, they were required to use their hands and arms. He testified that the person in the best position to know the frequency with which a specific job duty was performed was the person performing it. (RX8).

On cross-examination, Dr. Williams testified that he believed there was a shift rotation at Pinckneyville every 90 days, but had been told that that did not always occur. He agreed that if the facility went on lockdown, it would insinuate that the officers were required to use their hands and arms more because the inmates were not leaving their cells. He testified that he had received information at one point that the facility was on lockdown for approximately three months in a particular year, but admitted that he could not remember which year it was. He agreed that the doors were made of steel, but admitted that he did not know how much a door weighed. He further agreed that it was possible that the doors could stick in the summer when the steel expanded. (RX8).

On cross-examination, Dr. Williams agreed that the job site analysis or video did not describe or show opening of cell doors, nor did they ever show chuckholes being opened or closed. He further agreed that they did not show inmates resisting when being cuffed or uncuffed. He agreed that it was possible that when a correctional officer was attempting to restrain a resisting inmate, it would increase the pressure on a correctional officer's arms and hands assuming that he had to restrain the individual. He agreed that there was nothing in the job site analysis or video about lifting or moving property boxes. (RX8).

On redirect examination, Dr. Williams testified that 60% or greater of the cases of carpal tunnel syndrome were idiopathic, and that most cases of cubital tunnel syndrome were also of unknown etiology. As to the nerve conduction studies performed by Dr. Alam, Dr. Williams testified that the 3.2 meters per millisecond finding was a normal finding. He testified that if one averaged the two values of 3.2 and 4.0, the 3.6 meters per millisecond was .1 above normal and that Dr. Brown himself noted it was high normal. He agreed that he testified that with wing checks it did not have sustained forceful activity, because they pull on a door for a couple of seconds, rest and move on to the next door. He testified that the activity involved rest in between performing the activity, which was not by definition sustained because it was done infrequently. (RX8).

The medical records of Dr. Dale Blaise/Medical Arts Clinic were entered into evidence at the time of arbitration as Respondent's Exhibit 9. The records reflect that Petitioner was seen on March 7, 2012 at which time Petitioner reported a history of carpal tunnel syndrome that was getting worse. It was noted that Petitioner saw an orthopedic physician in the past, and that he was advised to see a local orthopedic by his attorney. Petitioner was given a referral at that time and instructed to follow-up if there was no improvement or if his symptoms worsened. (RX9).

The records of Dr. Blaise reflect that Petitioner was seen on November 23, 2011, at which time it was noted that he had a worker's compensation injury and had exhausted his two physician visits. It was noted that Dr. Paletta would see Petitioner as long as he had a referral from Dr. Blaise. The records reflect that Petitioner was seen on March 10, 2011, at which time Petitioner stated he a hand injury (repetitive motions at work) which was noted to be a worker's compensation claim. Petitioner's current symptoms included arm weakness. He was assessed with neuralgia, neuritis and radiculitis. (RX9).

The records of Dr. Blaise reflect that Petitioner was seen on October 15, 2010 for an evaluation of wrist pain. It was noted that the onset was gradual following no specific incident and had been occurring in a persistent pattern for years, and that the course had been gradually worsening. It was noted that the

wrist pain was mild to moderate and characterized as a burning sensation. It was noted that the wrist pain was on both sides (primarily right) and was described as being located in the volar wrist. Aggravating factors included physical activity, radial deviation and work duties. Associated features included decreased range of motion and painful range of motion. The assessment was noted to be neuralgia, neuritis and radiculitis. Petitioner was recommended to undergo an EMG of the upper extremities. (RX9).

Included within the medical records was a letter dated November 17, 2011 from Thomas C. Rich directed to Dr. Blaise. The letter indicated that Petitioner had already used his two choices of physicians and that his treating physician, Dr. Brown, was unwilling to move forward with treatment on State of Illinois claims due to payment authorization issues. The letter requested a referral to Dr. Paletta. (RX9).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on October 29, 2010, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator finds the opinions of Dr. Williams, board-certified in orthopedic surgery with an added qualification for hand and upper extremity surgery having specifically trained in microsurgery and upper extremity surgery, to be more persuasive than the opinions provided by Dr. Brown by virtue of the fact that Dr. Williams' opinions are more informed and well-founded given the evidence as a whole. The Arbitrator finds to be highly significant the fact that Dr. Williams had opportunity to tour the facility at issue and actually perform some of the duties of a correctional officer, which Dr. Brown did not have the opportunity to do. Dr. Williams testified that while he was on tour of Pinckneyville he had opportunity to open the cell doors by using the key, and testified that the force required to open the door was of low magnitude and was not any activity that was sustained for any significant period of time. He testified that opening and closing chuckholes also required a low magnitude of force. He testified that his understanding of how often bar rapping was done was very infrequently. (RX8). The Arbitrator places greater weight upon the opinions of Dr. Williams that he did not find the job duties -- *which he actually had opportunity to perform* -- to either be sustained or repetitive forceful gripping and/or pinching and/or any significant exposure to vibration. As such, the Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent

The Arbitrator notes that Dr. Brown's opinions in this case were based in part upon the deposition testimony of several other individuals whose testimony was not admitted into evidence at the time of arbitration. The Arbitrator notes that Dr. Brown testified that he relied on the deposition transcripts and the testimony of a locksmith and several other correctional officers in forming his opinions, and that it was part of the information that he relied on in addition to the job description obtained from Petitioner. (PX6). As such, the Arbitrator places lesser weight upon the opinions of Dr. Brown and finds them to be not as well-founded as those proffered by Dr. Williams as they assume facts not in evidence in this case.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on October 29, 2010, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of notice, date of accident, medical bills, and prospective medical treatment are moot, and the Arbitrator makes no conclusions as to those issues.

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

Rocky Flack,

Petitioner,

vs.

NO: 11 WC 247

Menard Correctional Center,

17IWCC0552

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 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 below modifications to the permanent partial disability award.

1. Petitioner's award for the loss of use of his right hand is reduced from 12.5% to 10%. Pursuant to section 8(e) of the Workers' Compensation Act, Respondent shall pay Petitioner the sum of $664.71 per week for 20.5 weeks.
2. Petitioner's award for the loss of use of his left hand is reduced from 12.5% to 10%. Pursuant to section 8(e) of the Workers' Compensation Act, Respondent shall pay Petitioner the sum of $664.71 per week for 20.5 weeks.
3. Petitioner's award for the loss of use of his left arm is reduced from 37.5% to 27.5%, which, offset by a 22.5% credit for prior award, yields a net of 5%. Pursuant to section 8(e) of the Workers' Compensation Act, Respondent shall pay Petitioner the sum of $664.71 per week for 12.65 weeks.
4. Petitioner's award for the loss of use of his right arm is reduced from 35% to 25%, which, offset by a 20% credit for prior award, yields a net of 5%. Pursuant to section 8(e) of the Workers' Compensation Act, Respondent shall pay Petitioner the sum of $664.71 per week for 12.65 weeks.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/15/16 is modified as stated herein.

17IWCC0552

IT IS FURTHER ORDERED that Respondent shall pay permanent disability benefits to Petitioner in the sum of $663.71 per week for 66.3 weeks.

DATED: SEP 7 - 2017
o:8/25/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLACK, ROCKY
Employee/Petitioner

Case# **11WC000247**

SOI/MENARD CORR CTR
Employer/Respondent

17IWCC0552

On 1/15/2016, 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 0.47% 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:

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
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 15 2016

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

17IWCC0552

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

ROCKY FLACK
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD CORR. CTR.
Employer/Respondent

Case # 11 WC 00247

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 **Collinsville**, on **November 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 **Is Respondent entitled to credit under section 8(e)17?**

17IWCC0552

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,522.00**; the average weekly wage was **$1,106.19**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent child(ren).

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

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

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

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $45,033.50, as set forth in PX1 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.

The Arbitrator finds Petitioner is now permanently and partially disabled to the extent of 37.5% loss of use of the left arm, 35% loss of use of the right arm, 12.5% loss of use of the left hand (25.625 weeks), and 12.5% loss of use of the right hand (25.625 weeks), as provided in Section 8(e) of the Act. Petitioner has sustained serious and permanent injuries in this case that have resulted in an additional 15% (37.95 weeks) loss of use of left arm, and 15% (37.95 weeks) loss of use of right arm above and beyond his prior injuries for which Respondent is entitled to a credit of 22.5% of the left arm (56.925 weeks) and 20% of the right arm (56.925 weeks).

After applying the awarded credit, Respondent shall pay Petitioner the sum of **$663.71**/week for a further period of **127.15** weeks.

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

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

Signature of Arbitrator

1/11/16
Date

FINDINGS OF FACT

On the date of accident Petitioner was a 45-year-old Correctional Officer (CO) at Menard Correctional Center. He has been so employed for 24 years. For the vast majority of his service he worked the day and/or afternoon shifts.

The record contains an extensive amount of evidence regarding Petitioner's job duties. Petitioner offered into evidence a CorVel Job Site Analysis procured at the request of Respondent. (PX 11) Petitioner also offered a DVD produced by CorVel at Respondent's direction which depicts the job duties of a CO. (PX12) In addition, Petitioner offered a position description of a Menard Correctional Officer. (PX15) These exhibits indicate the duties of a CO require frequent lifting and/or carrying up to 25 pounds. Officers are required to frequently pull open doors from 2 ½ hours to 5 ½ hours per day, up to 66% of the time, or up to 200 times per day. This includes pulling open chuckhole doors as needed during lockdowns for dining, and cuffing and uncuffing inmates. Wrist turning is required 34-66% of the time, 2 ½ to 5 hours per day, or 33 to 300 times per day. The DVD depicts various job tasks, assignments, areas, equipment and mechanisms demonstrated by a variety of Correctional Officers, and walkthroughs of numerous areas of the facility. Each area requires opening and closing multiple doors and using multiple keys, including large Folger Adams keys. Bar rapping was also simulated in the DVD and the Officer explained that, depending upon the shift, all open bars will be rapped for security purposes. Officers listen to the sound to ensure that the bar is solid and that the inmates have not tampered with the cell doors. The Officer held the bar with his right hand and struck the cell bars approximately 60 times to demonstrate bar rapping on 1 cell. Officers perform bar rapping at the beginning of each shift on the gallery where they are assigned. There are 55 cells per gallery. The DVD also shows a lock becoming stuck which required the CO to turn it multiple times to get it to work. In one portion, a CO struggled to open a cell door by yanking on it repeatedly with both hands. There was obviously a mechanical problem. (PX12, at 23:30 – 24:50) While Petitioner generally agreed with the duties depicted, he indicated that the DVD did not show the actual pace at which Correctional Officers worked. Petitioner also agreed with the contents of the position description of a Menard Correctional Officer which indicates the duties include pulling cell doors twice to ensure that cells are securely locked, random checking of all locks on the gallery, checking cell locks prior to moving inmates into respective cells, performing actual body (skin) counts by looking in or opening the cells, removing inmates from cells for escort, monitoring all movement, searching cells prior to placement of inmates, checking all locks, doors and restraints to ensure they are in proper operational order and secured, shaking down workers and inmates, keying in and out inmates from cells for all movement that is not a mass line movement, searching inmates entering and leaving the gallery, and securing grill and front doors. Petitioner testified that he performed all these duties daily.

Petitioner gave detailed testimony about the stress the job duties placed on his upper extremities. He testified that it requires force and grip to operate Folger Adams keys because the key turn actually moves a locking mechanism in the prison doors so that the doors can open. He explained that the locks do not always work smoothly, and that many times both hands are needed to turn the key and someone else has to pull the door closed while the key is being turned. He estimated that he has turned Folger Adams keys thousands of times over the course of his 24 year career. Petitioner testified that the doors at Respondent's facility are heavy steel sliding bar doors and that it requires considerable force, and at times both hands, to move these doors. He testified that he pulled thousands of doors over the course of his career. Petitioner also testified that he turned

gallery cranks and opened chuckholes. Turning cranks requires forceful gripping. He indicated that the chuckholes at the facility, which are opened with Folger Adams keys or padlocks, are difficult to open because they stick due to age and neglect. Petitioner testified that he has to continue pulling on chuckholes in order to open them when they stick. Petitioner further testified that he bar rapped thousands of bars over the course of his career. He testified that he performed this activity nearly every day of his career. When the facility is on lockdown, where all inmate movement is restricted, a CO's duties "build up considerably" because there are no inmate workers and Officers have to do all the feeding, laundry, cleaning, and mail delivery. Lockdown also requires him to do a lot more keying because each inmate has to be keyed out individually. Everything is delivered through chuckholes during a lockdown. Lockdown occurs several times a year. In addition Petitioner would perform shakedowns, which involves searching inmates and their cells for contraband. During this process the CO pulls out property boxes and sifts through their contents, and lifts/flips mattresses during a 15 to 20 minute process per cell. Property boxes themselves weigh 50 to 60 pounds or more. He indicated that these activities produced numbness and tingling in his upper extremities.

Petitioner called Major Robert Hughes, the day shift supervisor who was present on behalf of Respondent, as an adverse witness. He testified that he agreed with Petitioner's testimony.

During the course of his job duties, Petitioner developed symptoms of numbness and tingling in his upper extremities.

Petitioner initially saw Dr. David Brown on 1/12/09 regarding a traumatic injury to his left elbow. He sustained that injury at work in the fall of 2008 when his arm was caught between a van and a wall. In the course of this treatment, Petitioner underwent EMG/NCV of his left upper extremity. In addition to being positive for ulnar neuropathy at the left elbow, it showed a very mild mild demyelinative median sensory neuropathy across the left carpal tunnel. Petitioner was diagnosed with left cubital tunnel syndrome and eventually underwent a left ulnar nerve transposition on 3/5/09. The Arbitrator notes that Petitioner testified that the incident with the van had resulted in a "lateral epicondylitis injury." The medical records however clearly indicate that the diagnosis was left cubital tunnel syndrome. His postoperative course was unremarkable. The numbness and tingling in the left little and ring fingers resolved, and he was eventually returned to full duty without restrictions on 5/11/09.

Petitioner continued to follow up with Dr. Brown regarding his left cubital syndrome surgery following his release to work. Petitioner returned to Dr. Brown He returned on 6/15/09 with complaints of occasional clicking in his left elbow as well as some numbness in the thumb, index and middle fingers on the left as well as a little bit on the right side. Dr. Brown felt he had very mild carpal tunnel syndrome on the left side and that he also possibly had mild carpal tunnel syndrome on the right side. Dr. Brown recommended conservative treatment. Petitioner returned on 8/20/09 still having intermittent numbness and tingling in the thumb, index and middle fingers bilaterally. He was also complaining of some pain over his left lateral elbow, worse with use. Dr. Brown's impression at that time was that he had some symptoms consistent with bilateral carpal tunnel syndrome, as well as some evidence of left lateral epicondylitis. He was given a forearm brace to wear over the proximal forearm. Dr. Brown next saw Petitioner on 10/21/09. At that point he was still having some occasional numbness in the thumb, index and middle fingers bilaterally. His left lateral elbow pain was improved. At that point, Dr. Brown indicated that "[w]ith regards to his history of left cubital tunnel syndrome and the subsequent ulnar nerve transposition I had no further recommendations. He was scheduled to have

surgery on his neck on 11-10-09 and I explained to him if he was still having a problem with his upper extremities following his neck surgery I'd be happy to reevaluate him." (PX3, p.13)

Petitioner next saw Dr. Brown on 11/8/10 complaining of continued pain over his left lateral elbow, worse with gripping. Dr. Brown diagnosed left lateral epicondylitis. Since he continued to be symptomatic in spite of wearing a forearm brace and a home therapy stretching program, Dr. Brown recommended a steroid injection, as well as continued forearm counter strap bracing, a home therapy stretching program, and nonsteroidal anti-inflammatory medication.

Petitioner returned to Dr. Brown on 12/20/10. At that point he was continuing to complain of numbness and tingling in both his hands. On the left side he stated the numbness was in his thumb, index and middle fingers and on the right side in all of the digits. He was also still having pain over his left lateral elbow. Dr. Brown recommended he undergo a repeat nerve conduction study.

Dr. Phillips performed a repeat EMG/NCV on 12/20/10 which revealed a moderate sensory motor median neuropathy across the right carpal tunnel and a mild median sensory neuropathy across the left carpal tunnel. There was also evidence of a mild demyelinative ulnar neuropathy across the right elbow. The left ulnar nerve values had improved, consistent with decompression. The examining neurologist noted on examination at that time, Petitioner had a positive Tinel' s sign at the right cubital tunnel, positive Tinel' s and Phalen's signs at both carpal tunnels, and also tenderness over the left lateral epicondyle. Dr. Brown's diagnosis on 12/20/10 was that Petitioner had bilateral carpal tunnel syndrome, right cubital tunnel syndrome, confirmed by electro diagnostic studies, and left lateral epicondylitis. He recommended continued conservative treatment. Dr. Brown also noted that Petitioner worked at Menard Correctional Center for 40 hours a week turning performing job duties, such as turning Folger-Adams keys, bar rapping, and opening and closing cell doors. He believed that Petitioner's employment at Menard since 1991 was an aggravating factor in Petitioner's need for treatment.

Petitioner testified that 12/20/10 was the first day he was given a work-related diagnosis of bilateral compression neuropathy. The Arbitrator notes that 12/20/10 is the first note in which Dr. Brown addresses the issue of the relationship of Petitioner's condition to his employment. Petitioner completed a Notice of Injury and submitted same to Respondent on 12/22/10. (RX2)

When Petitioner returned to Dr. Brown on 2/14/11, Dr. Brown noted that Petitioner had slipped, fallen and sustained a left elbow contusion; however, this resulted in no additional treatment or change in Petitioner's plan of care. Dr. Brown's impression was that he had a resolving contusion of his left elbow as a result of the 2/10/11 fall. Dr. Brown anticipated those symptoms would resolve. When Petitioner returned to Dr. Brown on 7/30/12 the doctor noted that Respondent had "authorized him for one more visit to be reevaluated." Petitioner indicated that since last seeing Dr. Brown his symptoms had worsened. He complained of increased numbness and tingling in both his hands and stated that his hands went cold. He also described nocturnal paresthesias. He had weakness in both his hands and what he described as "extreme pain" in his left lateral elbow. The numbness and tingling in the right hand was constant and involved all the digits. On the left hand, he had constant numbness in the thumb, index and middle fingers. He had some intermittent numbness and tingling in the left little and ring fingers. He had been compliant with conservative measures. His physical examination remained consistent with bilateral compression neuropathy. Dr. Brown recommended repeat nerve conduction

studies and an MRI of the left elbow. (PX3, 7/30/12) Due to Respondent's dispute of his claim, Petitioner was unable to return to Dr. Brown or follow-through with his recommendations.

Petitioner ultimately came under the care of Dr. Stephen Young on 2/24/15. (PX5, 2/24/15) Petitioner's physical examination remained positive and Dr. Young agreed with the diagnosis previously rendered by Dr. Brown. Dr. Young recommended a new nerve conduction study. *Id.* Petitioner's new nerve conduction studies confirmed right carpal tunnel syndrome and right cubital tunnel syndrome, and Petitioner's physical examination continued to demonstrate tenderness over the left lateral epicondyle and positive signs of left carpal tunnel syndrome over the left median nerve. Dr. Young recommended surgery on Petitioner's right upper extremity first. On 4/15/15, Dr. Young performed a right carpal tunnel release and right ulnar nerve transposition. On 6/5/15, Dr. Young performed a left carpal tunnel release, a left lateral epicondylar release with bone debridement and tendon reattachment, and a left de Quervain's release. Petitioner recovered postoperatively with therapy and bracing, and was released from care with regard to his upper extremities on 8/24/15. (PX6)

Petitioner testified that the long delay in having surgery was due to the denial of his claim. Petitioner had these surgeries performed while he was off work for an unrelated back injury. Petitioner testified that his condition improved following surgery. Despite the improvement, however at the time of hearing Petitioner continued to experience residual tingling in his wrists. He also suffers reduced grip strength. With regard to his arms, Petitioner testified that he experiences pain when carrying objects or holding his arms outstretched. He testified that the intensity of his symptoms varies with his level of activity. Petitioner testified that mowing his grass with a push mower, performing overhead work, and lifting objects provoke his symptoms. He also has difficulty driving long distances.

Respondent had Petitioner examined by Dr. Anthony Sudekum on 2/18/13 pursuant to §12 of the Act. Dr. Sudekum testified by way of deposition. The Arbitrator notes that Dr. Sudekum did not waive signature and there does not appear to be a signature page attached to his deposition transcript. Dr. Sudekum performed his own nerve testing using a NeuroMetrix machine in his office which he interpreted as entirely normal. Dr. Sudekum indicated that he did not believe that Petitioner suffered from any sort of peripheral neuropathy, and that any alleged condition or complaints would not be related to Petitioner's employment. He felt Petitioner was exaggerating his symptoms. Dr. Sudekum admitted to rendering an opinion in the past that the work activities performed by Correctional Officers at Menard Correctional Center could potentially aggravate repetitive trauma conditions, but did not believe Petitioner's employment played any role in his condition of ill-being because his "condition" was non-existent. He also acknowledged that Petitioner may suffer from left lateral epicondylitis, but declined to affirmatively agree or disagree with the diagnosis because Petitioner was never able to obtain an MRI to confirm his diagnosis. He admitted, however, that if Petitioner did suffer from lateral epicondylitis, then Petitioner's work could have served as an aggravating factor to his left lateral epicondylitis.

Dr. Daniel Phillips testified by deposition as well. (PX8) Dr. Phillips is board certified in both neurology and in electrical diagnostics. (PX8, p. 4) Dr. Phillips testified that he is familiar with Dr. Sudekum and that Dr. Sudekum has referred patients to him in the past. (*Id.* at 9, 10) Dr. Phillips testified that there is nothing subjective about a nerve test in any way. (*Id.* at 16-18) He indicated all the values used, whether relative or absolute, have been standardized and published in medical texts. (*Id.*) His test and device are vastly

different from the NeuroMetrix machine used by Dr. Sudekum, which is a portable handheld device that uses stick on pads over the wrist. (*Id.* at 20, 21) Dr. Phillips explained at great length why NeuroMetrix testing provides unreliable results. (*Id.*, at 20-36)

Dr. Phillips testified that his studies clearly demonstrated that Petitioner's nerve conduction velocities were abnormal over the left ulnar motor nerve and mildly abnormal over the ulnar sensory nerve, and that his left median orthrodromic peak latency was mildly prolonged based on relative comparative values. (*Id.* at 22, 23) On Petitioner's right side, which was tested in 2010, his right median motor terminal latency was relatively prolonged, as well as his sensory motor terminal latency. (*Id.* at 24) Petitioner's orthrodromic peak latency was 2.8, which was abnormal and above the normal limit of 2.2, and his ulnar motor latency was 45.5, below the normal limit of 50. (*Id.*) He testified that contrary to Dr. Sudekum's allegations, the studies did show Petitioner's right antidromic latency to the ring finger, measured at 4.3, which was also prolonged. (*Id.* at 24, 25) On Petitioner's left side, his median antidromic measurement was mildly prolonged at 2.4, and his ulnar was mildly prolonged, measuring at 3.8 versus the normal limit of 3.2. (*Id.* at 25) These results were forwarded to Dr. Brown, who also concluded that Petitioner's results were abnormal. (PX3)

Dr. David Brown also testified by deposition. (PX10) Dr. Brown is a board certified plastic and reconstructive hand surgeon licensed in the states of Illinois, Missouri and Texas. Dr. Brown had Petitioner's complete medical history and records from all of the physicians who previously evaluated Petitioner. He reviewed both of Petitioner's electro-diagnostic studies as well as the exhibits described above which outline Petitioner's job duties. (*see* PX11, PX12, PX15) He also reviewed Dr. Sudekum's report and deposition. (PX10 at 17, 18)

Dr. Brown testified that occupational risk factors for the development of carpal tunnel syndrome include vibration, repeated or sustained gripping, repeated or sustained pinching, as well as awkward positions of the wrist, such as twisting or flexion of the wrist performed repeatedly. (*Id.* at 11) He testified that the same factors are also risk factors for the development of cubital tunnel syndrome. (*Id.* at 13, 14) The risk factors for lateral epicondylitis, unlike those for carpal and cubital tunnel syndrome, are strictly mechanical, making it an activity-related condition. (*Id.* at 14)

Dr. Brown testified that Petitioner initially came under his care in January of 2009 as a result of a traumatic injury which led to the development of symptoms in the ulnar nerve distribution of his left upper extremity. Dr. Brown referred Petitioner to Dr. Phillips for EMG/NCV studies. (*Id.* at 21) Dr. Brown reviewed Dr. Phillips' study and confirmed that it showed severe slowing of the ulnar nerve conduction across the left elbow with mild carpal tunnel syndrome. (*Id.* at 22, 23) Petitioner's condition failed conservative treatment and required surgical intervention. (*Id.* at 25) Petitioner eventually improved following surgery and was released to full duty work on 5/11/09. (*Id.* at 27)

Dr. Brown did not render treatment for carpal tunnel syndrome during the 2009 surgery because at that time Petitioner was not having symptoms of carpal tunnel syndrome, and the provocative tests during his physical examination were negative for carpal tunnel syndrome. (*Id.* at 27) It was not until 12/20/10, that Petitioner had developed bilateral complaints that warranted further evaluation. (*Id.* at 31, 32) Physical examination on that day was positive for right cubital tunnel syndrome, left lateral epicondylitis, and bilateral

carpal tunnel syndrome. (*Id.* at 32, 33) These clinical diagnoses were confirmed by repeat electro-diagnostic studies performed by Dr. Phillips. (*Id.* at 33, 34) Based upon his knowledge of Petitioner's job duties, Petitioner's 20-year-long exposure to provocative activities, and his review of Exhibits depicting Petitioner's duties, Dr. Brown concluded that Petitioner's employment was an aggravating factor in his conditions and need for treatment. (*Id.* at 35, 36) Dr. Brown specifically noted that Petitioner did not have any comorbid risk factors such as diabetes, hypothyroidism, arthritis, obesity or a history of smoking. (*Id.* at 37, 38) Dr. Brown also testified that Petitioner's symptoms would not necessarily subside or improve simply because he was off work for a period of time. (*Id.* at 43) He testified that when peripheral compression neuropathy causes epineural thickening, removal from the contributing factor does not resolve this issue. (*Id.* at 44) Dr. Brown also testified that the NeuroMetrix machine was a substandard testing device that did not perform important measurements needed for an accurate diagnosis of peripheral compression neuropathy such as ulnar motor conduction across the elbow and segmental evaluations. (*Id.* at 49-57)

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 Appellate 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 his hands and arms extensively during the performance of his job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Dr. Brown and Dr. Phillips much more persuasive than those of Dr. Sudekum in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent and that his 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. *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 same. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *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.*)

In *Linda Peters v. Village of Caseyville*, the Commission gave significant weight to the date on which the claimant possessed a "confirmed diagnosis" of her condition in setting the manifestation date. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

> The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. Based on our determination of the date of accident, we find that Petitioner provided timely notice of her accidental injuries. *Id.*

In this case Petitioner testified that he first became aware that his conditions of ill-being were work related when he met with Dr. Brown on 12/20/10. This testimony is corroborated by the medical record and the testimony of Dr. Brown. The first mention of the relationship between Petitioner's employment and his upper extremity conditions is contained in Dr. Brown's record of 12/20/10. The Arbitrator further notes that although Dr. Brown's earlier records do contain entries regarding "mild" carpal tunnel, etc. the records also corroborate the fact that the earlier treatment was being authorized by Respondent. It is clear that Dr. Brown was communicating the information to Respondent's representative presumably in order to obtain authorization for further testing and/or treatment. Respondent was in possession of exactly the same medical information as Petitioner.

It is undisputed that a Notice of Injury form was submitted to Respondent on 12/22/10. (T.28; RX2)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that 12/20/10, is an appropriate manifestation date under the Act. Petitioner has met his burden of establishing his 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?

The Arbitrator finds that all of Petitioner's medical care has been reasonable and necessary. The Arbitrator notes that considerable effort was spent attempting to manage Petitioner's complaints conservatively prior to surgery being recommended. Only when all other methods failed did Dr. Young proceed to surgically correct Petitioner's complaints. Petitioner submitted medical bills totaling $45,033.50. (PX1)

Respondent is therefore ordered to pay the medical expenses of $45,033.50 and shall have credit for any

amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

Issue (L): What is the nature and extent of the injury?
Issue (O): Is Respondent entitled to credit under section 8(e)17?

As a result of his accidental work-related injuries, Petitioner developed bilateral carpal tunnel syndrome, right cubital tunnel syndrome, and left lateral epicondylitis, which were surgically corrected by Dr. Young. Petitioner testified that his condition improved following surgery. Despite the improvement Petitioner continues to experience residual tingling in his wrists. Petitioner also suffers reduced grip strength. With regard to his arms, Petitioner testified that he experiences pain when carrying objects or holding his arms outstretched. Petitioner testified that the intensity of his symptoms varies with his level of activity. Petitioner testified that mowing his grass with a push mower, performing overhead work, and lifting objects provoke his symptoms. Petitioner also has difficulty driving long distances.

Respondent offered evidence of Petitioner's prior permanent partial disability awards in three cases. In 09 WC 1778 (left elbow) and 09 WC 1779 ("multiple parts) Petitioner was awarded 30% loss of the body as a whole and 22.5% loss of the left arm. In 09 WC 47346 (right shoulder) Petitioner was awarded 20% loss of the right arm. The parties stipulated on the record that Respondent was entitled to credit for 22.5% of the left arm and the Arbitrator so finds. The Arbitrator also finds that Respondent is entitled to a credit for 20% loss of the right arm.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner is now permanently and partially disabled to the extent of 37.5% loss of use of the left arm (253 weeks x 37.5% = 94.875 weeks), 35% loss of use of the right arm (253 weeks x 35% = 88.55 weeks), 12.5% loss of use of the left hand (205 x 12.5% = 25.625 weeks), and 12.5% loss of use of the right hand (205 x 12.5% = 25.625 weeks) as provided in Section 8(e) of the Act. The parties agreed that Petitioner received a prior award of 22.5% of the left arm (253 weeks x 22.5% = 56.925 weeks). In addition the Arbitrator finds Petitioner received a prior award of 20% of the left arm (253 weeks x 20% = 50.6 weeks).

Left Arm	94.875 weeks – 56.925 weeks	=37.95 weeks
Right Arm	88.55 weeks – 50.6 weeks	=37.95 weeks
Left Hand		=25.625 weeks
Right Hand		=25.625 weeks
		127.15 weeks

The result of applying that credit is that Respondent shall pay Petitioner an additional $663.71/week for 127.15 weeks on account of the current claim.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEITH BUCKINGHAM,

Petitioner,

vs.

NO: 11 WC 475

17IWCC0542

UNITED STATES STEEL CORPORATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that the Petitioner established that he sustained a work-related accident arising out of and in the course of his employment on November 23, 2010.

The Commission further finds that Petitioner established proper notice pursuant to the Act, and that his current condition of ill-being was causally related to the November 23, 2010 accident; as a result, Petitioner is entitled to reasonable, necessary, and related medical expenses in the amount of $22,300.54, nine (9) 6/7 weeks of TTD, from February 21, 2011 through March 28, 2011 and August 19, 2015 through September 22, 2015, and 41 weeks of PPD benefits as Petitioner sustained disability to the extent of 10 percent (or 20.5 weeks) loss of use of the left hand and 10 percent loss of use of the right hand pursuant to Section 8(e) of the Act.

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

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1) Petitioner worked for 26 years as a pitman/steel worker for Respondent. (T.13). He worked eight to 16 hours per day, 40 to 80 hours per week. (T.41).

2) Petitioner described the various tools and machines that he used at work. (T.14; PX10). He spent approximately one to three hours driving the Gradall – sometimes up to six hours. (T.15-16; T.21; PX10). Petitioner used both hands to maneuver the controls on the Gradall, and the machine would shake and jerk him around. He would notice pain in his hands and numbness. (T.15-16; T.20; PX10). Petitioner also worked with a smaller version of the Gradall called the Grant machine. (T.21). The Grant machine was operated by remote control. (T.21). Petitioner used this machine for two to six hours, moving the controller with his thumbs and hands. (T.21-22). He would notice pain, tingling, or numbness in his hands when he performed this work. (T.22). On occasion, Petitioner used a small Gradall, which was similar to the Grant, but only used this machine once a week for about 15 minutes. (T.22).

3) Petitioner used both hands to operate a 40-pound rivet buster that vibrated. (T.16-17). Petitioner testified that he consistently used the rivet buster to break up hard ceramic from a wall. (T.17; PX10). He would use the rivet buster for approximately 15 minutes, and sometimes up to an hour. (T.17). Petitioner's Exhibit 10 indicated that Petitioner used the rivet buster to "take ceramic bands out 2 to 4 hrs." (PX10).

4) Petitioner also spent 20 to 30 minutes, or up to three hours, operating lances. (T.19). The number of times he had to do this type of work varied – from two to three times in an eight-hour shift or not at all for a month. (T.23-24). Petitioner noticed pain, tingling, or numbness in both hands when operating lances. (T.18).

5) Both hands were again required to operate a bobcat. Petitioner spent a half hour to four hours using the hand controls. Petitioner noticed only a little pain, tingling, or numbness when performing this job. (T.19; PX10).

6) Petitioner described an additional duty on his Exhibit 10 called "slidegate." It involved using chipping guns, the rivet buster, an air mixer, a ladle bar, a ¾" impact wrench, a forklift, and other hand tools, including a 12-pound sledgehammer to "service returning gates up to 13 in an 8 hr shift using some or all of these tools. Time for each [ladle] is 15 to 20 minutes. This is a repetitive production job." (PX10). Petitioner did not perform this job often. (T.24).

7) Petitioner's duties varied hour by hour, but it was consistent. "Consistent, yes, same one over and over again, just how many times do you do it in a day." (T.18-19; T.42; T.59).

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8) Prior to working for Respondent, Petitioner did not have pain or numbness in his hands. (T.35). He testified that the onset of symptoms may have begun on October 14, 2010 or earlier. (T.28; T.38). "I probably had it before that but, like I said, didn't know what it was and it wasn't that bad, wasn't serious enough to seek medical help for it." (T.39). At that time, Petitioner did not think it was related to work. (T.39).

9) On November 23, 2010, Petitioner visited his primary doctor, Dr. Melissa Smith-Kalaher. He presented with complaints of numbness and tingling in both hands. Petitioner felt that he had decreased grip strength; and, he was often dropping things because he did not feel well with his fingers. Dr. Smith-Kalaher indicated that Petitioner never had a history of similar symptoms and did not recall any injury. The office visit note for November 23, 2010 stated that Petitioner's symptoms were constant, but he felt worse when he was working. Dr. Smith-Kalaher noted that Petitioner was a steel worker, and his duties involved "holding a jackhammer like tool in his hands. He also operates heavy machinery with the controls." (PX1).

10) Dr. Smith-Kalaher mentioned that Petitioner no longer did wood carving due to the decreased sensation in his fingers. Petitioner also smoked a half pack of cigarettes per day. Dr. Smith-Kalaher diagnosed Petitioner with bilateral carpal tunnel syndrome. She prescribed medication and ordered cock-up splints. She also referred Petitioner to an orthopedic doctor. (PX1). Petitioner testified that November 23, 2010 was the first time he was aware that he may have carpal tunnel syndrome. (T.29).

11) On December 9, 2010, Petitioner consulted with Dr. Susan Mackinnon, of Barnes Jewish Hospital/Washington University Physicians: Division of Plastic & Reconstructive Surgery. Dr. Mackinnon noted that Petitioner was six feet and weighed 250 pounds. He had smoked a quarter pack of cigarettes per day. Dr. Mackinnon dictated a letter on December 18, 2010 to Dr. Smith-Kalaher:

> This gentleman is 57 years old and right-hand dominant. He has problems with significant bilateral carpal tunnel syndrome, more so in the left hand than the right hand. He works as a steel worker and has done that for 20 years. He uses a rivet buster and has heavy work and high exposure to vibration, as well. (PX1).

12) Dr. Mackinnon's examination indicated positive Tinel's and Phalen's signs at both wrists, and some median nerve compression in both forearms. An EMG/NCV study, completed on December 14, 2010, revealed evidence of bilateral mild carpal tunnel syndrome, worse on the left. Dr. Mackinnon recommended left carpal tunnel release and possible right carpal tunnel release. (PX1).

13) Petitioner informed his foreman, Kenny Kent, about the need for surgery, and was told to complete an accident report. (T.31). Petitioner apparently completed the report on December 21, 2010. That was the first time Petitioner notified Respondent of his condition. (T.38). The accident report was not offered into evidence by the parties.

14) At arbitration, Petitioner was questioned about checking off a box on a medical intake form, indicating that his condition was sudden and the result of an accident or definable event. Petitioner explained, "I obviously didn't understand what they were talking about." (T.49; PX4).

15) Petitioner proceeded with the left carpal tunnel release on February 22, 2011. (PX5). His recovery progressed thereafter, with Dr. MacKinnon noting that Petitioner reported doing well post-surgery and he was undergoing physical therapy at The Rehabilitation Institute of St. Louis – Milliken Hand Rehabilitation Center. (PX5; PX7). Petitioner had commenced post-surgery physical therapy on March 23, 2011, and was subsequently discharged on April 11, 2011. (PX7).

16) Petitioner followed-up with Dr. MacKinnon on April 14, 2011. Dr. MacKinnon noted in a letter to Dr. Smith-Kalaher, dated April 19, 2011, that Petitioner was "doing beautifully," although he had some discomfort at the incision site. "My hand therapist has talked to him today about physical therapy, desensitizing, and a soft, padded splint. I think with time this is going to settle down for him. His carpal tunnel symptoms are completely clear. I anticipate an excellent long term result for him." (PX6).

17) Following Petitioner's left carpal tunnel release, he continued to follow-up with Dr. Smith-Kalaher for other unrelated medical conditions. By February 21, 2014, Dr. Smith-Kalaher noted that Petitioner continued to struggle with bilateral hand pain from carpal tunnel, and he was reporting numbness and tingling. The medical record noted that Petitioner did not want to pursue surgery at that time, and Dr. Smith-Kalaher prescribed hydrocodone instead.

18) On February 5, 2015, Petitioner was experiencing tenderness in his left palm and right wrist. He had also developed a ganglion cyst on the right wrist. Tinel's and Phalen's signs were positive on the right. Dr. Smith-Kalaher believed that Petitioner needed to proceed with surgery, and referred him to an orthopedic doctor for evaluation. (PX3).

19) Petitioner consulted with Dr. Michael Beatty, of Southwestern Illinois Plastic & Hand Surgery, on May 11, 2015. Dr. Beatty ordered an updated EMG study, and was concerned with a potential nerve issue in Petitioner's left hand. The medical records indicated that Petitioner discussed his work duties with Dr. Beatty. Petitioner was concerned about not being able to complete the slidegate duties. Dr. Beatty suggested that Petitioner discontinue using the sledgehammer and chipping gun until a proper treatment plan was in place. The medical records also indicated that Petitioner's hobbies included hiking and canoes. (PX10).

20) Petitioner underwent a second EMG/NCV study on June 10, 2015. The findings were consistent with moderate bilateral carpal tunnel syndrome. Following the results of the EMG/NCV, Dr. Beatty recommended proceeding with a right carpal tunnel release. This was completed on August 19, 2015 at Edwardsville Surgery Center. Petitioner's post-operative diagnosis was median nerve compression and right carpal tunnel syndrome. (PX10; PX11).

21) Petitioner did not undergo physical therapy after his right carpal tunnel release. (T.54). Following the removal of his splint and sutures, Dr. Beatty discharged Petitioner full duty on September 23, 2015. (PX10). Petitioner returned to work for Respondent following his release.

22) At arbitration, Petitioner indicated that Dr. Beatty had suggested additional surgery to his left hand, but Petitioner did not proceed with this because he could not afford to lose time from work. (T.34-35). Petitioner confirmed that he did not receive TTD for any time off work. (T.35). However, he received short-term disability benefits while he was recovering from his carpal tunnel releases. (T.40).

23) Petitioner testified that his hands were better since surgery, but he still experienced pain. (T.51). He also continued to feel numbness and weakness in both hands. "[S]ometimes I drop a lot of things, can't hold on to them, you don't know you really have it." (T.36). Petitioner's condition affected his ability to work. (T.36). His condition further affected his activities outside of work, such as wood working and riding his motorcycle. "Anything that I used to do with my hands I gave up because it's too painful." (T.36-37).

24) Petitioner continues to follow-up with Dr. Smith-Kalaher for pain medication for his hands. (T.48). An office visit note from Dr. Smith-Kalaher, dated February 2, 2016, noted that Petitioner did have a history of high cholesterol and was borderline diabetic. (PX3). He has not returned to Dr. Beatty since his release in September 2015. (T.54).

25) Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Mitchell Rotman, on January 9, 2012. Dr. Rotman is a board-certified orthopedic hand surgeon. (RX1, pg. 4). His evidence deposition was taken on May 8, 2014. He testified consistent with his reports.

26) Dr. Rotman stated that Petitioner was diagnosed with carpal tunnel syndrome on October 14, 2010. There is no medical record in evidence to corroborate this. Dr. Rotman noted that Petitioner underwent left carpal tunnel release in February 2011 and was reporting no problems with the left hand. However, Petitioner did have discomfort in his right hand and was told he had borderline carpal tunnel there. According to Dr. Rotman, Petitioner was able to tolerate his symptoms, and as of the January 9, 2012 Section 12 examination, Petitioner was not interested in surgery. Petitioner also described numbness and tingling in

the right thumb, index, and middle fingers, and there was a burning sensation in the palm. (RX1, Respondent's Deposition Ex. 2).

27) Dr. Rotman noted that Petitioner was presently working full duty for Respondent. He reviewed a video of Petitioner's job duties and noted Petitioner's use of the Gradall machine, chipping gun, rivet buster, and the lances. Dr. Rotman also mentioned a February 18, 2011 work analysis performed by Apex Physical Therapy of Petitioner's job. This analysis was not offered into evidence by the parties. The assessment suggested that operating the Gradall and bobcat equipment may include some repetition and there was some risk there and a possible need for ergonomic change. There was also some risk with regard to the rivet buster tool. (RX1, Respondent's Deposition Ex. 2).

28) As to Petitioner's physical examination, Dr. Rotman wrote that Petitioner was six feet tall and 220 pounds. He had a well-healed carpal tunnel release – was not particularly tender; Petitioner had full range of motion of the left wrist and digits, and testing for carpal tunnel was negative on the left. On the right side, there was tenderness at the carpometacarpal joint, with no swelling. Petitioner had a negative Tinel's on the carpal tunnel on the right side; median nerve compression testing on the right caused some numbness in his fingers. Dr. Rotman stated that Petitioner smoked one pack of cigarettes per day. He indicated that Petitioner had been a wood worker, but had not done any carving in about five years. Petitioner also occasionally rode a motorcycle; he mainly rode on the weekends or in the summers. (RX1, Respondent's Deposition Ex. 2).

29) Dr. Rotman opined that Petitioner had mild carpal tunnel on the left hand and was at maximum medical improvement (MMI). As to Petitioner's right hand,

> He may eventually require a carpal tunnel release on the right side, but presently he seems to be doing well with conservative care with splinting. His carpal tunnel condition would be considered idiopathic. Some of the activities that he does at work may cause symptoms depending on how heavy he may be gripping at the time. It sounds like he is doing the heaviest gripping when he is supporting these angles lances with his left hand and trying to keep them from twisting. He does that for a very small period of time during the week and in fact the activities that he does most of the time are the Gradall operation, which involves very small gripping forces. Considering the other activities are done on a limited basis throughout the course of the week and most of his activities are with the Gradall operation, I would state his work at this point is not an aggravating factor for his bilateral idiopathic carpal tunnel. If he was doing a more forceful activity such as the use of a chipping gun, rivet buster, or the lance activities for a more significant amount of time during the course of the week, then I would have considered

his work to be an aggravating factor, but that is not the case here. (RX1, Respondent's Deposition Ex. 2).

30) On cross-examination, Dr. Rotman testified that he was not aware of any duty that did not require Petitioner to use his hands. (RX1, pg. 21). Petitioner confirmed this. (T.26).

31) Dr. Bruce Schlafly, of Hand Surgery Associates, P.C., conducted a Section 12 examination on behalf of Petitioner on June 11, 2013. His evidence deposition was taken on March 5, 2014. (PX9). Dr. Schlafly was board-certified in hand surgery and orthopedic surgery, but his surgical practice was limited to hand surgery. (PX9, pgs. 5-6). Dr. Schlafly testified consistent with his June 11, 2013 report.

32) Dr. Schlafly noted Petitioner's work duties, which included working on a full-time and overtime basis for Respondent as a pitman for approximately 25 years. (PX8). Dr. Schlafly reviewed a video that depicted Petitioner's job duties (e.g., using a jackhammer to break-up concrete, banging with a metal rod, operating a bulldozer, etc.). (PX8; RX3). Dr. Schlafly stated that one scene was shot from the individual's right side, which made it difficult "to tell to what extent he is using the left hand but the scene then shifts and he is moving a joystick with the left hand forwards and backwards, and using his left thumb, and then the right thumb on the control mechanism on that side." (PX8; RX3). Dr. Schlafly had also personally discussed with Petitioner his job duties, which were consistent with the description provided above. Dr. Schlafly added that the lance Petitioner used at work exerted 150 pounds of force and was 10 to 20 feet in length. "He holds it as he operates valves, and he describes a mechanism to lock it in place with a lot of pressure. He says there is another part of the job not shown on the video, which requires him to burn open equipment using a 14 inch pipe." Dr. Schlafly stated that in summary, Petitioner's work required constant use of both hands, with force, vibration, and/or motion. (PX8).

33) By the June 11, 2013 Section 12 examination, Petitioner had only proceeded with the left carpal tunnel release. Dr. Schlafly noted Respondent's Section 12 examiner's diagnosis and recommendation for right carpal tunnel release. Petitioner presented on this date with complaints of pain and numbness in the right hand. Dr. Schlafly noted no prior history of hand or wrist fractures. "Mr. Buckingham tells me that he has been experiencing symptoms of pain and numbness in his hands for several years, perhaps even 10 years, although at first the symptoms were mild and they only gradually increased in intensity. His hands were fine when he began his employment at US Steel." (PX8).

34) Dr. Schlafly's review of Petitioner's medical records was consistent with the record. After considering Petitioner's history, reviewing the medical records and video, and performing a physical exam, Dr. Schlafly diagnosed Petitioner with left carpal tunnel syndrome with left carpal tunnel release, and right carpal tunnel syndrome. (PX9, pg. 12). Dr. Schlafly opined that, "Mr. Buckingham's repetitive work with his hands at his place of employment at US Steel is the primary and prevailing factor in the cause of his bilateral carpal tunnel

syndrome and in the need for bilateral carpal tunnel releases. The treatment given by Dr. Mackinnon was appropriate, for the left carpal tunnel syndrome." (PX8).

35) On cross-examination, Dr. Schlafly testified that Petitioner did improve with the left carpal tunnel release, but "when an individual has marked compression of the median nerve in the carpal tunnel as described by Dr. Mackinnon, it's probably unrealistic to expect a completely normal and full recovery following surgery." (PX9, pg. 27). Dr. Schlafly stated that it would not be unusual to still have a positive Tinel's sign a couple of years later. (PX9, pg. 28). He provided a 5% impairment rating for the left hand. (PX8; PX9, pgs. 12-13).

36) Dr. Schlafly testified that he would recommend right carpal tunnel release. "My opinion is that his need for right carpal tunnel release is due to his work with his right hand at U.S. Steel." (PX9, pg. 13). Dr. Schlafly believed that surgery was necessary to prevent irreversible nerve damage in the right hand. (PX9, pgs. 13-14).

37) On July 23, 2013, Dr. Rotman authored a Section 12 addendum report, wherein he agreed with Dr. Schlafly's 5% impairment rating for the left hand. (RX1, Respondent's Deposition Ex. 3). He also opined,

> [B]ased on his nerve studies that were performed in the last two years on the right side showing just mild or borderline carpal tunnel syndrome, it would be my opinion that only after two years his nerve studies would not get to the point where his condition would become irreversible or guarded.

38) Dr. Rotman recommended new nerve studies for the right hand and possible right carpal tunnel release. However, his opinion as to causal connection remained the same – Petitioner's condition and need for treatment was not work related. (RX1, Respondent's Deposition Ex. 3). Finally, Dr. Rotman authored yet a third addendum report dated March 28, 2016, wherein he noted that Petitioner underwent right carpal tunnel release but his opinion on causation did not change. (RX2).

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony, and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Indus. Comm'n*, 216 Ill. App. 3d 1048, 1054 (3rd Dist. 1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Dep't v. Indus. Comm'n*, 83 Ill. 2d 528, 533-34 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator found Petitioner credible and noted that some of Petitioner's work duties were hand intensive. However, the Arbitrator concluded that Petitioner failed to prove that he

sustained an accident which arose out of and in the course of his employment. The Arbitrator based her Decision on the fact that Petitioner's work duties varied, and therefore not repetitive. The Arbitrator also emphasized that neither of Petitioner's treating physicians, namely Dr. Mackinnon and Dr. Beatty, proffered a causal connection opinion. The Arbitrator further noted that Dr. Schlafly's opinion in support of Petitioner's repetitive trauma claim was the result of Petitioner "shopping" around to secure such an opinion. As the Arbitrator did not find accident, she considered the remaining issues moot.

An employee who suffers a repetitive-trauma injury is still required to meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Indus. Comm'n*, 224 Ill. 2d 53, 64 (2006). "That means, *inter alia*, an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person." *Id.* at 65. This is otherwise known as the "manifestation date." *Id.* As the same standards apply in repetitive-trauma claims, a claimant must also prove, by a preponderance of the evidence, that he suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). More importantly, "A work-related injury 'need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being.'" (Emphasis in original). *Dunteman v. Ill. Workers' Comp. Comm'n*, 2016 IL App (4th) 150543WC, *citing Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

The Commission finds that the evidence in the record supports Petitioner's alleged manifestation date of November 23, 2010. Petitioner testified to and the medical evidence demonstrates that Petitioner had no pre-existing condition or previous injury to his hands when he first started working for Respondent nearly 30 years ago. (T.13; T.35). Petitioner admitted that the onset of symptoms in his hands may have begun on October 14, 2010 or earlier. (T.28; T.38-39). However, it was not until November 23, 2010, that Dr. Smith-Kalaher diagnosed Petitioner with bilateral carpal tunnel syndrome. (T.29; PX1). Although Dr. Smith-Kalaher did not provide a formal causal connection opinion, her medical notes indicated that Petitioner discussed his duties as a steel worker, which involved "holding a jackhammer like tool in his hands. He also operates heavy machinery with the controls." The office visit note for November 23, 2010 further stated that Petitioner's symptoms in his hands were constant, but he felt worse when he was working. (PX1). The record, therefore, provides a reasonable basis for the alleged manifestation date of November 23, 2010, which was when Petitioner's bilateral carpal tunnel condition and its causal link to his work duties became apparent.

The Commission further finds support in favor of Petitioner on the issue of causal connection. In repetitive trauma claims, the issues of accident and causal connection are intertwined. Thus, the Arbitrator, in not finding accident, also denied causal connection – and based her decision on the fact that Petitioner's duties varied. Respondent's Section 12 examiner, Dr. Rotman, also did not attribute Petitioner's bilateral carpal tunnel condition to his job duties because Petitioner either performed his duties "for a very small period of time" or the more time-

consuming work did not involve significant force. Neither Dr. Rotman nor the Arbitrator disagreed with the fact that Petitioner's work was indeed hand intensive. In fact, Dr. Rotman stated,

> If he was doing a more forceful activity such as the use of a chipping gun, rivet buster, or the lance activities for a more significant amount of time during the course of the week, then I would have considered his work to be an aggravating factor, but that is not the case here. (RX1, Respondent's Deposition Ex. 2).

The Arbitrator's Decision and Dr. Rotman's opinion are contrary to the evidence in the record, and the Arbitrator's Decision is contrary to what case law dictates. In *Edward Hines Precision Components v. Indus. Comm'n*, our Appellate Court stated that, "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." 356 Ill. App. 3d 186, 193-194 (2nd Dist. 2005); *See also City of Springfield v. Ill. Workers' Comp. Comm'n*, 388 Ill. App. 3d 297 (4th Dist. 2009). In other words, repetitive work does not only mean performing one task over and over.

In this claim, Petitioner testified that although his work varied, it was consistent and repetitive in nature. (T.18-19; T.42; T.59). Petitioner testified to using both hands to maneuver controls on a bobcat, as well as the Gradall and Grant machines, which shook and jerked him around. (T.15-16; T.19-22; PX10). He also used both hands to hold and operate a 40-pound rivet buster that vibrated. (T.16-17). Petitioner testified that he consistently used the rivet buster to break up hard ceramic from a wall. (T.17; PX10). Both hands were again required to operate lances. Dr. Schlafly noted that the lance Petitioner used at work exerted 150 pounds of force and was 10 to 20 feet in length. (PX8). Petitioner participated in slidegate duties, which he did not do often. (T.24). However, when he did, it involved using chipping guns, the rivet buster, an air mixer, a ladle bar, a ¾" impact wrench, a forklift, and other hand tools, including a 12-pound sledgehammer to "service returning gates up to 13 in an 8 hr shift using some or all of these tools." (PX10).

Petitioner testified that he performed a combination of these jobs within an eight to 16-hour day, 40 to 80 hours per week. (T.41). Notwithstanding Dr. Rotman's opinion, Petitioner spent approximately 15 minutes up to six hours on one of the above-referenced tasks. (T.15-17; T.21-22; PX10). He would subsequently experience pain, tingling, and/or numbness in his hands. (T.15-16; T.18-20; T.22; PX10).

Further, although Drs. Smith-Kalaher and Mackinnon do not provide formal causal connection opinions in their records, they did consider Petitioner's work duties. For example, Dr. Mackinnon, not only underscored Petitioner's "significant bilateral carpal tunnel syndrome," she followed this statement with information that Petitioner was "a steel worker and has done that for 20 years. He uses a rivet buster and has heavy work and high exposure to vibration, as well." (PX1). Petitioner also treated with Dr. Beatty for his carpal tunnel condition. In reviewing Petitioner's condition, Dr. Beatty's records indicated that Petitioner's work duties were again considered. In fact, Dr. Beatty suggested that Petitioner discontinue using the sledgehammer and

chipping gun until a proper treatment plan was in place. (PX10). Whether or not Drs. Smith-Kalaher, Mackinnon, and Beatty offered causal connection opinions is of no consequence. No inference can be taken against Petitioner's position based upon their failure to so opine, and none is taken by this Commission.

Finally, Dr. Schlafly, a board-certified hand surgeon and Petitioner's Section 12 examiner, stated that Petitioner's work required constant use of both hands, with force, vibration, and/or motion. He opined that Petitioner's "repetitive work with his hands at his place of employment at US Steel is the primary and prevailing factor in the cause of his bilateral carpal tunnel syndrome and in the need for bilateral carpal tunnel releases." He took into account Petitioner's history, the medical records, a video of Petitioner's job duties, and his own physical examination of Petitioner. (PX8). Dr. Rotman was also provided this same information for his review. He also described a February 18, 2011 work analysis performed by Apex Physical Therapy of Petitioner's job. This analysis was not offered into evidence by the parties. The assessment suggested that operating the Gradall and bobcat equipment may include some repetition and there was some risk there and a possible need for ergonomic change. There was also some risk with regard to the rivet buster tool. (RX1, Respondent's Deposition Ex. 2). On cross-examination, Dr. Rotman testified that he was not aware of any duty that did not require Petitioner to use his hands. (RX1, pg. 21).

The Commission notes that in terms of comorbidity factors, no opinion was offered by the parties that either Petitioner's age, sex, height, weight, hobbies, or the fact that he was borderline diabetic and was a smoker, was the cause of his bilateral carpal tunnel condition.

In light of the record in its entirety, the Commission hereby reverses the Arbitrator's Decision and finds that Petitioner not only suffered an accident and injury which arose out of and in the course of his employment, but that said employment was a causative factor in the resulting bilateral carpal tunnel condition.

The Commission further finds that Petitioner established proper notice pursuant to Section 6(c) of the Act. Petitioner testified that he informed his foreman, Kenny Kent, about the need for a left carpal tunnel release, and completed an accident report on December 21, 2010. (T.31; T.38). Respondent does not dispute this assertion; no accident report was offered into evidence by the parties. Moreover, the Application for Adjustment of Claim was signed on December 24, 2010, apparently mailed to Respondent on December 29, 2010, but filed on January 7, 2011. Taking into consideration the latest date of January 7, 2011, this date is still 45 days from the alleged manifestation date/accident of November 23, 2010, and meets the statutory deadline for notice under the Act. 820 ILCS 305/6(c).

The record also demonstrates that the Respondent took a credit under Section 8(j) of the Act for the payment of medical charges. On oral argument, Respondent agreed that the credit was taken from the first medical visit. Accordingly, the statute of limitations for notice and filing was tolled and the notice given by Petitioner was timely.

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As Petitioner met his burden of proof relative to accident, notice, and causal connection, the Commission finds he is entitled to reasonable, necessary, and related medical expenses as contained in Petitioner's Exhibit 12 in the amount of $22,300.54. Petitioner is also entitled to TTD from February 21, 2011 through March 28, 2011 and August 19, 2015 through September 22, 2015, representing 9 6/7 weeks.

As to the extent of Petitioner's disability, the Commission finds no dispute as to Petitioner's diagnosis of bilateral carpal tunnel syndrome, or the need for bilateral carpal tunnel releases. Petitioner's condition was confirmed by two EMG/NCV studies, positive physical examination findings by the treating physicians as well as the Section 12 examiners, and as actually seen during surgery. Petitioner underwent physical therapy only after the left carpal tunnel release.

Following the second and last surgery, this time to the right hand, Petitioner was discharged from treatment on September 23, 2015, and allowed to return to work with no restrictions. At arbitration, Petitioner testified that his hands were better since surgery, but he still experienced pain. (T.51). He also continued to feel numbness and weakness in both hands. "[S]ometimes I drop a lot of things, can't hold on to them, you don't know you really have it." (T.36). Petitioner's condition affected his ability to work. (T.36). His condition further affected his activities outside of work, such as wood working and riding his motorcycle. "Anything that I used to do with my hands I gave up because it's too painful." (T.36-37).

Petitioner testified that Dr. Beatty had suggested additional surgery to his left hand, but Petitioner did not proceed with this because he could not afford to lose time from work. (T.34-35). He continues to follow-up with Dr. Smith-Kalaher for pain medication for his hands. (T.48).

Although Petitioner's Section 12 examiner, Dr. Schlafly, provided a 5% impairment rating for the left hand, he stated that, "when an individual has marked compression of the median nerve in the carpal tunnel as described by Dr. Mackinnon, it's probably unrealistic to expect a completely normal and full recovery following surgery." (PX8; PX9, pgs. 12-13; 27).

It should be further noted that Petitioner was 57 years old on the date of injury, is right-handed, and has returned to his previous job with Respondent.

The Commission, therefore, finds Petitioner sustained disability to the extent of 10 percent (20.5 weeks) loss of use of the left hand and 10 percent loss of use of the right hand pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on October 5, 2016, is hereby reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable, necessary, and related medical expenses in the amount of $22,300.54 pursuant to Sections 8(a) and 8.2 of the Act.

17IWCC0542

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay temporary total disability benefits from February 21, 2011 through March 28, 2011 and August 19, 2015 through September 22, 2015, representing 9 6/7 weeks, at a rate of $888.93 per week.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 41 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused 10 percent (or 20.5 weeks) loss of use of the left hand and 10 percent loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: SEP 7 - 2017
MJB/pm
O: 8-15-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCKINGHAM, KEITH
Employee/Petitioner

Case# **11WC000475**

17IWCC0542

UNITED STATES STEEL CORPORATION
Employer/Respondent

On 10/5/2016, 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 0.49% 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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
3 S MAIN ST SUITE #2
HARRISBURG, IL 62946

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KEITH BUCKINGHAM
Employee/Petitioner

v.

UNITED STATES STEEL CORPORATION
Employer/Respondent

Case # 11 WC 00475

Consolidated cases: 17IWCC0542

An *Application for Adjustment 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 **May 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. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

17IWCC0542

On **November 23, 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 **$69,336.40**; the average weekly wage was **$1,333.40**.

On the date of accident, Petitioner was **57** 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 **$6,070.87** for other benefits, for a total credit of **$6,070.87**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment on November 23, 2010. All benefits are denied. The Arbitrator makes no findings regarding the remaining issues.

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

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

Signature of Arbitrator

October 4, 2016
Date

OCT 5 - 2016

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KEITH BUCKINGHAM
Employee/Petitioner

v.

Case #: **11 WC 00475**

UNITED STATES STEEL CORPORATION
Employer/Respondent

17IWCC0542

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging repetitive trauma injury to his bilateral upper extremities arising out of and in the course of his employment with Respondent. The Application alleged an accident/manifestation date of November 30, 2010. At the time of trial, Petitioner amended the date to November 23, 2010.

At the time of his alleged accident, Petitioner was 57 years old and single with no dependents. He was 63 years old at the time of trial. He was employed by Respondent as a pit man, and had been so employed for 26 of the last 27 years with Respondent. Petitioner testified he had several job duties, and he identified a handwritten document contained within Petitioner's Exhibit 10, on which he indicated his various duties. He testified he switches back and forth constantly between all the jobs and that it is never a steady job all day.

Petitioner testified one job duty is wrecking ladles with a Gradall. A Gradall is a machine that is driven and which has a big jackhammer on it. It is used to take the bad brick out and leave the good brick. He uses both hands to operate the Gradall and he noted the job might take one hour or might take three hours, and he could potentially perform this duty each day. He testified he notices pain and numbness when performing this duty.

The second job duty is using a rivet buster for trimming. He testified the rivet buster weighs approximately 40 pounds and is used to clean out and trim the leftover ceramic so the bricklayers can lay new brick. The machine vibrates and "gets harder than a 90-pound jackhammer". He uses both hands to operate the rivet buster and he noted the job might take 15 minutes to an hour, and he could potentially perform this duty each day.

The third job duty is lance burning. To perform this job duty, Petitioner testified he takes an oxygen hose with a couple hundred pounds of pressure and sticks it into a ten foot piece of

half-inch steel pipe and lights it with a torch. It is then used to burn through giants blocks of steel. To perform this duty he holds the lance with both hands over his head in different kinds of positions. He testified he could perform this duty a couple times a week and the job might take 20 minutes to three hours. He notices pain, tingling, or numbness when performing this duty.

The fourth job duty is operating a Bobcat. A broom or shovel is hooked to the Bobcat, which is used to clean up piles of dirt or sweep the floor. Petitioner testified he uses both hands to control and drive the Bobcat, and uses his feet to control the bucket. He notices pain, tingling, or numbness when performing this duty, but not as bad as with other duties.

The fifth job duty is digging ladles with the Gradall. This job duty is similar to the first job duty, but this involves using the Gradall to scrape out the crust and dig the ladles and clean the rubble pit. Petitioner testified he uses both hands to operate the equipment and notices pain, tingling, or numbness when doing so.

The sixth job duty Petitioner testified about is using a Grandt machine. This is a smaller version of the Gradall and is operated by remote control to clean the crust off the vessel where the steel is made. He stands in front of the vessel with the Grandt for two to three hours, sometimes five or six, and operates the controller with his thumbs and hands. He has to constantly move and dig with the jackhammer using the controller. He testified he notices pain, tingling, or numbness when performing this duty.

The seventh job duty is using a small Gradall, which is more like a Grandt machine and is also operated by remoted control. Petitioner testified he did not use this machine very often, maybe once a week.

The eight and final job duty Petitioner testified about is burning, using a torch and lance. It is done to burn the ladles to get the steel out of the way and get the brick out, for what is called returns. He testified he uses a 14 foot pipe with a 90 degree bend in it to burn open a hole in the bottom of the ladle. To perform the duty he has to lean over and push it through "with all the strength you have", and he uses both hands to perform this job. This is not a duty that he performs every day. He also testified that about once a year he works the slide gate, which is used to fix a valve on the bottom of a ladle.

Petitioner testified that he reviewed the DVD admitted as Respondent's Exhibit 3, which depicts some of the job duties he performs. He noted the video did not depict him using the Grandt machine or the Bobcat, but did show him hooking up a lance pipe. It did not show him burning anything or show how he would use his arms and hands to burn.

Petitioner testified that his job duties varied throughout each day, but all of them involved using his hands on a regular basis, and he notices pain, tingling, or numbness in his hands when he performs the duties. He testified that he also has those symptoms when he gets off work, and that they wake him up at night. The symptoms began slowly, about two or three years before he said anything. He had pain and began dropping things so he went to a doctor and was told it was probably carpal tunnel. He first sought treatment on November 23, 2010, with Dr. Smith. He told Dr. Smith what his work duties were and he was prescribed medication and hand splints,

which did not help much with the pain or numbness in his hands. Dr. Smith referred him to an orthopedic specialist, Dr. Mackinnon, who took over his care. He had a nerve conduction study, which revealed he had carpal tunnel syndrome, and Dr. Mackinnon recommended surgery. She recommended surgery on the left hand first, as it was worse than the right. At that point, Petitioner informed his foreman, Kenny Kent, and was instructed to fill out a written accident report, which he did.

Petitioner testified he had surgery by Dr. Mackinnon on February 22, 2011, and was taken off work at that point. He had some therapy following surgery, which helped a little. He returned to work after therapy and continued to have soreness in his left hand, as well as continued symptoms in his right hand. His job duties were the same as they had been prior to surgery. At his attorney's request, Petitioner presented to Dr. Bruce Schlafly for an independent medical examination. He also presented to Dr. Beatty, an orthopedic surgeon, on May 11, 2015. He discussed his work duties with Dr. Beatty, and handwrote a job description, previously referred to in testimony. Dr. Beatty ordered an updated nerve conduction study, which revealed Petitioner had carpal tunnel syndrome in his right hand. Dr. Beatty recommended surgery on the right hand, which was performed on August 19, 2015. He also discussed with Petitioner the possibility of additional surgery on his left hand, which has not yet been done.

Petitioner testified he is borderline diabetic and is controlling it with diet. He continues to have pain, numbness, and weakness in both hands. It hurts when he works but he tries not to let it interfere with his job duties. He testified his hobbies include woodcarving, woodworking, and riding his motorcycle, and that he can no longer do those activities due to pain.

On cross-examination, Petitioner did not disagree that he reported his condition to his employer around December 21, 2010, and that he reported he had an onset of symptoms around October 14, 2010. He agreed that when he filled out paperwork for the EMG/NCS on December 14, 2010, that he reported he had had symptoms for six or seven months. He testified he probably had it before then, but it was not serious enough to seek medical help and he did not think it was related to work. He agreed that he received short term disability benefits while he was recovering from both carpal tunnel releases.

Petitioner is right-handed and does the majority of his activities with his right hand, both at work and at home. He acknowledged he did not have a lengthy discussion with Dr. Mackinnon about his job duties. He agreed that when he was seen by Dr. Rotman he sat down with him and watched the job video and talked about his job duties. He reported he had worked for Respondent since 1988, worked eight to sixteen hours a day and 40 to 80 hours per week, and that his primary job was as a pit man. He also reported to Dr. Rotman that he spent three to five hours a day operating the Gradall, depending on the week. Petitioner testified that his job varied every day, hour by hour, and had so varied for 28 years. He did not repetitively perform the exact same duty for eight hours each day. Petitioner confirmed that the handwritten job description he completed was done so for Dr. Beatty, and that it was never given to Dr. Schlafly.

Petitioner confirmed that he told Dr. Rotman he used the chipping gun or a rivet buster up to two or three hours a day when required, but he testified there would be days when he would not use it at all. He confirmed that he told Dr. Schlafly he used a jackhammer anywhere

from five minutes to an hour on a weekly basis. He did not go into a lot of detail with Dr. Schlafly regarding the hours and jobs he performed, as they changed frequently.

Petitioner acknowledged that following each surgery he returned to his regular duties without restrictions. Following the left carpal tunnel surgery on February 22, 2011, he returned to work and did not report any complaints. He continued working his normal job until undergoing treatment with Dr. Beatty in 2015. With regard to his current complaints, Petitioner acknowledged that has not been back to health services, has not reported problems to his supervisors, and has not sought treatment from Dr. Beatty since being released. He does, however, see his regular physician for pain medication for his hands.

Petitioner testified he completed a patient questionnaire when he presented for the EMG/NCS in December 2010, which is part of Petitioner's Exhibit 4. Question seven asked how the pain occurred and there were four options: sudden onset with accident or definable event, slow progressive onset, slow progressive onset with acute exacerbation without accident, or definable event. Petitioner acknowledged that he marked "sudden onset with accident or definable event". Question nine asked if movement had any effect on pain and there were three options: pain is not altered by use and movement, pain is always worsened by use or movement, or pain is usually worsened by use and movement. Petitioner acknowledged that he marked "pain is not altered by use and movement". Petitioner testified he did not understand the questions, that his symptoms were from a gradual onset, and that he understood question nine to ask whether the pain went away with movement, which it did not.

Petitioner testified he saw Dr. Schlafly on only one occasion and did not receive treatment from him. He confirmed he did not seek any treatment in between the time he was released by Dr. Mackinnon and when he saw Dr. Schlafly. He was referred to Dr. Beatty by his regular physician when he continued to have problems, and thereafter had right carpal tunnel release on August 29, 2015. He did not have therapy after that surgery, as it was not recommended, and he has since been released by Dr. Beatty.

Petitioner acknowledged that two co-workers work with him during each shift, and they alternate positions. He estimated working one-third of each shift as a safety man, where he would observe co-workers performing the labor. He further acknowledged there was downtime and breaks between each task.

Petitioner initially sought medical treatment on November 23, 2010, when he presented to Dr. Melissa Smith of Granite City Clinic. His chief complaint was numbness in bilateral hands for past one to two months, with left being worse than right. He reported it was constant and sometimes seemed worse when he was at work. He further reported he was a steel worker, which often required him to hold a jackhammer-like tool in his hands and to operate heavy machinery with the controls. He complained of decreased grip strength and often dropped things because he could not feel well with his fingers. He denied a history of similar problems and did not recall any particular injury. He stated he did wood carving as a hobby, but could no longer do that because he could not feel well enough with his fingers. He denied pain into his elbows or shoulders, though did have chronic pain in the left elbow from a previous injury. He had a history of multiple orthopedic injuries from motor vehicle and motorcycle accidents, and history

of surgery to his left forearm, left elbow, and abdominal hernia. It was noted Petitioner was a steel worker and that he smoked a half pack of cigarettes a day. On examination, he had positive Tinel and Phalen's tests. Dr. Smith's assessment was bilateral carpal tunnel syndrome. She prescribed Anaprox and bilateral cock-up splints, which Petitioner was to wear as much as possible outside of work. Dr. Smith referred Petitioner to an orthopedic specialist, noting that he "he works with his hands and his hobby is working with his hands". Petitioner requested that he be referred to Dr. Susan Mackinnon, which was done. PX1.

On December 9, 2010, Petitioner presented to Dr. Susan Mackinnon at Washington University Physicians. The nurse's note indicates Petitioner had constant bilateral forearm pain, bilateral numbness in the first three digits, and continuous bilateral swelling of the hands. He stated he had spoken to co-workers, who recommended he see Dr. Mackinnon, and that he asked Dr. Smith for the referral. Petitioner completed a Pain Questionnaire, on which he noted he had tingling and numbness in both wrists. He indicated he had "sudden onset with accident or definable event", that the pain was "not altered by use and movement", and that "damp or cold weather have no effect on the pain". Dr. Mackinnon noted Petitioner had significant bilateral carpal tunnel syndrome, left worse than right. She further noted Petitioner had been a steel worker for twenty years and used a rivet buster, had heavy work, and had high exposure to vibration. Examination was positive for bilateral carpal tunnel syndrome and negative for cubital tunnel syndrome. It was noted he did have a little bit of median nerve compression in both forearms. Dr. Mackinnon recommended left carpal tunnel release, and indicated Petitioner may need release on the right as well. She ordered electrodiagnostic studies. PX4.

Petitioner underwent an EMG/NCS on December 14, 2010. He reported numbness and tingling of both hands, left more than right, over the past six to seven months. The results revealed Petitioner had bilateral mild carpal tunnel syndrome, worse on the left. PX4.

On December 21, 2010, Petitioner returned to Dr. Smith for follow up of carpal tunnel and pain in his hip, knee, and back. He reported he had been wearing the cock-up wrist splints at night and taking the Anaprox without any improvement in his symptoms. He had not slept well for two weeks, due to increased pain. He reported he had fallen on the ice the prior week, which exacerbated his chronic pain in his knee, back, and hips. He related he had been under a lot of stress, both in his personal life and at work. Dr. Smith prescribed Vicodin for the orthopedic pain and continued use of the splints for the carpal tunnel until surgery. PX1.

On January 18, 2011, Petitioner followed up with Dr. Smith regarding his orthopedic pain and stress. He reported he had only taken a few of the Vicodin tablets for the pain. He noted his stress level had not changed but he declined medication for it. It was noted he was scheduled for carpal tunnel surgery on the left wrist. PX1.

On February 22, 2011, Petitioner underwent left carpal tunnel release by Dr. Mackinnon at Barnes Jewish Hospital. Dr. Mackinnon indicated in a letter to Dr. Smith on February 28 that there was significant compression seen at the time of surgery. Petitioner was seen post-operatively on February 25 and March 11, 2011. It was noted he was doing well, with no concerns. He was to begin physical therapy and return in four to six weeks. PX5.

On March 22, 2011, Petitioner returned to Dr. Smith for follow up of chronic pain and recent mood disturbance. He reported he was doing great with regard to his chronic pain, as well as post-operatively from his left carpal tunnel surgery. It was noted he was returning to work light duty the following Monday. His primary complaint was his poor mood, due to stress with work, his divorce, and very low libido. He reported his interests, energy, and concentration were poor. He was started on depression medication and was to continue taking Vicodin as needed for his chronic pain. PX2.

Petitioner participated in physical therapy from March 23, 2011, through April 11, 2011. It was noted in the records that he had made steady improvement but continued to have some tightness in the ring and small fingers. He was to continue a home strengthening program. PX7.

On April 19, 2011, Petitioner followed up with Dr. Mackinnon, who noted he was "doing beautifully". He had some discomfort in the incision, and Dr. Mackinnon's hand therapist spoke to him about therapy, desensitizing, and a soft, padded splint. It was noted his carpal tunnel symptoms were completely clear and she anticipated an excellent long term result for him. PX6.

Petitioner returned to Dr. Smith on April 26, 2011, in follow up for his depression. He reported he was taking the medication daily but had not noticed much change in his mood. He noted he had more stress from work but that he was coping with it. PX2.

The next medical record is January 9, 2012, when Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Mitchell Rotman. He reported he worked eight to sixteen hours per day, 40 to 80 hours per week as a pit man. He noted he had left carpal tunnel release in February 2011 and had no problems with his left hand at that time. He had some discomfort in his right hand but reported it was tolerable and he was not interested in proceeding with surgery yet. Symptoms on the left had been completely relieved, but he had numbness and tingling in the right thumb, index, and middle fingers and burning in the right palm. He noted he wore a brace on the right, which has been helpful. Petitioner reported he smoked one pack of cigarettes a day. He further reported he had been a woodworker and did a lot of carving in the past, but stated he had not done that in about five years. He also had a Harley Davidson motorcycle, which he rode mostly on the weekends or in the summer.

Dr. Rotman talked with Petitioner about a job video taken by Apex, and he recalled being involved with its making. He stated he could spend up to three to five hours a day in the Gradall operation. He noted the Gradall had no suspension, which bothered him, and he noted he constantly used the hand controls with both hands. Other activities were varied during the course of the day, and from day to day. Petitioner might use a chipping gun or rivet buster two or three hours a day, or might not use it for a few days or few weeks.

Dr. Rotman reviewed medical records, including a work analysis performed by Apex Physical Therapy on February 18, 2011. The Arbitrator notes this analysis was not in the record. He noted the assessment suggested that operating the Gradall and Bobcat equipment may include some repetition, that there was some risk with those activities, and that there was a possible need for ergonomic change. It was noted there was also some risk with regards to a rivet buster tool. Dr. Rotman noted that for the Gradall operation, it involved sitting in the seat to operate joystick

controls and that fingertip pressure only was required to operate the joystick controls. Dr. Rotman noted that the assessment contained several numbers given for cumulative risk, and that if there was a risk score greater than 15 it would suggest further action may be required to reduce musculoskeletal risk. The rivet buster tool use was an 18, the Gradall use was 14 and the angled lance use was 13.

Dr. Rotman also reviewed records from Dr. Mackinnon, Dr. Golumbek (EMG/NCS), Rehab Institute of St. Louis, and the Apex Physical Therapy DVD of Petitioner's work analysis. He noted the DVD contained short segments, and he described them as follows:

(1) The rivet buster tool use, showing the use of the chipping gun and ladle bar. He noted the video only showed a ladle bar being used, which was a long handled object with an angled pick on the end of it to remove debris. There was a photograph of the pneumatic rivet buster tool in the picture section, but the videotape did not depict its actual use. Both hands were used to grab the handle with thick gloves, similar to a thin handled shovel.

(2) The Gradall operation, which showed typical handheld levers and involved minimal forces to the hand. There were levers for both hands, which did not involve much heavy hand activities or heavy gripping. The controls were mainly maneuvered with the shoulder moving forward and backward with minimal hand gripping required. The handles remained in the palm and were maneuvered with the fingers, with pushing and pulling from the shoulders, and a little pinching from the thumbs. The fingers made about a 30% fist with maneuvering the handles.

(3) The angled lance demonstration, which was a long thin pole that was maneuvered with both hands, while wearing thick gloves. The air hose was attached to the pole. The individual in the DVD used both hands, with the right hand on the handle area and the left hand more towards the middle to support it, and then maneuvered it mainly with the elbows and shoulders. The hands were about 50% cupped around the pole, but were not actually gripping the handle too tightly. They were mostly supporting the weight of the tool. He noted that no activities were actually observed with the angled lance, rather just the maneuvering of it.

On examination, Petitioner had negative testing for cubital tunnel syndrome. The left hand was healed and not tender, and he had full range of motion of the left wrist and digits. Testing for carpal tunnel was negative on the left. He had no atrophy, no arthritic changes, and no calluses. His left elbow lacked about five to ten degrees of extension, and it was noted he had an old pin placed in his olecranon as a child that still remained. He had some thickness of the bursa but no tenderness. On the right, Petitioner had some tenderness at the CMC joint with grind maneuver, but the motion was smooth and there was no swelling. He had a negative Tinel's on the right, but median nerve compression testing caused some numbness in his fingers. He had no evidence of epicondylitis on either side. Grip and pinch strength was slightly less on the right, as compared to the left.

Dr. Rotman opined that Petitioner was doing very well from his left carpal tunnel release, was at maximum medical improvement with full resolution of his symptoms, and required no further treatment. On the right, Petitioner had tolerable symptoms from mild to borderline carpal tunnel syndrome. He opined Petitioner may eventually require a carpal tunnel release, but that presently he was doing well with splinting. Dr. Rotman opined that Petitioner's carpal tunnel condition was idiopathic. He noted some of the work activities may cause symptoms, depending on how heavy he may be gripping at the time. He noted Petitioner was doing his heaviest

gripping when he was supporting the angle lances with his left hand and trying to keep them from twisting. He further noted that Petitioner did that for a very small period of time during the week, and that most of the time his activities were the Gradall operation, which involved very small gripping forces. Dr. Rotman opined that since the other activities were done on a limited basis throughout the course of the week, and that most of Petitioner's activities were with the Gradall operation, his work was not an aggravating factor for his bilateral idiopathic carpal tunnel syndrome. He noted that if Petitioner was doing a more forceful activity, such as using the chipping gun, rivet buster, or lance activities, for a more significant amount of time during the week, then he would have considered his work to be an aggravating factor. However, he noted that was not the case for Petitioner. With regard to treatment, Dr. Rotman opined Petitioner should continue with conservative care for his right carpal tunnel with night bracing, as needed, and that no treatment was needed on the left side. RX1, Dep. RX2.

The Arbitrator notes that Petitioner submitted a bill from Dr. Smith for date of service May 1, 2013. However, there was no corresponding medical record for this date of service.

The next medical record submitted is dated June 11, 2014, which is Petitioner's own independent medical evaluation by Dr. Bruce Schlafly, arranged by his attorney. The record includes three pages of handwritten notes, which are very difficult to decipher. Dr. Schlafly's report indicates he reviewed submitted medical records, as well as a video by Apex Physical Therapy depicting Petitioner's job duties. Petitioner reported his job as a pit man is strenuous. He reported he had undergone left carpal tunnel release, which helped a great deal, but that he had not undergone surgery on the right. He complained of a great deal of pain and numbness in the right hand. PX9.

Petitioner reported he had been experiencing pain and numbness in his hands for several years, perhaps as long as 10 years, and that his symptoms were mild at first and gradually increased in intensity. He noted his hands were fine when he began working for Respondent some 25 years prior. He first sought medical attention in 2010 for numbness and tingling in both hands, and was diagnosed with bilateral carpal tunnel syndrome by Dr. Smith. Dr. Schlafly reviewed and noted the medical treatment since that time. Petitioner complained of significant pain and numbness in his right hand and noted he dropped things with the right hand. PX9.

Petitioner reported his job required regular use of a rivet buster, which was similar to a heavy jackhammer, weighed 40 pounds, and carried a lot of vibration. He used it on at least a weekly basis, for anywhere from five minutes to an hour. He also operated heavy equipment, shown on the video, which required constant manipulation of control levers with both hands, and which vibrated. He reported the force required to grip the control levers was not extreme, but the motion with his hands and wrists was constant, in steering the heavy equipment and controlling the work it does. Petitioner also reported using a lance, which had 150 pounds of pressure and was ten to twenty feet long, and which he held as he operated valves. Petitioner reported there was another part of his job not shown on the video, which required him to burn open equipment using a 14 inch pipe. He also reported use of a chipping gun, which was like a rivet buster. Overall, the work required constant use of both hands with force, vibration, and/or motion. PX9.

Petitioner reported he worked a lot of overtime and did not have much time for other activities, but did spend time with his eight grandchildren. At one time he did amateur wood carving, but had not been able to do so for several years, due to the condition of his hands. PX9.

On examination, Petitioner had very good range of motion at both elbows. His range of motion was nearly equal in both wrists. Grip strength testing caused pain in the right hand. He had a positive Tinel sign at the median nerve of both wrists and a positive Phalen's test at the right wrist only. Dr. Schlafly's diagnosis was bilateral carpal tunnel syndrome, with left having been treated with a release. He recommended similar release on the right. He opined Petitioner was a maximum medical improvement with regard to the left hand, but not so with regard to the right hand, since he needed surgery. He opined that further delay in surgery could cause nerve damage. Dr. Schlafly opined that Petitioner's repetitive work with his hands with Respondent was the primary and prevailing factor in the cause of his bilateral carpal tunnel syndrome and the need for bilateral releases. He noted the previous treatment by Dr. Mackinnon was appropriate. He opined Petitioner had 5% impairment of the left upper extremity, due to the work related left carpal tunnel syndrome, pursuant to the AMA Guides to the Evaluation of Permanent Impairment (Sixth Edition). PX9.

On August 1, 2013, Dr. Rotman issued a revised Addendum report, following the exam and report by Dr. Schlafly. He noted Dr. Schlafly did not perform an updated EMG/NCS, and that the previous study showed only mild or borderline carpal tunnel syndrome. Based on that, he opined that after only two years Petitioner's studies would not get to the point where his condition would become irreversible or guarded. He noted carpal tunnel syndrome did progress over several years, but not that quickly. Dr. Rotman opined that new nerve studies could be obtained, but that if Petitioner's symptoms were worse he would recommend he undergo a right carpal tunnel release. He did not feel, however, that Petitioner would have irreversible nerve damage if he waited for the surgery. He agreed that if Petitioner's symptoms on the right had become intolerable, that surgery was appropriate. He opined that if Petitioner had surgery on the right he would have full relief of symptoms, as he did on the left. However, Dr. Rotman's opinion with regard to the etiology of Petitioner's carpal tunnel condition had not changed, and the need for surgery was not related to Petitioner's work. He noted he had an adequate amount of information at the time of his original exam and opinion in January 2012 with regard to the etiology, and he continued to opine that Petitioner's work was not an aggravating factor for the idiopathic carpal tunnel condition. RX1, Dep. RX3.

The next medical record in evidence is February 21, 2014, when Petitioner was seen by Dr. Smith/Kalaher for hyperlipidemia and hyperglycemia, for which lab work was completed. Dr. Kalaher also noted Petitioner's history of carpal tunnel syndrome. PX3.

Dr. Schlafly testified by way of deposition on March 5, 2014. He is a Board Certified Orthopedic Surgeon and Hand Surgeon, and he limits his surgical practice to hand surgery. He routinely sees carpal tunnel syndrome cases in his practice, and performs more than one hundred carpal tunnel surgeries each year. He testified consistent with his report of June 11, 2013. PX9.

Dr. Schlafly testified that the activities depicted in the job analysis video were hand-intensive activities and were strenuous with respect to use of the hands. The activities in the

video were consistent with the job duties Petitioner described. Dr. Schlafly testified Petitioner's work duties with Respondent caused his bilateral carpal tunnel syndrome and need for treatment, including past surgery on the left hand and recommended surgery on the right hand. PX9.

On cross-examination, Dr. Schlafly acknowledged that he examined Petitioner at his attorney's request. He agreed that the passage of time could interfere with the patient's ability to record events and circumstances, such that the history given closest to the event could be more accurate than the history given later. Dr. Schlafly reviewed Dr. Mackinnon's initial record of December 9, 2010, and the intake sheet completed by Petitioner, wherein he circled that his current pain was due to sudden onset with accident or definable event. Dr. Schlafly conceded that Petitioner did not describe to him any sudden onset with accident or definable event when he examined Petitioner on June 11, 2013. PX9.

Dr. Schlafly testified the video of Petitioner's job did not depict or describe how long Petitioner engaged in any of the activities in the video, and he conceded that that might have some impact on his opinion concerning causal relationship. He testified that the only job duty that he commented on, with regard to the time spent on the activity, was the heavy jackhammer/rivet buster, which Petitioner stated he used at least on a weekly basis for anywhere from five minutes to one hour. He testified that all of the job activities were relevant, but that use of a jackhammer on a regular basis, in and of itself, could cause carpal tunnel syndrome, and that it was the main factor in his causation opinion. He testified that use of the chipping gun also was a factor in his opinion, which Petitioner stated he used on a weekly basis for five minutes to an hour per week. Dr. Schlafly conceded he did not have a measure of the amount of flexion and extension required in terms of operating the heavy equipment, or a measure of the vibration. Dr. Schlafly did not know how long Petitioner operated the heavy equipment on a weekly basis, how many times he used the lance each week, nor the other activities depicted. PX9.

Dr. Schlafly testified he reviewed the nerve conduction studies performed on December 14, 2010, which revealed mild sensory bilateral carpal tunnel syndrome, left worse than right. He acknowledged that Petitioner is right-handed. He did not arrange for any updated EMG studies at the time he examined Petitioner. He agreed that there are people with carpal tunnel syndrome who have it from an unknown or idiopathic cause. He testified that it was not unusual for a patient to continue to have a positive Tinel after surgery, when there was severe compression prior to surgery, as Dr. Mackinnon noted in this case. Dr. Schlafly did not have information as to the amount of overtime Petitioner actually worked. He was not aware of when Petitioner actually stopped doing wood carving. PX9.

Dr. Rotman testified by way of deposition on May 8, 2014. He is a Board Certified Orthopedic Surgeon and Hand Surgeon. He testified consistent with his reports of January 9, 2012, and August 1, 2013. RX1.

Petitioner provided a history of his job duties and treatment to date. He also reported he rode a motorcycle and had done a lot of wood carving up until five years prior. Dr. Rotman reviewed the video done by Apex Physical Therapy and discussed the contents with Petitioner in detail, and testified he had a good understanding of the requirements of Petitioner's job. He testified Petitioner used the Gradall machine for most of the time at work, and the more hand-

intensive activities were not done very often. Rather, they were sporadic and not done on a repetitive basis. He testified that use of the Gradall machine was just use of levers, and that this kind of work was not an aggravating factor for an idiopathic carpal tunnel condition, because the grip forces were not significant enough to be a factor. He explained that "idiopathic" referred to the fact that it was not posttraumatic, such as with a wrist fracture or dislocation that caused swelling, and that the cause was unknown. Dr. Rotman testified that, based on Dr. Schlafly's report, it appeared Petitioner's right-sided symptoms were getting worse, and that it would be appropriate for him to have right carpal tunnel release. He disagreed that surgery was emergent, however, and testified Petitioner should have an excellent result post-operatively. RX1.

On cross-examination, Dr. Rotman conceded Petitioner did perform work that was hand-intensive and repetitive, but testified it was on an occasional basis only. He acknowledged that the video did not contain all of the jobs Petitioner performed throughout a day, including use of the chipping gun. Dr. Rotman testified that when people have carpal tunnel syndrome, they have symptoms, and certain activities cause the symptoms. For example, sleeping with your wrist flexed or holding a steering wheel or other object for awhile causes symptoms of numbness and tingling. He testified that the activity did not cause or aggravate the carpal tunnel syndrome, but rather the activity triggered the symptoms. RX1.

The next treatment record is February 5, 2015, when Petitioner returned to Dr. Kalaher with a growth in the palm of his left hand for about one and a half months. He had no injury but reported he worked with his hands. He had no popping, locking or pain in the finger. It was noted he also had right carpal tunnel syndrome and a ganglion cyst that needed surgery. Examination of the right wrist revealed a tender cyst, and positive Tinel's and Phalen's. The left palm contained a tender knotted tendon at the base of the fourth digit. Dr. Kalaher gave Petitioner an orthopedic referral for both. PX3.

On May 11, 2015, Petitioner presented to Dr. Michael Beatty, upon referral by a fellow worker. He reported a history of right carpal tunnel syndrome, as well as complaints in the left palm. Dr. Beatty noted there was a potential nerve issue with the left hand and he recommended an EMG/NCS prior to surgery. In conjunction with the examination, Petitioner completed a "Job Description", noting he used a sledgehammer, rivet buster, chipping gun, ladle bar, shovels, cutting torch, oxygen lance, hammers, and wrenches. He further noted that as a pit man and ladle digger he performed a variety of duties using various equipment, and that changes to the job duties occurred as the need arose. He handwrote a page of tasks he completed as a pit man and on the slide gate. The tasks listed were those Petitioner testified to, and the estimated time spent on each task varied, consistent with Petitioner's testimony. Petitioner noted his hobbies included hiking and canoeing. On another form, Petitioner reported he had been smoking for five years. It was noted they discussed Petitioner's work situation and his concerns that he was unable to do slide gate activity. Dr. Beatty noted he would discontinue use of a sledgehammer and chipping gun until a treatment plan was developed and Petitioner's condition was resolved. PX10.

On May 21, 2015, Petitioner returned to Dr. Kalaher with complaint of a spot on his right temple, present for a few months, with no itching, pain, flaking, or bleeding. He noted he continued to have carpal tunnel pain and was planning to have surgery to correct it. He reported

he used hydrocodone sparingly for severe pain. Assessment was seborrheic keratosis which appeared to be benign, but Petitioner was to return for a biopsy if the spot changed. PX3.

On June 10, 2015, Petitioner underwent an EMG/NCS at Anderson Hospital, at the request of Dr. Beatty. The findings were consistent with moderate bilateral carpal tunnel syndrome. On June 19, 2015, Dr. Beatty sent a letter to Petitioner advising of the results of the EMG and recommending surgery. On August 19, 2015, Petitioner underwent surgical release of the right carpal tunnel by Dr. Beatty at Edwardsville Surgery Center. (PX11.) He followed up postoperatively with Dr. Beatty on August 26, 2015, at which time he was taken out of the splint. He followed up again on September 2, 2015, and the sutures were removed. It was noted he complained of a palmar mass on the left hand, and Tinel's was positive on the left. Dr. Beatty recommended a CT scan and noted exploration may need be undertaken. On September 23, 2015, Petitioner returned to Dr. Beatty and was given a release to return to work. PX10.

The next medical record is February 2, 2016, when Petitioner presented to Dr. Kalaher with complaints of pain in his right hip and right hand. He noted the hip pain was waking him up several times every night and that he was using hydrocodone to help with the pain. The pain was in the right groin and it felt like the hip popped out of place easily. He reported he had had a motorcycle accident in 1995, was initially told he broke his pelvis, that it was not treated properly, and that he had had issues off and on since then. He noted long-standing numbness in his outer thigh and weightbearing made the pain worse. With regard to his right hand, Petitioner complained of pain in the right thumb at the base, which he thought was arthritis. He reported he had some popping and creaking. Assessment was hip pain and thumb pain. On February 4, 2016, Petitioner underwent x-rays. Right hand x-rays were negative for fracture, but did show moderate to severe osteoarthritis at the carpal-metacarpal joint of the thumb, as well as mild radiocarpal osteoarthritis and mild osteoarthritis of the interphalangeal joints of the fingers and thumb. Right hip x-rays revealed mild to moderate osteoarthritis, possible ossific loose body in the right hip joint space, and prominence of the right femoral head/neck junction as would be seen in a CAM-type femoral acetabular impingement. PX3.

Respondent entered into evidence the DVD of Petitioner's job duties, as referenced by Dr. Schlafly and Dr. Rotman. The Arbitrator viewed the DVD, which depicted, among other things, Petitioner using a tool which, by his testimony, appeared to be a rivet buster. It resembled a hand-held jackhammer and was being used to chip away chunks of ceramic. Petitioner testified it weighed about 40 pounds, and that estimation appeared to the Arbitrator to be accurate. Petitioner forcefully gripped the tool with both hands and pushed it into the ceramic to break it up. The machine forcefully vibrated, like a jackhammer, the entire time it was being operated. In reviewing Dr. Rotman's report of January 9, 2012, it does not appear that he viewed this portion of the DVD, as he stated, "There was a photograph of the pneumatic rivet buster tool in the picture section, but I did not see a videotape of its use." He later stated, "The video only lasted one minute or two on each segment. As stated, it did not actively demonstrate the use of the pneumatic rivet buster tool." Dr. Rotman referenced observing demonstrations of only the ladle bar, the Gradall, and the angled lance on the DVD. The Arbitrator observed these demonstrations as well, in addition to the rivet buster. The ladle bar resembled a garden hoe, and was used to remove debris. Petitioner used both hands to grab the bar, while wearing thick gloves. The Gradall operation was performed with the use of levers, or large joysticks, in both

hands. There did not appear to be much force needed to maneuver the levers. The angled lance was a long thin pole that Petitioner indicated would be maneuvered using both hands while wearing thick gloves, and would be gripped for the duration of its use. RX3.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011). In order to satisfy the "arising out of" requirement of the Act, the Petitioner must show the injury was in some way incidental to his employment, creating a causal connection between his employment and the injury. *Caterpillar Tractor Co. v Industrial Commission*, 129 Ill.2d 52, 57 (1989).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment. In so concluding, the Arbitrator finds compelling that neither of Petitioner's treating physicians, Dr. Mackinnon or Dr. Beatty, proffered an opinion regarding medical causation. Petitioner testified he did not have a lengthy discussion with Dr. Mackinnon about his job duties. However, with Dr. Beatty he completed a two-page "job description" and handwrote a page of duties and tasks his job entailed. Neither doctor commented in their records, or testified, as to a causal relationship between Petitioner's carpal tunnel syndrome and his work as a pit man for Respondent. It is reasonable to conclude, therefore, that neither Dr. Mackinnon nor Dr. Beatty believed Petitioner's condition was causally related to his work activities. The only doctor who found Petitioner's condition causally related to his work was Dr. Schlafly, who saw Petitioner at his attorney's request nearly four years after Petitioner's alleged date of manifestation. A reasonable inference can be drawn that doctor shopping was necessary for Petitioner to secure a causation opinion, and the Arbitrator is disinclined to give weight to Dr. Schlafly's opinion.

Though Petitioner had not established causation, Respondent nonetheless sought a causation opinion by Dr. Rotman. Dr. Rotman went into detail about Petitioner's job duties, after having viewed the DVD and spoken at length with Petitioner. He conceded in his report and in his testimony that some of the activities Petitioner did at work may cause symptoms, depending on how heavy he may be gripping something. However, he noted that these gripping activities were done on a limited basis through the work week, and that most of Petitioner's activities were with the Gradall operation. He further conceded that if Petitioner was doing a more forceful activity, such as using a chipping gun or rivet buster, for a more significant amount

of time during the week, he would have considered his work to be an aggravating factor. However, such was not the case, and Dr. Rotman therefore concluded that Petitioner's carpal tunnel condition was idiopathic in origin and not caused or aggravated by his work activities. The Arbitrator finds Dr. Rotman had a good understanding of Petitioner's work activities. His opinion is well-founded in the record and the Arbitrator finds his opinion to be persuasive.

Having viewed the DVD and considered Petitioner's testimony, the Arbitrator is mindful that parts of Petitioner's job are hand-intensive. Operation of the rivet buster in particular appears to be fairly vibratory. However, it is but one of many job tasks that Petitioner performs, and he candidly testified that his job varied "hour by hour" on a daily basis and that his job activities were not repetitive. He further testified, and related to Dr. Rotman, that most of his activities are with the Gradall operation which, as depicted in the DVD, does not involve forceful, prolonged, or vibratory gripping. Petitioner also testified that two co-workers work with him in the same position during each shift, and they alternate positions. He estimated that one-third of each shift was worked as a safety man, where he would observe co-workers performing the labor.

While the Arbitrator found Petitioner to be candid and forthright, the medical evidence simply does not support a finding of a compensable accident. Petitioner failed to prove by a preponderance of the evidence that he sustained an injury on November 23, 2010, that arose out of and in the course of his employment with Respondent. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

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 Down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Buchanan,

Petitioner,

vs. NO: 11 WC 16599

Olin Corporation,

Respondent.

17IWCC0591

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice provided to all parties, the Commission, after considering the issues of benefit rates, causal relationship, temporary total disability benefits, medical expenses, maintenance versus PPD advancement and permanent disability and being advised of the facts and the law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision- finding Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on April 18, 2011 and her current condition of ill-being as it relates to her cervical spine. Based on this finding, the Commission vacates the Arbitrator's award of medical expenses.

The medical records evidence although Petitioner complained of neck pain, she did not receive treatment for her cervical spine until almost four years after her April 18, 2011 accident, absent a cervical MRI performed on July 1, 2013 at her request. During this period, Petitioner treated for her low back condition with Dr. Gornet, who performed a laminotomy and foraminotomy at L5-S1 on the right side on November 30, 2011. Dr. Gornet

felt Petitioner reached maximum medical improvement on July 12, 2012, noting he agreed with the functional capacity evaluation which placed her at a sedentary level. Thereafter, on January 24, 2013, Petitioner reported her symptoms in her neck, shoulders and arms had worsened, and Dr. Gornet recommended a cervical MRI. On May 23, 2013, Petitioner reported having right-sided low back pain on the same side as her decompression which Dr. Gornet felt might be a recurrent disc herniation and recommended a lumbar MRI. Dr. Gornet noted, "I have again asked her to not move forward with any issues on her neck, as I believe this will be a prolonged fight with the employer insured, but certainly I think it is reasonable and all parties could agree that if she is having increasing symptoms in her low back to the right side, this would warrant further workup." On July 1, 2013, Petitioner reported to Dr. Gornet she underwent a cervical MRI under her own insurance. Dr. Gornet reviewed the MRI and recommended Petitioner try and live with her neck symptoms, and her pain was predominately in her low back, right buttock, and right leg. (The Commission notes neither the July 1, 2013 MRI report nor bill were offered into evidence). On October 28, 2013, Petitioner underwent a lumbar MRI which Dr. Gornet interpreted as evidencing a continued disc herniation- central right at L5-S1, which correlated with Petitioner's right buttock and leg pain. Dr. Gornet opined no further treatment was recommended; permanent restrictions of no lifting greater than 10 pounds, no repetitive bending or lifting; and placed Petitioner at maximum medical improvement. PX4, DepEx2.

On November 3, 2014, a year later, Dr. Gornet re-evaluated Petitioner who reported neck pain into both shoulders with some right scapular and arm pain. Dr. Gornet recommended an oral steroid and a cervical MRI. The Commission notes this was the commencement of Petitioner's treatment for her cervical complaints. Petitioner underwent a cervical MRI on November 21, 2014 which was compared to the July 1, 2013 MRI. The radiologist's impression was: 1) degenerative disc disease primarily involving the C3-4 through C6-7 disc levels with disc bulges and disc protrusions; there was multilevel central canal stenosis spanning from C3-4 through C6-7 levels; and 2) varying degrees of neural foraminal exit stenosis, most severely involving the bilateral C5-6 and C6-7 neural foramen. Petitioner underwent two epidural steroid injections on January 5 and 14, 2015 performed by Dr. Boutwell. On March 16, 2015, Dr. Gornet evaluated Petitioner for a final time noting further treatment might be necessary for her cervical complaints but ultimately releasing her on an "as needed" basis. PX4, DepEx2.

At his April 20, 2015 deposition, Dr. Gornet testified as of July 12, 2012, he placed Petitioner at maximum medical improvement for both her back and neck as further treatment was not indicated. PX4, p. 29. Dr. Gornet opined a causal relationship exists between Petitioner's cervical symptoms and the April 18, 2011 accident, based upon her complaints to him. PX4, p. 15.

Dr. Lange evaluated Petitioner at various times pursuant to §12 of the Act at Respondent's request. On June 21, 2011, Dr. Lange examined Petitioner and reviewed the medical records to date and noted Petitioner's complaints of low back pain and to a lesser degree discomfort in the neck and intrascapular area. Dr. Lange noted it was Dr. Gornet's plan to address Petitioner's neck as a secondary issue. On September 19, 2011, Dr. Lange examined

Petitioner and reviewed Dr. Gornet's records since his prior evaluation and again noted Dr. Gornet planned to address Petitioner's residual intrascapular discomfort in a secondary fashion. Dr. Lange opined addressing cervical/intrascapular complaints with more treatment, particularly invasive, was not indicated. On March 29, 2012, Dr. Lange evaluated Petitioner and opined 1) she reached maximum medical improvement, and 2) further diagnostic testing was not necessary nor indicated. RX5.

On October 22, 2013, Dr. Lange evaluated Petitioner for a final time noting primarily persistent low back complaints and some aching into the neck extending slight to the arm. Dr. Lange noted his prior evaluation approximately one and half years ago, at which time he opined Petitioner reached maximum medical improvement and was in no need of further treatment. Dr. Lange noted Petitioner continued to seek treatment with Dr. Gornet. Dr. Lange noted although Petitioner exhibited multiple signs of symptom magnification, she complained of both axial neck and low back pain. Dr. Lange opined Petitioner suffered from low back pain which was impossible to quantify objectively and re-iterated maximum medical improvement occurred approximately one and half years previously. Dr. Lange again opined regarding the cervical spine finding Petitioner suffered from multilevel degenerative changes and re-iterated further treatment was not indicated. PX11.

The Commission finds, based on 1) the nearly four-year gap in treatment, 2) Petitioner being declared at maximum medical improvement numerous times (July 12, 2012, March 29, 2012, October 22, 2013, and October 28, 2013 by both Dr. Gornet and Dr. Lange), and 3) Dr. Lange's opinion cervical treatment was not indicated, Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on April 18, 2011 and her current condition of ill-being as it relates to her cervical spine. The Commission vacates the medical expenses awarded of $11,931.02 as such expenses as outlined in PX9 relate to treatment for the cervical spine. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's September 6, 2016 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of medical expenses contained in PX9 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing October 14, 2014, Respondent pay to Petitioner the sum of $723.41 per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of Petitioner.

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

17IWCC0591

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. The Commission notes Respondent paid $132,381.75 in temporary total disability benefits and $32,450.00 in permanent total disability benefits following October 14, 2014 for a total credit of $164,831.75.

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 commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

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

DATED: SEP 27 2017
LEC/maw
o08/02/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCHANAN, LAURIE
Employee/Petitioner

Case# **11WC016599**

OLIN CORPORATION
Employer/Respondent

17IWCC0591

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:

0487 SMITH ALLEN MENDENHALL ET AL
DOUG MENDENHALL
PO BOX 8248
ALTON, IL 62002

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Laurie Buchanan
Employee/Petitioner

v.

Olin Corporation
Employer/Respondent

Case # 11 WC 16599

Consolidated cases: N/A

17IWCC0591

An *Application for Adjustment 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 **8/25/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0591

FINDINGS

On **4/18/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$56,425.62**; the average weekly wage was **$1,085.11**.

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

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

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

Respondent shall be given a credit of **$132,381.75** for TTD, and maintenance, and **$32,450.00** for other benefits (PTD) paid following 10/14/14, for a total credit of **$164,831.75**.

ORDER

Respondent shall pay reasonable and necessary medical services of $11,931.02, as set forth in PX9, 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 and total disability benefits of **$723.41**/week for life, commencing **10/15/14**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

8/13/16
Date

ICArbDec p. 2

SEP - 6 2016

FINDINGS OF FACT

Petitioner, 48 years of age, worked for Respondent as a quality group leader. Her job required walking, bending, stooping, measuring, auditing and reporting on production. She oversaw other employees' work. She occasionally was required to lift up to 30 pounds. On April 18, 2011she sustained an undisputed accident when she sat on a stool which broke, causing the chair to turn and flip her sideways onto a tub of bullets with a steel bar. She landed on tub and bar, and twisted her body. She felt excruciating pain and something popped in her lower back. Her right shoulder and neck also hurt.

Her supervisor sent her to the Respondent's medical department where she saw Dr. Sun. She was sent to the emergency room at Alton Memorial Hospital. She had a CT scan at the hospital and was discharged. The next morning she could hardly walk from pain in her right back side and neck. She contacted and saw her family physician, Dr. Crancer, who prescribed medication and ordered her off work.

Soon thereafter, on May 5, 2011, Petitioner saw Dr. Gornet. She reported a chief complaint of low back pain as well as neck pain. Dr. Gornet stated neck treatment would be put on hold. A lumbar MRI was ordered. Petitioner was prescribed prednisone and four weeks of physical therapy. (PX 4). Jerseyville Therapy records reflect a diagnosis of low back pain. Petitioner received therapy for the lumbar spine alone. (PX 3; RX 9).

Petitioner returned to Dr. Gornet on June 16, 2011. Dr. Gornet interpreted the MRI to reveal a central right sided disc herniation at L5-S1. He recommended three lumbar epidural steroid injections. Petitioner reported only temporary relief from the injections. Dr. Gornet recommended surgery. A second lumbar MRI was ordered prior to surgery. (PX 4).

Dr. David Lange evaluated Petitioner on June 21, 2011 at the request of Respondent. Dr. Lange documented low back pain as well as neck pain. The cervical pain did not radiate to her upper extremities. Dr. Lange documented that Petitioner weighed 298 pounds and was very obese. Dr. Lange believed the accident resulted in her low back pain. Dr. Lange agreed with Dr. Gornet's recommendation for lumbar injections. (RX 5). Dr. Lange generated an addendum report dated August 8, 2011 following review of additional records. He noted Petitioner had been diagnosed with a L5-S1 herniation in 2006, but still believed the accident triggered symptoms in her low back. (RX 5).

Dr. Lange re-examined Petitioner on September 19, 2011. He opined surgery would be reasonable, but Petitioner should anticipate ongoing lower extremity and low back complaints after surgery. He opined that prolonged rehab activities would not change her outcome because of her pre-existing psychological disease, obesity and multiple complaints. He stated there was no point in obtaining multiple diagnostic tests with respect to her cervical spine because axial pain does not respond to invasive treatment whether by injection or surgery. (RX 5).

On November 30, 2011, Petitioner underwent a laminotomy and foraminotomy at L5-S1. Following surgery, Petitioner reported that her leg pain was better with alleviation of pain below the knee. She continued to experience pain in her back. She reported having intermittent stabbing pain and pressure in her back. (PX 4).

Petitioner returned to Dr. Lange on March 29, 2012. Petitioner confirmed that the surgery was beneficial with regard to her radicular symptoms. Dr. Lange noted that Petitioner presented with a very flat affect and was resistant during physical examination. Dr. Lange opined Petitioner had reached maximum medical improvement with respect to her work related injury. He reiterated additional diagnostic testing would be pointless. Dr. Lange opined that Petitioner had significant psychological issues, but she could work at the sedentary demand level. (RX 5).

Petitioner continued to follow up with Dr. Gornet post operatively. When Petitioner returned three months following surgery Dr. Gornet testified "we had her involved with exercise conditioning, and she developed increasing low back pain, which would be fairly typical." (PX 4, p.10) A new MRI was recommended and ultimately performed on May 10, 2012.

Petitioner underwent an FCE on May 29, 2012. The study revealed that Petitioner provided a fair but guarded effort. The therapist concluded Petitioner could function at a sedentary physical demand level. (PX 5).

Petitioner returned to Dr. Gornet on July 12, 2012. Permanent restrictions were imposed. Dr. Gornet concluded that Petitioner was capable of work with a 10 pound restriction, no repetitive bending or stooping, and she should be also allowed to change positions, sit or stand as needed. (PX 4 p. 10; RX 4).

In September of 2012 Petitioner met with June Blaine at the request of Respondent. They discussed her background work, training and experience. Respondent then advised they were not able to provide a job within her restrictions.

Petitioner returned to Dr. Gornet on January 24, 2013. Petitioner reported having symptoms in her neck, shoulder and arms, but denied a new accident. Dr. Gornet recommended a cervical MRI scan.

In April of 2013 there was another meeting with June Blaine to look at the idea of training and computer skills. Petitioner knew a little typing because she had entered data on a system at Respondent's facility. She still does not know how to use the Internet or use a computer at home. She completed high school and had taken some community college courses after high school in the 1980s. She had done some keyboard typing to create keypunch cards. All of her work experience was working in factory or warehouse settings performing manual labor.

Under the direction of Ms. Blaine, a private training program was set up at CALC, in Alton, IL. The plan was to become trained to be an administrative assistant. She understood the training to involve light typing and computer programs and literacy. She started into the program in April of 2013 and it was to be concluded by October, 2014. There was a break in her training from February 22, 2014 to May 6, 2014 during which time she was hospitalized as a result of complications with stress and anxiety. She has had anxiety and depression problems since her early twenties. She has been treated with medication since that time. She was going through a change in medications when complications arose, giving rise to the need for hospitalization. She had been taking medication for these conditions while working for Respondent. Petitioners had a similar reaction to medication changes in 2010 which required her to miss approximately six weeks while working for Respondent. She felt she coped well with the anxiety over 11 years while working for Respondent.

Petitioner returned to Dr. Gornet on May 23, 2013 reporting the cervical MRI would not be authorized. Petitioner also reported recurrent low back pain and was concerned with a kidney issue. Dr. Gornet recommended Dr. Crancer work Petitioner up for the kidney issue. He also recommended that she undergo an updated lumbar MRI. (PX 4).

Petitioner met with Steve Dolan, a vocational counselor, at her attorney's request in May, 2013. She was at his office in Alton for almost 4 hours. She answered his questions concerning how she was doing and took a series of tests including reading, spelling and math. She tried hard on the tests. She thought she did fairly well but the result showed her reading was poor. He advised her to get counseling treatment for her anxiety and depression which she did at Wellspring in Jerseyville Illinois. The counseling she has received has helped and she has also gone through medication changes.

Mr. Dolan testified that he is a certified vocational rehabilitation counselor who performed a vocational assessment of the Petitioner on referral from her attorney. Over 20 years he served in various capacities with the Illinois Department of Rehabilitation Services including Administrator of Field Operations for the entire agency and finally, as Acting Deputy Director for the agency. He now maintains a private practice, consulting with the Social Security Administration and performing vocational assessments and counseling on a private referral basis. (PX 7)

He met with Petitioner on April 1, 2013 to assess her ability to work and if necessary, provide vocational rehabilitation services. He reviewed various records involving Petitioner including transcripts from Lewis and Clark Community College, school records, employment application from Olin, and medical records including those from Dr. Gornet and Dr. Lange. He interviewed the Petitioner gathering background information about employment history and function, day-to-day activities and function and then gave her a battery of tests, the Wide Range Achievement Test.

Her educational background reflected some community college course work after high school including a medical transcriptionist program. But this was not completed and she stated she had not done well at typing. Her data entry training was for operating a keypunch machine, a technology which is no longer used. She stated she was to begin a proprietary business training program the day following their meeting. Essentially she had worked at physical labor type jobs including various kinds of factory jobs since the middle 1990s. She had no specific vocational skills that would transfer to other types of work. Her last job with Olin required bending and stooping and lifting to inspect ammunition product. She and her team were supposed to find defective product and let the machine operator or supervisor know that something was wrong with the production process. She had a medical history that included anxiety and depression for which she had been on medication for some years. He recommended that she seek treatment at a local community counseling program to treat her current symptoms for that condition.

He reviewed medical records from Dr. Gornet and Dr. Lange. He also reviewed the functional capacity examination stating that she could lift only 10 pounds occasionally and 3 pounds frequently. It stated that she functions at the sedentary level and that her work was further eroded because she can't sit constantly. He felt this was consistent with restrictions from Dr. Gornet of no lifting over 10 pounds and no repetitive bending or lifting.

He testified that he went through her day-to-day activities with her. He stated she limited her driving. Her daughter and her husband did all the cooking and household cleaning including vacuuming, dishes, laundry and outside lawn work. Her daughter would do the grocery shopping and lifting and the Petitioner would ride an electric cart. Her sleep was reported as interrupted through the night. Typically she would be lying down for several hours during the day. She reported she no longer goes to activities such as movies or playing bingo because she cannot sit very long.

He noted on page 6 of his report that during the three hours and 45 minutes she was there she stood 11 times and during 20 minutes of the time she was lying on her left side on the carpet. He testified that he observed that he she could not sit very long. He felt that she was very credible during the interview process because her anxiety and depression prevented her from any deception.

On the Wide Range Achievement Test her scores were below average. He made a follow-up telephone call to her on May 2, 2013 to check on the training program at CALC. She reported she was having trouble with pain, spending time on a couch and had trouble focusing on the material.

Mr. Dolan concluded that she had no transferable skills for any new employment. With the restrictions from Dr. Gornet and Dr. Lange, there were jobs which hypothetically she might be able to perform. However she would need training. Based on her reading and math abilities shown in the testing, he felt she would have a difficult time with clerical training. Later reports from June Blaine dated December 13, 2013 showed Petitioner was only progressing slowly with her CALC training. It appeared she would not be able to obtain certification as an administrative assistant as hoped. It was his opinion that Petitioner will not be able to perform any employment for which a reasonably stable labor market exists. She would not be able to do that unless the pain could be brought under control and her anxiety and depression improved. Based on the pain condition alone, he did not feel that she could tolerate a regular work schedule because she has to lie down periodically. He noted the records from June Blaine showed some progress at the training but not what was expected from an average student. Further, his testing showed Petitioner was unlikely to be successful in clerical training and she had never done well in previous attempts in community college.

Petitioner proceeded with a cervical MRI under her own health insurance. Dr. Gornet reviewed the study on July 1, 2013 and recommended that Petitioner try and live with her neck symptoms. He noted that her predominant pain was low back and right leg at that time. No new restrictions were imposed. (PX 4).

Petitioner returned to Dr. Lange on October 22, 2013. Dr. Lange again stated no further diagnostic testing or treatment interventions were necessary. Petitioner informed Dr. Lange that she had enrolled in a CALC program, but from the very beginning she did not believe it was practical due to her learning deficiencies. Dr. Lange noted there was a difference between the vocational opinions of Ms. Blaine and Mr. Dolan as to whether Petitioner is fit for clerical work from an intelligence standpoint. He opined that Petitioner's medication might result in difficulties with keyboard speed and concentration. Dr. Lange could not objectively quantify the amount of low back pain Petitioner was reporting. Based on Petitioner's physical capabilities, Dr. Lange did not believe she was totally disabled for all occupations. Dr. Lange stated that while Petitioner may not be a candidate for a clerical position (based on Mr. Dolan's reported intellectual testing), he could certainly envision several occupations at the sedentary physical demand level. (PX 11).

On October 28, 2013, Dr. Gornet stated that Petitioner could work with permanent restrictions of no lifting greater than 10 pounds and no repetitive bending or lifting. Petitioner was again placed at maximum medical improvement. (PX 4). On October 29, 2013 Petitioner underwent the lumbar MRI that Dr. Gornet recommended May 23, 2013. (PX 4).

Petitioner did not progress well with the training at CALC. She was having physical issues with back, neck and shoulder pain. Her schedule was three days per week for four hours per day. There was a schedule set out for how she was to progress. She strained her neck while typing and had headaches. Sitting for a period of time caused her back to spasm. Her instructor allowed her to leave the room and walk around and sit at a couch on another level to prop up her leg. She took her book to study and try to read.

The beginning computer skills she learned without much trouble. However, learning the Word program and on to the intermediate level was a problem. She felt she had a reading comprehension problem because she would read things two or three times to try to retain it. It was a self-paced training program and she did not feel she could teach herself. The instructor Jim Applegate was very helpful. She would read and retain material for a short time but then later have to go back again and repeat study. Although she fell behind in her classes, she kept trying. She began to come in an extra day each week on Mondays to try to catch up. She also took books home. Her typing speed improved to about 12 words per minute. But she would have to stop typing due to neck pain. She stated she did not feel she could spend an hour at a time at a computer job. She could not sit that long due to pain in her neck and back. She does not feel she would be able to complete the training at CALC. She continuing to work at the program until October 14, 2014. At that time there was a meeting with Jim Blaine and Mr. Applegate. They told her that even though she tried she wasn't going to be able to complete the work in sufficient time and they needed to drop her from the program.

James Applegate testified that he was subpoenaed to appear for the hearing. He is employed by CALC Institute of Technology. It is an adult education trade school, teaching technology for office administration. It is a privately owned company. Mr. Applegate has been an instructor at CALC for five years. He has 20 years of experience in computer technology. He has taught a couple hundred students over the years in that role.

He identified documents involving Petitioner and her enrollment at CALC. Her records included admission documents, verbal tests skills, grade reports and monthly evaluation reports which are done for all students. He was also asked to fill out a form monthly and provide that to June Blaine who had referred Petitioner to the program. He also used it to go over the monthly evaluation with the student. He was the instructor for Petitioner.

The records reflect that she was in the program from April 2013 to October 2014. He observed her during the course of her training. She received an excellent grade on the basic computer skills course teaching her how to use a computer. She moved on to Microsoft Word. The training is self-paced. The student is given a course and he monitors the progress. He will assist and help them out with any questions. Petitioner was expected to complete each course program within a certain timeline. For instance, Word Basic was to have been completed by May 7, 2013. Word Intermediate should have been done by May 21, 2013 and Word Advanced by June 4, 2013. She did not complete the program. She was too have completed all the training by September 15, 2014. He observed that she was having difficulty from day one sitting at her desk for any long periods of time.

She would have to get up and walk around in sit in more comfortable areas and this continued throughout her time at CALC. They accommodated her because she was in rehabilitation. They would accommodate any student with the same request.

She completed the practical PC training but then her progress slowed significantly with Word. It was his observation that she was eager to be in school but she had difficulties. He discussed with her about being away from her desk and whether she was able to sit at the desk longer. His observation was that she was in pain and having difficulty. She definitely cooperated and that is reflected in the monthly evaluations. She did what he asked in terms of trying and doing paperwork. Eventually she completed all three segments of Word, Basic, Intermediate and Advanced. This took the entire time that she was there. This should have been done within about six weeks of starting the program. She did have a leave of absence and the administration received notes that she was to be away from school.

In his opinion there was not a potential for her to complete the program that was outlined for her. She could not make the progress. Mr. Applegate approached the director of the school and advised him that he did not see enough progress to continue. He felt that June Blaine should be contacted and advised that nothing more could be accomplished. There was a meeting with Petitioner's attorney and June Blaine in October of 2014. During this time Mr. Applegate felt that Petitioner was giving a full effort to complete the training. He believed the director spoke to Petitioner about terminating the program because she was not progressing as expected.

Petitioner completed 4 of 26 courses of the program planned for her. She also worked on keyboarding but she didn't complete the keyboarding program. She tried to certify as a Microsoft Office Specialist in Word. He advised the director that he did not feel they were doing Petitioner any good.

The witness was asked to compare Petitioner's progress up to December, 2013 to that of a student who was receiving Title IV government funding. Based on government standards for required progress to continue funding, Petitioner would have been discontinued from the program due to lack of adequate progress to that point. It was acknowledged that the private funding for Petitioner was not being cut off.

Petitioner testified that June Blaine never suggested that she undertake a job search. No one has offered to help her do a job search. If she was able to complete the CALC training they were going to help her find a job. She feels she could work at a job emotionally but not physically. She could not do any of the work she has done in the past. She wishes she could have her old job back. She had some back pain in 2006 but she was treated with therapy and continued to work for Respondent. She had no other injury before the accident of 2011.

Petitioner returned to Dr. Gornet on November 3, 2014 complaining of neck pain radiating into both shoulders and her right arm. Dr. Gornet described these symptoms as "part of her original work related injury." On January 5, 2015 and January 14, 2015, Petitioner underwent C5-6 epidural injections. (PX 6). Respondent has disputed payment of those bills. The bills purportedly remain outstanding. (PX 9). Petitioner last returned to Dr. Gornet on March 16, 2015. Dr. Gornet's review of the cervical MRI revealed multilevel problems involving pathology at C3-C7. He indicated the injections in January provided some relief and suggested steroid injections might be indicated on an intermittent basis. He further indicated she may require cervical disc replacement at some point, but he was content with managing her condition conservatively for the time being. (PX 4). Dr. Gornet testified that the additional cervical MRI and lumbar MRI would help to reassure that no

further surgery was needed and that Petitioner should be managed conservatively. The later treatment of her cervical spine was due to chronic symptoms attributable to the work accident because no other intervening accident broke the chain of connection.

Petitioner testified that she lives at home with her husband and grandson. She gets up in the morning and walks around but doesn't do a lot physically. Her husband does the cooking and the housework and cleaning. Her daughter died in May. Her husband takes care of the housework. At some point during the day she has to lie down for a while. She takes pain medication and then she is tired and drowsy and she has to alleviate the pain from her leg. She can stand for perhaps 15 to 30 minutes before having problems. Sitting is probably 15 minutes to a half hour depending on pain medication. She watches television and reads her Bible. She visits her mother and takes her grandson to a park next to her house where she can sit and stand on the porch and watch him. He is seven years old and in school. She can dress her upper body but her husband does her shoes and socks because she cannot bend that low. She drives to her mother's but does not drive a lot and relies on her sister. She stays in her home area usually driving only to local doctor appointments. She will shop at Walmart usually riding and electric cart.

It was noted on the record that during the course of her testimony Petitioner stood up and down several times.

Among other records admitted into evidence, Alton Memorial Hospital emergency room records for the date of accident show a prescription from Dr. Shaping Sun, Olin Corporation, prescribing a CT scan of the cervical spine. The parties stipulated that most of Petitioner's medical bills have been paid. Petitioner submitted bills for treatment of the cervical spine totaling $11,931.02 which were unpaid. Respondent disputed the bills as unnecessary and unrelated. The primary dispute between the parties is with regard to Petitioner's cervical spine condition.

CONSLUSIONS

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

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

The evidence indicates that Petitioner injured her back and neck when she fell from the broken chair at work on April 18, 2011. She was sent from Respondent's medical facility to the emergency room at Alton Memorial Hospital with a prescription from Respondent's physician, Dr. Sun, for a CT scan of the cervical spine. She complained to her family doctor of neck pain on her first visit, two days after the incident and she complained to Dr. Gornet of neck and shoulder pain on the first visit with him May 5, 2011. Respondent's examining physician, Dr. Lange saw Petitioner June 21, 2011 with complaints of discomfort in the neck and into the interscapular region. Nothing in Dr. Lange's records disputes the causal relationship between the fall and injury to Petitioner's cervical spine. The only medical opinion was from Dr. Gornet who testified that there was a causal relationship. The fact that she continued to complain of neck symptoms is reflected in the records admitted from physical therapy, Dr. Gornet, Dr. Lange and vocational assessment and training. Based upon the

foregoing and the record taken as a whole, the Arbitrator finds Petitioner's current cervical condition is causally related to the injury.

Dr. Gornet testified that he initially placed treatment of Petitioner's neck and shoulder "on hold" to concentrate on the low back condition. Petitioner continued to complain of neck symptoms as reflected in various records. Petitioner testified credibly that her neck pain and shoulder complaints never resolved and she continued to seek treatment. Eventually in 2013 and 2014 Dr. Gornet diagnosed herniations at C5 – 6 and C6 – 7. He recommended cervical epidural injections which were performed by Dr. Boutwell in January, 2015. Petitioner testified that the injections gave her some relief of the neck pain. Dr. Gornet testified that the treatment was necessary and reasonable. Although Petitioner had been placed at maximum medical improvement, treatment can be required if symptoms persist due to the work-related injury. Dr. Lange was not asked to render an opinion as to the reasonableness of the epidural steroid injections. The only opinion came from Dr. Gornet.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the cervical treatment was reasonable and necessary and Respondent is ordered to pay $11,931.02 as listed in PX 9 pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any bills paid.

Issue (K): What temporary benefits are in dispute?

Issue (N): Is Respondent due any credit?

The parties agree that as the date of hearing Petitioner had been paid $164,831.75. Petitioner received $132,381.75 for temporary total and maintenance benefits paid from April 20, 2011 through October 14, 2014 when her CALC program was discontinued. Thereafter Petitioner received $32,450.00 in permanent disability payments. Payments post-dating October 14, 2014 are deemed permanent total disability advancements.

Respondent shall be given a credit of $132,381.75 for TTD, and maintenance, and $32,450.00 for other benefits (PTD) paid following 10/14/14, for a total credit of $164,831.75.

Respondent is entitled to an 8(j) credit for any medical bills submitted and paid by the group insurance carrier.

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

Petitioner was released with permanent restrictions from Dr. Gornet of no lifting over 10 pounds, no repetitive lifting or pending. He testified that he also included a restriction of the need to alternate sitting and standing as needed. Although this was not included on the specific instruction sheet issued in July 2012, he testified that this was expected with any such sedentary release. His dictated note of May 10, 2012 reflected that restriction. Respondent's examining physician, Dr. Lange also stated that Petitioner could function at a sedentary level only.

Based on these physical restrictions Petitioner was evaluated by vocational counselor Stephen Dolan at the request of Petitioner's attorney and by June Blaine at Respondent's request. Petitioner was placed in a clerical training program but was unable to complete the program. Her instructor, James Applegate testified that she gave consistent effort but clearly had pain which restricted her ability to perform typing at a computer as

needed. He felt that she could not complete the program since she had only completed a word processing course during many months of study.

Stephen Dolan opined that Petitioner will not be able to perform any employment for which a reasonably stable labor market exists. She would not be able to do that unless the pain could be brought under control and her anxiety and depression improved. Based upon the pain condition alone, he did not feel that she could tolerate a regular work schedule because she has to lie down periodically. He observed her for hours and felt her pain complaint were credible.

Dr. Lange, Respondent's examiner, saw Petitioner October 22, 2013. He felt she had mechanical low back discomfort which was to be expected. He stated it would not be unusual to have axial low back pain with prolonged sitting. He said these symptoms are extremely common in post-discectomy patients with prolonged sitting.

This evidence confirms Petitioner's testimony about ongoing pain and limitations. Petitioner testified credibly and appeared to be uncomfortable during her testimony. June Blaine was not called to testify and no opinion was presented stating that Petitioner was capable of gainful employment. The only opinion came from Mr. Dolan who stated Petitioner was unable to perform any work for which a reasonably stable job market existed.

Pursuant to *ABB C-E Services v. Industrial Commission*, 316 Ill.App.3d 745, 737 N.E.2d 682, 250 Ill.Dec. 60 (2000), a claimant is not required to perform a job search to prove entitlement to an odd-lot permanent total disability. He may show that, by virtue of his present condition, age, training and experience, he is unfit to perform any but the most menial tasks for which no stable labor market exists. Petitioner has met that burden here.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay Petitioner permanent and total disability benefits of $723.41/week for life, commencing 10/15/14, as provided in Section 8(f) 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

Rosario Negrete,

Petitioner,

vs. NO: 11WC 16853

Tyson Foods,

17IWCC0587

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 denial of reinstatement and being advised of the facts and law, affirms and adopts the Notice of Motion and Order, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Notice of Motion and Order filed October 27, 2015, is hereby affirmed and adopted.

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

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

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

DATED: SEP 26 2017
TJT:yl
o 9/12/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

17IWCC0587

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

FILED
2015 AUG 26 AM 9:06
CIRCUIT COURT
2015 AUG 26 AM 9:06

Rosario Negrete
Employee/Petitioner

v.

Tyson Foods
Employer/Respondent

Case # **11** WC **16853**

TO: **Ganan & Shapiro, 210 West Illinois, Chicago, IL. 60654**

On **10/02/15**, at **2:00** PM, or as soon thereafter as possible, I shall appear before the Honorable **Arb. Thompson-Smith**, or any arbitrator or commissioner appearing in his or her place at **Illinois Workers' Compensation Commission, 100 W. Radnolph St. Ste. 8-200, Chicago**, Illinois, and present the attached motion for:

- ☐ Change of venue (#3072)
- ☐ Consolidation of cases (#3071) (list case#)
- ☐ Dismissal of attorney (#3052)
- ☐ Dismissal of review (#3085)
- ☐ Fees under Section 16 (#1600)
- ☐ Fees under Section 16a (#1645)
- ☐ Hearing under Sect.19(b) (#1902)
- ☐ Penalties under Sect. 19(k) (#1911)
- ☐ Penalties under Sect. 19(l) (#1912)
- ☒ Reinstatement of case (#3074)
- ☐ Request for hearing (#R33)
- ☐ Withdrawal of attorney (#3073)
- ☐ Other (explain) ____

Signature Petitioner ☒ Respondent ☐

James Ellis Gumbiner #243
Attorney's name and IC code # (please print)

James Ellis Gumbiner & Associates
Name of law firm, if applicable

180 N. Michigan Ave. Ste 2100
Street address

Chicago, IL 60601
City, State, Zip code

312-236-9761
Telephone

E-mail address

ORDER

The motion is set for hearing on ____

Signature of arbitrator or commissioner

APPROVED BY AUTHORITY OF THE ILLINOIS WORKERS' COMPENSATION COMMISSION pursuant to the provisions of the Workers' Compensation and Workers' Occupational Diseases Acts

OCT 27 2015

Date

By Kelli Sharp Stellen, Arbitrator

ORDER

The motion is ____ Granted ____ Withdrawn ____ Continued to ____
~~X~~ Denied ____ Dismissed ____ Set for trial (date certain) on ____

Signature of arbitrator or commissioner

Date

17IWCC0587

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, James Ellis Gumbiner, affirm that I delivered ☐ mailed with proper postage ☒

in the city of Chicago a copy of this form

at 5:00 PM on 09/04/15 to each party at the address(es) listed below.

Ganan & Shapiro, 210 West Illinois, Chicago, IL. 60654

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public

[1] The Workers' Compensation Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY MALINOWSKI,

Petitioner,

vs. NO: 11 WC 17918

CHICAGO TRANSIT AUTHORITY,

17IWCC0568

Respondent,

DECISION AND OPINION ON REVIEW

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

Although the Commission agrees that Petitioner was entitled to a wage differential, the Arbitrator calculated the wage differential by utilizing wages as follows: 1) what Petitioner would have been making as an hourly rate ($35.03), and 2) the lowest potential wage proposed by Respondent's vocational rehabilitation specialist ($8.87), to determine a wage loss of $1046.40, resulting in a Section 8(d)1 award of $697.60/week. We find, under the facts of this case, the wage differential should be based on the average of Petitioner's job earning potential ($8.87 and $10.30 for an hourly rate of $9.59) for that of a clerk. Therefore, we find that Petitioner's wage loss is $1017.60, and the award is $678.40 per week pursuant to Section 8(d)1 of the Act and *Crittenden v. Illinois Workers' Comp. Comm'n*, 2017 IL App (1st) 160002WC.

The Commission notes that the Arbitrator gave a credit for $251,322.60 for TTD, however no award for TTD was entered. The credit of $251,322.60 is for TTD accumulated to date, and should not be applied against the award herein.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $678.40 per week commencing September 19, 2016, and for the duration of

17IWCC0568

the disability, because the injuries sustained caused a loss of earnings, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,271.00 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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: SEP 21 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 8/30/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MALINOWSKI, JEFFREY
Employee/Petitioner

Case# **11WC017918**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

17IWCC0568

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:

0159 FRANCIS J DISCIPIO LAW OFFICE
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

17IWCC0568

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

JEFFREY MALINOWSKI,
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY,
Employer/Respondent

Case # 11 WC 17918

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **September 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. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ **Other: Maximum Wage Differential**

17IWCC0568

FINDINGS

On **4/22/2011**, 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 **$70,408.00**; the average weekly wage was **$1,354.00**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$251,322.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$251,322.60**. Respondent is entitled to a credit of **$n/a** under Section 8(j) of the Act.

ORDER

By stipulation, Respondent shall pay the reasonable and necessary medical services of **$1,271.00**, 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.

Respondent shall be given a credit of **$251,322.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$251,322.60**.

Therefore, Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 19, 2016** of **$697.60/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. Against this award, Respondent shall be entitled to credit for any benefit(s) paid during this time period.

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

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

11-28-2016
Date

NOV 28 2016

FINDINGS OF FACT

Jeffrey Malinowski ("Petitioner") alleged he sustained accidental injuries on April 22, 2011 arising out of and in the course of his employment with the Chicago Transit Authority ("Respondent"). On September 19, 2016, the parties proceeded to Arbitration on the issues of nature and extent of Petitioner's injuries and maximum wage differential benefits. Opening statements by both parties revealed that there was no dispute as to causal connection between Petitioner's undisputed work accident and the undisputed resultant injuries/conditions to the head, neck and cervical spine. Further, vocational assessments undertaken at the request of Respondent concluded Petitioner's earning potential was below what he would be earning in his normal capacity as a former truck driver for Respondent thereby resulting in a wage loss.

It is undisputed that on April 22, 2011, Petitioner worked for Respondent as a truck driver and was injured when his work truck was rear ended by another driver. Petitioner sought immediate medical treatment. On April 22, 2011, Petitioner was taken via ambulance to Holy Cross emergency department. Px1. Petitioner reported neck pain after being involved in a motor vehicle accident. On exam, Petitioner was positive for headaches and neck pain but negative for confusion, dizziness or changes in vision. Clinical impression was cervical sprain due to motor vehicle car accident.

On April 25, 2011, Petitioner followed up with his primary care doctor, Dr. Shaw. Px2. The doctor noted Petitioner's recent work accident along with pain in the neck and constant headache. Impression was cervical and lumbar strain following rear end motor vehicle accident. Petitioner was continued on ibuprofen and Flexeril. Prior records show that in 2008, Petitioner treated with a chiropractor for cervical conditions and was eventually released.

In 2008, Petitioner is seen by family care Associates in follow-up for neck pain, left arm radiculopathy. It was noted he was under the care of a chiropractor at that time three times per week but continue with severe neck pain it had developed tension headaches symptoms later in the day. MRI showed degenerative disease and severe neural foraminal involvement of the C-4 nerve root on the left. Referral to neurosurgery was generated. In August 2008, Petitioner continued to follow up with Dr. Shaw who diagnosed traditional cervical radiculopathy and ordered an MRI.

In May 2011, Petitioner continued to follow up with Dr. Shaw. He reported some improvement in low back and neck pain but had symptoms of contraction headache. He reported getting headaches as the day progresses starting in the occipital region and radiating around to the floor bed. He was removed from work, referred to physical therapy with Athletico and to Dr. Sean Salehi for ongoing neck/cervical complaints. In May 2011, Petitioner began physical therapy with Athletico for a diagnosis of low back strain and right groin strain. Petitioner attended physical therapy at Atletico from May 18, 2011 through July 11, 2012 to address low back strain, right groin strain and cervical spondylosis. Px4.

On May 11, 2011, Petitioner was evaluated by Mercy Works at the request of Respondent. Px3. Petitioner related his work accident and symptoms to the lower back and right groin. Diagnosis was lumbar strain and right groin strain. He was referred to physical therapy and continued on Ibuprofen. He was released to return to work with regular duties but limited to a four hour day. He continued to follow up through June.

On June 6, 2011 Petitioner returned to Dr. Shaw. He related that he returned to work for one day but while looking up he became dizzy and the back of his neck hurt along with headache. Impression was top shelf vertigo. The plan was to follow sodium intake and follow blood pressure. On June 9, 2011, Petitioner returned to Dr. Shaw for re-check of high blood pressure. He continued to relate dizziness and headaches while looking

up. CAT scan was positive for C5-6 disease. On June 10, 2011, Petitioner returned to Dr. Shaw unchanged. The doctor again recommended neurosurgery before returning to work. The doctor noted high blood pressure possibly due to non-steroidal Aleve.

On July 5, 2011, Petitioner presented to Dr. Sean Salehi. Px5. Chief complaint was neck pain, headaches and low back pain. Petitioner related his history of present illness along with medical treatment to date. The doctor noted that Petitioner had a prior history of neck and left arm pain in 2008 treated conservatively with chiropractic care. He was symptom free through the date of the recent work accident. The doctor reviewed CT of the cervical spine and diagnosed cervical spondylosis, noting that Petitioner likely had an aggravation of cervical spondylosis as a result of the work injury. He recommended Aleve, physical therapy and light duty and possible MRI of the cervical spine.

On August 23, 2011, Dr. Salehi read cervical MRI to show moderate to significant disc degeneration at C4-5 manifested by height loss, retrolisthesis of C4 over C5 and anterior traction osteophytes, significant left C4-5 and moderate right C4-5 foraminal stenosis due to disc osteophyte complex. Px5. The doctor noted neck pain and suboccipital pain most likely on the basis of cervical spondylosis at C4-5 and recommended cervical facet injections. Petitioner remained on light duty. During this time, Petitioner continued with physical therapy.

On August 31, 2011, Petitioner began treating with Dr. Bayran at Dr. Salehi's referral for bilateral intra-articular facet joint injections at C4-5. Px7. Dr. Bayran performed intra-articular facet joint injection at C4-5 bilaterally. Px9. On September 7, 2011, Petitioner followed up with Dr. Bayran and reported relief which lasted 3 to 4 days then a return to baseline.

On October 5, 2011, Petitioner was evaluated by Dr. David Marder at the request of Respondent. Rx4. The doctor noted Petitioner complained of posterior neck and occipital head pain since April 2011. The doctor diagnosed cervical strain status post motor vehicle crash, cervical spondylosis and hypotension. The doctor noted that it was unlikely Petitioners headaches and dizziness with the result of high blood pressure based upon medical notes with his primary care physician. The doctor did note however that the hypertension was unrelated to the accident. The doctor recommended high-dose non-steroidal anti-inflammatory medication and continued physical therapy. If there was no improvement, then additional injections could be considered. Dr. Marder also noted that Petitioner was not yet at maximum medical improvement and would be temporarily disabled possibly longer if treatment was delayed. The doctor did not believe Petitioner's neck pain from 2008 was a significant factor the doctor opined that all treatment to date has been necessary and related to the injury. The doctor recommended that Petitioner returned to work at the light to medium physical demand level.

On November 14, 2011, Dr. Salehi explained that Petitioner had mechanical neck pain and headaches as a result of the cervical spondylosis at C4-5 exacerbated by the work accident. While he was not a surgical candidate, cervical facet injections were recommended for symptomatic relief. On December 17, 2011, Petitioner underwent and Dr. Bayran performed second bilateral facet joint injection at C4-5. Px9.

On December 20, 2011, Petitioner followed up with Dr. Salehi. Px5. He was ordered to follow up with Dr. Bayran for possible rhizotomy at C4-5. On January 11, 2012, Petitioner returned to Dr. Bayran, who recommended medial branch cervical block at C4-5. Px7.

On February 8, 2012, Dr. Marder issued an addendum report. Rx3. He opined that based on updated medical records, information was insufficient to recommend radiofrequency fluoroscopy at C4-5 medial branch nerve block and instead recommended injections using lidocaine or bupivacaine over Kenalog. Depending upon response, consideration should then be given to radiofrequency neurotomy. Regarding work restrictions, the

doctor opined that Petitioner could not get returned to work full duty but could return to work at the light to medium lifting category. On March 21, 2012, Petitioner again returned to Dr. Bayran. Px7. The doctor agreed with Dr. Marder's assessment that Petitioner should undergo cervical medial branch nerve block using lidocaine or bupivacaine.

On March 14, 2012, Dr. Salehi noted that Petitioner's ongoing symptoms were secondary to C4-5 spondylitic changes on MRI. Given the pathology was limited to one level, the doctor opined that Petitioner was a good candidate for facet injections or rhizotomy. Px5. During this time, Petitioner continued to follow up with Dr. Shaw.

On April 11, 2012, Petitioner underwent and Dr. Bayran performed cervical medial branch blocks at C4-5 bilaterally. Px9. Petitioner returned to Dr. Bayran and reported an eventual return of pain following recent injection. The plan was for radiofrequency ablation of the cervical medial branches at C4-5 bilaterally in hopes of improving neck pain and headaches.

On May 2, 2012, Petitioner underwent radiofrequency ablation of the cervical medial branches at C4-5 bilaterally. Px9. Petitioner reported relief but continued to complain of headaches and that when looking up, he still experienced lightheadedness.

On May 25, 2012, Petitioner returned to Dr. Salehi. Px5. He reported 40% improvement in headaches following rhizotomy and was able to sleep much better. He continued, however, with neck pain and dizziness and lightheadedness. Impression was cervical spondylosis. The doctor recommended additional physical therapy, continued light duty and follow up as needed.

On June 14, 2012, Petitioner returned to Dr. Shaw's office. Px2. The doctor noted chronic vertigo with triggers including position change and head movement. Diagnosis was unspecified peripheral vertigo. Petitioner was referred to a neurologist.

On October 16, 2012, Petitioner presented to Dr. Wojcik, a neurologist. The doctor noted Petitioner's history of accident and the development of neck pain, headaches, lightheadedness, dizziness and unsteadiness. The doctor assessed dizziness and headaches. At that time, examination did not support a middle ear vestibular dysfunction; rather the doctor suspected Petitioner may have sustained brief crimping or occlusion of the vertebral arteries running through the cervical spine. The plan was for CT angiogram, which was normal.

On December 18, 2012, Petitioner returned to Dr. Wojcik, unchanged. The doctor suspected vestibular dysfunction and that Petitioner may benefit from fixation gaze exercises. He was referred to physical therapy.

On February 26, 2013, Petitioner returned to Dr. Wojcik. The doctor noted he previously suspected vestibular dysfunction and sent Petitioner for fixation of gaze exercises via physical therapy. Petitioner was still symptomatic, however. The plan was for more aggressive fixation of gaze exercises at home and follow-up. Regarding headaches, he was told to follow up with his pain clinic.

On April 23, 2013, Petitioner returned to Dr. Wojcik. Petitioner continued to report unsteadiness when looking upward along with continued neck pain. The doctor assessed dizziness and vestibular dysfunction resulting from head trauma in the motor vehicle accident dating back to 2011. The doctor also assessed headaches and neck pain secondary to the work accident and recommended that he return to the pain clinic.

On April 30, 2013, Dr. Jeffrey Kramer performed evaluation at Respondent's request. Rx2. Dr. Kramer opined that the Petitioner sustained a whiplash injury with associated posttraumatic vertigo. Exam was consistent with peripheral vestibulopathy. The doctor recommended medications.

From June 2013 through June 2014, Petitioner continued to treat with Dr. Wojcik. Px8. Videonystagmography (VNG) and EMG testing was normal. Petitioner was placed on clonazepam and removed from work. Petitioner continued with dizziness, headache and vertigo. Petitioner was to follow up on a PRN basis. The doctor noted he did not believe Petitioner would be able to return back to work and agreed with Petitioner's early retirement decision.

On October 25, 2014, Petitioner underwent and Dr. Bayran performed a second radiofrequency ablation of the cervical medial branches at C3-4 bilaterally. Px7. Petitioner reported significant relief of pain on the right side. Assessment was cervical spondylosis without myelopathy, neck pain and headaches secondary to cervical facet joint involvement and vertigo. Dr. Bayran noted that consideration would be giving to a cervical medial branch nerve block at C5-6 since pain was lower than previous neck pain. Px7.

On February 10, 2015, Dr. Kramer performed an evaluation at the request of Respondent. Rx1. He noted improvement with vestibular exercise therapy. Petitioner continued to report episodic dizziness and recommended disability. The doctor also reviewed surveillance from October 2014 showing active in around the house. The doctor noted that at the time of the April 2013 report, Petitioner's diagnosis was exacerbation of underlying degenerative cervical condition. Since the exam and April 2013, Petitioner had no further vestibular therapy but continue to follow up his neurologist. Dr. Kramer noted that Petitioner continued to have intermittent dizziness that was variable in a short duration. The doctor opined that the treatment for the vertigo up to and including 2013 was reasonable necessary and had appropriate vestibular therapy. He opined that Petitioner's current complaints were direct and proximate result of the work accident, explaining that Petitioner had a whiplash injury on the date of the accident and that while his major complaint was neck pain, he also had an onset of positional vertigo. The doctor noted an acceleration/deceleration type injury is known to cause vestibular injury. He diagnosed posttraumatic vestibular dysfunction. Dr. Kramer felt Petitioner was capable of working full duty without heights or ladders. With bending and stooping, Petitioner would require assistance. He opined Petitioner was at maximum medical improvement for his work injury and required no further treatment.

On March 30, 2015, Petitioner presented to Silver Cross Hospital on an emergency basis following dizziness and a closed head injury without loss of consciousness following a fall. Px10. He was diagnosed with head injury, head contusion and concussion. The next day, Petitioner followed up with Dr. Shaw. Px2. The doctor ordered an MRI of the neck and brain.

On April 15, 2015, Petitioner followed up with Dr. Bayran. Px7. Assessment was unchanged from previous exam. The doctor noted Petitioner responded significantly to radiofrequency ablation of the cervical medial branches but complained of pain that was responsive with naproxen. He was ordered to follow-up as needed. On April 21, 2015, Petitioner returned to Dr. Wojcik. Px8. The doctor had no clear diagnosis and recommended the Petitioner continued to perform exercises for balance training. He was encouraged to follow up if he was worsening.

On June 11, 2015, Steve Blumenthal generated a vocational rehabilitation evaluation report at the request of Respondent and by agreement of the parties. Rx5. Blumenthal summarized Petitioner's accident and medical history. He noted Petitioner was receiving workers' compensation benefits biweekly, Social Security disability income and was retired from his union on pension as of April 1, 2015. Transferable skills analysis indicated

that Petitioner had the necessary aptitude and physical ability to perform work as an information clerk, hotel clerk, general clerk and/or telephone solicitor.

He provided wage data for each of the identified occupational titles and as well entry and median wages. Blumenthal then took into account the need to identify jobs that do not require balancing, stooping or climbing as a result of the work limitations imposed by Dr. Kramer. Blumenthal concluded that Petitioner has been unable to return to his job secondary to dizziness related to posttraumatic vestibular dysfunction per the diagnosis of Dr. Kramer. Blumenthal further noted that Petitioner had the ability to complete computer literacy training in order to access employment in a clerk capacity with an entry-level wage of $8.87 to $10.30 an hour and after several years of experience, the ability to earn a median wage of up to $14.16 an hour.

Blumenthal concluded that based upon Petitioner's lack of prior clerical office experience he would likely start with at entry-level wage level. Blumenthal surmised that estimated cost for training through Vocomotive would cost an initial $2,000.00 and post training would cost between $16-$20,000.00. It was his opinion that Petitioner would best be served by resolving his case based upon what he would be able to earn a post vocational rehabilitation training and job placement rather than being forced into a program that he was intellectually and physically capable of completing and of obtaining employment in, but for which he had no interest in. Thus Petitioner will have sustained a wage loss but rehabilitation services would be able to obtain employment in a stable labor market.

At trial, the parties stipulated that Petitioner would be earning $35.03 per hour per his prior union agreement through December 2016. On cross, Petitioner stated he was truthful to various examiners and admitted to previously holding various political offices.

CONCLUSIONS OF LAW

ISSUE (L) What is the nature and extent of the injury?
ISSUE (O) Maximum Rate Wage Differential

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. Petitioner claims entitlement to a wage differential under Section 8(d)1 of the Illinois Workers' Compensation Act. To qualify for a wage differential under Section 8(d)1, a claimant must prove (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment" and (2) impairment of his earnings. *Gallianetti vs. Indus. Comm'n*, 315 Ill. App. 3d 721, 730, 734 N.E.2d 482 (2000).

The credible and largely undisputed record demonstrates that Petitioner sustained injuries to his head and neck following a work accident on April 22, 2011. Petitioner underwent treatment for the cervical spine for aggravation/exacerbation of pre-existing cervical spondylosis by way of therapy, medications, injections and eventual radiofrequency ablation. During this same time, Petitioner also remained under active and ongoing treatment for what was properly diagnosed as posttraumatic vestibular dysfunction, treated with medications and therapy.

Vocational assessment undertaken at the request of Respondent concluded Petitioner's earning potential was at the entry level of clerical type work and thus below what he would be earning in his normal capacity as a former truck driver for Respondent, thereby resulting in a wage loss. At trial, Respondent indicated it stood by Blumenthal's assessment that Petitioner was capable of earning some wages. The Arbitrator finds the record as a whole credible and adopts the medical opinions of Drs. Salehi, Bayran, Wojcik, Kramer and Marder concerning Petitioner's conditions and inability to return to full duty work. Further, the Arbitrator adopts the

conclusions of vocational counselor Blumenthal, who credible opined that Petitioner, given his condition, experience and limitations, would be capable of earning the lower end of clerical entry level work. Blumenthal identified that entry level wage to be $8.87.

The Arbitrator concludes that as of September 19, 2016, Petitioner sustained a wage loss as a result of his work related injuries, which prevent him from returning to his normal job as a truck driver for Respondent. In support thereof, the Arbitrator notes that the parties stipulated that Petitioner was temporarily totally disabled through the "present" or the date of trial. Ax1.

For injuries occurring before September 1, 2011, wage differential benefits shall be calculated by determining, "66 and 2/3rds percent of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)1. Based on the foregoing, is liable for the sum of $697.60 per week, representing 2/3rds the difference between $1,401.20 and $354.80. Therefore, Respondent shall pay Petitioner permanent partial disability benefits, commencing **September 19, 2016** of **$697.60/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. Against this award, Respondent shall be entitled to credit for any benefit(s) paid during this time period.

Signature of Arbitrator

11-28-2016
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

Ramonia Aguirre,

Petitioner,

vs.

NO: 11 WC 17990

17IWCC0586

Regis Corporation d/b/a
Smart Style,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 4, 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.

17IWCC0586

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 26 2017
TJT:yl
o 9/12/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AGUIRRE, RAMONIA
Employee/Petitioner

Case# **11WC017990**

REGIS CORPORATION D/B/A SMART STYLE
Employer/Respondent

17IWCC0586

On 11/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 AGUIRRE, RAMONIA
5501 RIVERIA BLVD
PLAINFIELD, IL 60586

1109 GAROFALO SCHREIBER HART ETAL
DANIEL L GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0586

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

Ramonia Aguirre
Employee/Petitioner

v.

Regis Corporation d/b/a Smart Style
Employer/Respondent

Case # **11** WC **17990**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **September 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 24, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,652.38**; the average weekly wage was **$320.24**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **no** dependent child.

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

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

Respondent shall be given a credit of **$6,216.25** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,216.25**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 10 and 3/7th weeks, commencing October 13, 2010 through December 24, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 24, 2010 through September 15, 2015, and shall pay the remainder of the award, if any, in weekly payments.

As explained in the Arbitration Decision Addendum, Petitioner's claim for temporary total disability benefits from May 5, 2011 through September 15, 2015 is denied.

Medical Benefits

As explained in the Arbitration Decision Addendum, Petitioner's claim for payment of the medical bills submitted into evidence is denied.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole for his bilateral shoulder injuries, 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

November 2, 2015
Date

NOV 4 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Ramonia Aguirre
Employee/Petitioner

v.

Regis Corporation d/b/a Smart Style
Employer/Respondent

Case # **11** WC **17990**

Consolidated cases: **N/A**

FINDINGS OF FACT

Ramonia Aguirre ("Petitioner") appeared *pro se* for a hearing on the above-captioned matter. In the parties' Request for Hearing form, the parties indicated various issues in dispute including causal connection, Respondent's liability for certain medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing October 13, 2010 through December 24, 2010 and commencing May 5, 2011 through September 15, 2015, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The issue of attorney's fees for Petitioner's former counsel was also continued until the time of this hearing. Tr. at 4-5. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that on while she was at work on September 24, 2010, she was coloring a client's hair when the brush fell on the floor. Tr. at 31. She testified that she went to pick it up by bending down and she hit her temple in the "corner, we had like in the corner, so I hit my temple and then my body, it just, I went back and then I lost like conscious. The only thing I remember I hear the customer screaming and then I just come back and then I just -- my [right] arm was complete numb." Tr. at 31-32. Petitioner testified that she then went to the back and wanted to scream so loud, but she withheld because there was customer there. Tr. at 32. Petitioner then went out to finish the work with her customer. *Id.* When asked what body parts she injured specifically on the date of accident, Petitioner testified that she injured her head and also hit her low back when she fell backwards. Tr. at 39-40. On cross examination, Petitioner testified that she claims injury to her head, neck and low back as a result of her accident at work. Tr. at 51.

Petitioner testified that she was then told to go to the emergency room. Tr. at 32. She testified that she did not go to the emergency room right away because she did not have insurance and she did not know that workers' compensation insurance would pay. Tr. at 32. Petitioner explained that she was in this state for approximately two-to-three weeks when she could not sleep and her body started feeling weird. Tr. at 32. She explained that she began having headaches and then called the company's "800" number after which she saw Dr. Papaeliou. Tr. at 32-33.

Respondent submitted a job analysis of the "Hair Stylist – Regular Duty" position indicates that the essential tasks are to cut and style hair, sort and use different products to style hair, use blow dryers, use edgers, hot

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The Arbitration Hearing Transcript of September 15, 2015 is denominated as "Tr." with corresponding page numbers.

comb, clippers, blade cut, and scissors cuts. Sweep after each customer, clean shampoo bowl, remove hair from drain, stock dispensary with hair products and sweep hair into wall vacuum." RX4 (Dep. Exh. 3).

Medical Treatment

On October 12, 2010, Petitioner saw Dr. Papaeliou reporting that on September 21, 2010 "she bent down to pick up a brush and struck her left temporal region on the corner of a counter. She did not experience loss of consciousness but indicates that she began to fall backward and immediate onset of numbness in the entire right upper extremity. The numbness has since resolved. She has not used any medications for pain relief. She does complain of temporal cephalgia, however. Her medical history is unremarkable. Her husband is with her and is very concerned regarding some short-term memory loss. She described the discomfort in her head as 'pounding.' She has not experienced any nausea or vomiting." RX1 at 1-3.

On physical examination, Dr. Papaeliou noted a normal neurological examination, intact coordination and gait, a normal ENT examination, normal vital signs, and no tenderness in the cervical spine. *Id.* He also noted "[s]he does have some tenderness in the left temporal area without perceived edema or ecchymosis." *Id.* Dr. Papaeliou diagnosed Petitioner with head trauma and recommended over-the-counter analgesic for pain relief and rest. *Id.* He also ordered a plain CT scan of the brain and placed Petitioner off work. *Id.* The following day, Petitioner underwent the recommended brain CT scan. RX1 at 4-5; Tr. at 53. The results were normal. *Id.*

Petitioner returned to Dr. Papaeliou on October 15, 2010 reporting some continued cephalgia and her husband described some continued short term memory loss. RX1 at 6-7. Petitioner's physical examination was normal. *Id.* Dr. Papaeliou ordered continued rest and use of over-the-counter analgesics for pain relief, and kept Petitioner off work. *Id.* At her follow up visit on October 20, 2010, Dr. Papaeliou again noted a normal physical examination, but referred Petitioner for a neurological evaluation. RX2 at 8.

On cross examination, Petitioner acknowledged that when she first saw Dr. Papaeliou she did not complain of any pain in her neck or back. Tr. at 52-53. Petitioner testified that Dr. Papaeliou referred her to see Dr. Gulati. Tr. at 33. She explained that she told him everything that happened to her that day and that she did not feel good and felt weak. Tr. at 33-34. Petitioner testified that she told Dr. Gulati about a tingle in her leg and about her neck. Tr. at 34. She explained that he referred her to another doctor, but then nothing happened and she was going to see Dr. Gulati, but he would only check her eyes, ears, arm, and basically that was it. *Id.*

On November 10, 2010, Petitioner saw Surendra Gulati, M.D. ("Dr. Gulati") for a neurological examination regarding symptoms of headaches following a head injury. RX1 at 9, 11. Petitioner provided the following history:

> Patient reports that she had no history of headaches or previous head injury prior to the incident of 9-24-2010 when she was injured at work while doing a hair color, a brush fell, she bent down to pick up and hit the left pronto-temporal part of the head on the bottom corner of the cabinet as she came up. Immediately she noticed tingling sensation from right arm to the fingers that lasted for 2-3 minutes and did not affect the face. She did not faint or fall and did not sustain a laceration. She states pain was dramatic and severe and she ran to the back room. She had sustained a small lump to the head and had frontal pain. She was, however, able to work the remainder of the day though she became "forgetful" and had difficulty comprehending. She still continues to have difficulty with forgetfulness and difficulty with numbers.

> She continues to have intermittent headaches on the left side. Headaches are not daily and severity of the headache varies. Sometimes she has tingling or burning pain or severe pain in the left frontal region that will last for 2-5 minutes, sometimes she has a sensation of "moving in the brain" in the left frontal region. She denies any neck symptoms. She has not had any further arm symptoms. She has no lower extremity symptoms. The remainder of neuro-logic review of systems is negative though occasionally she feels a bit dizzy with quick movements. She has good bladder control.

Id. Dr. Gulati notes that Petitioner's neurological examination was normal, with the exception of some TMJ tenderness bilaterally. *Id.* He also noted that Petitioner "is able to des-cribe her symptoms in great detail to me." *Id.* Dr. Gulati indicated that he was "not impressed with anything organic of severe nature to account for patient's symptoms, however, patient's complaints of memory dis-turbance are of concern and I think she will need further diagnostic evalua-tion including EEG, MRI of the brain and possibly neuropsychological testing. For now, patient is being encouraged to return to work, working 4-hours per day and she will be seen back in my office for follow-up in two weeks." *Id.*

On cross examination, Petitioner disputed the accuracy of Dr. Gulati's records and testified that she reported pain all over her body to Dr. Gulati including pain in her neck, tingling in her leg, and pain in the low back. Tr. at 53-54. Petitioner testified that she called Dr. Gulati's office and spoke to his secretary asking her why he did not write down all of her complaints. Tr. at 54-55. Petitioner also testified that Dr. Gulati asked her if she would like to return back to work because she would not be doing anything at home and she felt weakness in her nerves from not moving. Tr. at 34. She testified that Dr. Gulati then recommended that she go back to work and "that's what I did. I followed the doctor what he told me to do." Tr. at 35. When she went back to work Petitioner testified that she noticed that she was feeling bad and that her neck hurt while working with customers. Tr. at 36. She testified that she reported it to her manager Alisa Adams ("Ms. Adams") with no response so she called the "800" number again reporting that she was feeling dizzy and did not know what was wrong with her. Tr. at 36-37. On another occasion, Petitioner reported that she was working with a customer and felt like she was going to faint after which she went to the doctor. Tr. at 37.

Petitioner returned to Dr. Gulati on November 23, 2010. RX1 at 10. She reported continued daily headaches, sharp, needle-like pain in the left side of the head, episodes of intermittent dizziness, and "memory disturbance in that she cannot remember things from day to day, things she had done some hours ago and has to make notes." *Id.* Petitioner also reported that she returned to work last Monday, but became dizzy and had to sit down after which her husband had to come and pick her up from work. *Id.* She indicated that the dizziness lasted a brief period and was induced by having to look down. *Id.* Dr. Gulati noted that Petitioner presented with post-concussion symptoms of sharp head pains, dizziness and memory disturbance, but her diagnostic work-up this far was normal. *Id.* He recommended Advil as needed for headaches and a vestibular rehab program. *Id.* Dr. Gulati kept Petitioner released to work four hours per day. *Id.*

On December 21, 2010, Petitioner underwent the recommended EEG. RX1 at 13. The results were mildly abnormal diffusely, in a non-specific fashion with dominant abnormality being excessive Beta activity with no spike discharge or focal delta activity present. *Id.* Petitioner also underwent the recommended MRI of the brain. RX1 at 14. The results were normal with the exception of an incidentally noted small sinonasal polyp or mucous retention cyst along the medial wall of the right maxillary sinus measuring 6 mm in diameter. *Id.* Petitioner testified that she understood that her brain MRI and EEG tests were normal. Tr. at 55.

Petitioner last saw Dr. Gulati on December 23, 2010. RX1 at 16-17. He noted Petitioner's report of worsening headaches occurring on the left side of the head maybe four times per day every day that last a minute. *Id.* She

also reported dizziness if she worked a lot. *Id.* Petitioner's physical examination was normal. *Id.* Dr. Gulati released Petitioner back to full duty work. *Id.* On cross examination, Petitioner disputed the accuracy of Dr. Gulati's records and testified that on this date she reported everything to Dr. Gulati, not just headaches. Tr. at 55-56.

On January 4, 2011, February 6, 2011, and February 7, 2011, Petitioner underwent a neuropsychological evaluation with a clinical psychologist, Michael Gelbort, Ph.D., as referred by Dr. Gulati. RX1 at 18-22; Tr. at 56-57. Dr. Gelbort took a history from Petitioner regarding her accident and subsequent symptoms and noted that she communicated well in English although Spanish was her first language. *Id.* Petitioner reported the following in pertinent part:

> She could not recall the specific date believing it was "the 21st or 24th of..." related paperwork which was reviewed shoed that it was September 24th, 2010. The patient explained that she saw the company doctor who referred her to Dr. Gulati. Apparently she recalls bending over to retrieve a brush while working as a hairdresser doing a color job and she fell striking the left side of her forehead. She then believes she fell back and landed on her right arm at which point her right arm when numb. She went to the back of the salon and explained to me that she "wanted to scream." Her manager asked if she was okay and she said that she was. A week later though she felt that she had "a pain like my brain was going to blow up, it was not normal." She complained of having problems and her manager then sent her to see the doctor per the patient's report. She was taken off of work for one month and referred on to Dr. Gulati who released her to return full-time to work approximately a month prior to this evaluation per Ms. Aguirre's report.

Id. Petitioner denied any amnesia or non-discontinuous memory at the time of the event. *Id.* She reported no laceration, but having a bump. *Id.* Petitioner and her husband also reported the following:

> Subsequently she has had difficulty recalling names, she forgets things like her cell phone or her purse, she reports that her attitude changed and that she was acting differently per the reflection of her manager. She stated that she need (sic) to have things repeated to her, that she would forget steps in procedural memories such as coloring someone's hair, and her husband said that she became lost even in the neighborhood and asked where things such as her shoes and shirt were. He also explained that she did not tell him about having been injured for about 15 days after the injury. ... Ms. Aguirre repeatedly noted that "I'm a person like that, I push myself, I don't want to have problems or complain about them." It was noteworthy thought (sic) that at the same time she described having a great number of problems including headache, running nose, feeling sick, dizziness, and not feeling good. She states that the headaches occur a couple times a week and can happen at any point in time. They tend to center on the area of trauma.

Id. Overall, Dr. Gelbort found that Petitioner showed a pattern of neuropsychological and clinical functioning characterized by feelings of dysphoria, worry, a tendency to repress or try to ignore/overlook problems, and emotional upset with complaints of physical symptoms which were rather pronounced. *Id.* He also found that Petitioner's testing patterns were "most commonly seen in individuals who are having an emotional reaction to a mild physical trauma. There does not appear to be indication of her having suffered an acute traumatic brain injury. Rather it would seem that while she protests and states that she is stoic that in fact her personality is otherwise. She is emotionally debilitated by having suffered an injury and it is most likely that she will benefit from returning to work in a slow and supported fashion. Getting back to her normal activities though will likely be the best thing for her." *Id.* Dr. Gelbort also recommended that Petitioner return to work in a slow and supported fashion noting that she may have increased anxiety and fatigue, which would improve over time. *Id.* He recommended a follow up re-evaluation in 4-6 months time. *Id.*

On February 16, 2011, Petitioner returned to Dr. Gulati. RX1 at 23. He noted that he received Dr. Gelbort's report and that Petitioner's symptoms were much improved. *Id.* Again, Petitioner was released to full duty work. *Id.* Petitioner again disputed the accuracy of Dr. Gulati's records and denied telling him that her headaches were becoming less frequent or that her symptoms were improving. Tr. at 59-60. Petitioner was working full duty at this time and testified that she said she wanted to return to full duty work. Tr. at 60.

Respondent offered into evidence a "leave request form" dated March 4, 2011 in which Petitioner requested leave pursuant to the Family and Medical Leave Act ("FMLA") for surgery for her husband from March 18, 2011 through April 21, 2011. RX2; Tr. at 60-61. Petitioner testified that she did return to work for Respondent on or about April 22, 2011. Tr. at 61-62. Petitioner testified that since May 5, 2011 she has not worked for anyone. Tr. at 71.

On May 6, 2011, Petitioner went to Provena St. Joseph Hospital reporting neck pain. RX1 at 24. She underwent x-rays of the cervical spine, which were normal. *Id.* Petitioner testified that the first time she reported neck pain was on this date. Tr. at 63. Petitioner testified that she also reported low back pain at this time and disputed the accuracy of the emergency room records if they did not reflect her complaints of low back pain. Tr. at 63-64. Petitioner also testified that she was placed completely off of work by one or more of her doctors for the claimed temporary total disability benefits period of May 5, 2011 through September 15, 2015. Tr. at 43.

Petitioner then saw Charles Majors, D.C. ("Dr. Majors") for chiropractic care on May 9, 2011. RX1 at 25-26. Petitioner reported "having a work accident, where she bent down and hit her head and experienced a whiplash effect in her neck. Since the accident, she complains of burning and stiffness in her neck that radiates to her right shoulder. She also states that she has headaches frequently." *Id.* Petitioner reported severe constant stiffness and burning pain at a level of 9/10. *Id.* Dr. Majors diagnosed somat dysfunc cervic reg, cervicalgia, neck sprain, and somat dysfunc thorac reg. *Id.* Petitioner testified that these chiropractic medical records are inaccurate because she also complained about low back pain. Tr. at 65-68.

When Petitioner returned for follow up on May 10, 2011, Dr. Majors recommended chiropractic adjustments at C5, C6 and T3 three times per week for eight weeks. *Id.* Petitioner continued to see Dr. Majors for chiropractic care through June 15, 2011. RX1 at 26-25. During these weeks, Petitioner reported continued neck pain at a level of 9/10, with some days reported at 7/10 and others at 10/10. *Id.*

On June 16, 2011, a nurse case manager for Respondent's workers' compensation insurance carrier contacted Dr. Majors at Planet Chiropractic to determine whether Petitioner was capable of returning to work. RX1 at 36-37. A colleague of Dr. Majors, Dr. Jena Petlan, indicated that Petitioner's pain scale had increased slightly and that she had continued difficulty with range of motion in the neck without pain for extended periods of time. *Id.* She placed Petitioner off work. *Id.*

On July 18, 2011, Petitioner sought treatment at Meridian Medical Associates. PX1 at 2-3; RX1 at 38. Petitioner reported that she was having head, neck and back pain with limited movement. *Id.* The form was electronically signed by "Maribel Rosinski" whose position with Meridian Medical Associates is unknown. *Id.*

On July 20, 2011, Petitioner returned to Meridian Medical Associates for a re-check on her injury of September of 2010. PX1 at 4-5. Petitioner reported that she was having head, neck and back pain and that her movements

were limited. *Id.* The form was electronically signed by "Maribel Rosinski" whose position with Meridian Medical Associates is unknown. *Id.*

On August 3, 2011, Petitioner returned to Meridian Medical Associates and saw Rebecca Kuo, M.D. ("Dr. Kuo"). RX1 at 39-41. She provided a history of hitting her left temple on a stand while coming up from picking up a brush that fell to the floor. *Id.* Petitioner indicated that "[i]nitially, there was pressure to the shoulder area and around March, she started having more pain. She is currently not working. She stopped in May after utilizing a chiropractor. She went to the emergency room in early May and was referred to her chiropractor. She saw a chiropractor alone with no relief. She had no physical therapy or epidural steroids. She notes the pain is worse with looking down, turning her head suddenly or when she arises from a flexed position, the neck feels stiff. It is better is she sits on a sofa or lays in bed. She denied any radicular type symptoms, balance problems or dexterity problems. She rates her pain as a 7/10. When I asked her to be more specific where her pain is, she states that it is everywhere over her neck and her shoulders but she does not give me any more specifics. She denies any back pain or radicular type symptoms." *Id.*

On physical examination, Dr. Kuo noted no specific areas of tenderness, tension or spasm. *Id.* She also noted no tenderness in the lumbar spine and an otherwise unremarkable physical examination with the exception of guarding and grimacing with movement of the neck. *Id.* Dr. Kuo diagnosed axial mechanical neck pain and possible cervical radiculopathy. *Id.* She noted her prior order for a cervical MRI and indicated that, if this was approved and turned out to be fairly unremarkable, she would likely order physical therapy whereas if it showed any significant herniations or such, she would likely order an epidural steroid injection. *Id.* Dr. Kuo placed Petitioner off work. *Id.*

Petitioner underwent the recommended cervical MRI on August 5, 2011, which showed a normal cervical spine. RX1 at 42-43. She then returned to Dr. Kuo on August 10, 2011. RX1 at 44. Dr. Kuo noted that Petitioner's MRI was unremarkable and showed only an incidental cyst on the right C7 nerve root, but no compression, herniations, fractures or other abnormalities. Dr. Kuo diagnosed Petitioner with a cervical strain, recommended a functional capacity evaluation with validity testing, and kept her off work in the interim. *Id.*

Section 12 Examination – Dr. Andersson

On September 6, 2011, Petitioner submitted to a medical evaluation at Respondent's request with Gunnar Andersson, M.D. ("Dr. Andersson"). RX4 (Dep. Exh. 2). Petitioner reported that she bent over to pick up a brush from the floor on September 21, 2010 when she struck her left temple on the corner of a counter. *Id.* She reported that she did not lose consciousness, but developed headaches and memory loss. *Id.* At the time of this examination, Petitioner reported pain in the neck and back which she reported was "the worst possible pain and it is burning and stabbing, but it is not associated with any radiation of pain into either the upper or lower extremities. OCcassionally she says there could be numbness in the right arm, but not in a dermatomal pattern and bowel and bladder function is normal." *Id.* Dr. Andersson reviewed various medical records from Dr. Papalieou, Will County Medical Associates, Dr. Gulati, Dr. Gelbort, the emergency room at St. Joseph Hospital, and Dr. Kuo. *Id.* He also personally reviewed Petitioner's cervical and lumbar x-rays as well as her cervical MRI, which were all normal. *Id.*

Dr. Andersson found that Petitioner had a completely normal physical examination with respect to the neck and back. *Id.* He noted that her cervical MRI of August 5, 2011 was completely normal, that Petitioner had no complaints regarding the neck for a long period of time after the accident, and that she was repeatedly evaluated by physicians thereafter finding no evidence of cervical symptoms. *Id.* Dr. Andersson concluded that "[i]t is

difficult, therefore, to in any way related this patient's symptoms back to the alleged accident." *Id.* He indicated that Petitioner should return to work at the earliest possible time initially limited to two hours then increasing two hours every second week until she works full time. *Id.* Dr. Andersson indicated that Petitioner did not require any further medical treatment and that there would be no permanent disability as a direct result of the injury to her neck and back. *Id.*

Continued Medical Treatment

On September 14, 2011, Petitioner underwent the recommended functional capacity evaluation. RX1 at 46-52; RX4 (Dep. Exh. 5). Petitioner reported low back pain, bilateral shoulder pain, and bilateral cervical pain. *Id.* The evaluating physical therapist noted the following:

> Ms. Aguirre self terminated her FCE secondary to increased pain complaints during the functional strength measurements. She reported increased pain to the lumbar spine, cervical spine, and bilateral shoulders. She reported difficulty breathing (describing shortness of breath), head-ache, and dizziness. Vital signs prior to objective measurements were 140/82 HR 60 and after complaints vital signs were 140/92 HR 66. Prior to Ms. Aguirre self terminating the FCE, she demonstrated the ability to function at the **SEDENTARY** Physical Demand Level as outlined by the U.S. Department of Labor during the activities of this evaluation.
>
> However, measured inconsistencies were present during this evaluation. These inconsistencies indicate a sub-maximal effort was given. Therefore, the true physical capabilities of Ms. Aguirre remain unknown at this time. ... The inconsistencies present during this evaluation are as follows:
>
> - Failed 7 of 7 validity criteria for upper extremity hand and pinch grip testing indicating a sub-maximal effort was given. Statistical Analysis was performed with X-RTS software.
> - Cross reference testing was unable to be performed secondary to Ms. Aguirre self terminating the FCE.

Id.

In a letter dated September 29, 2011, Donna Towne ("Ms. Towne"), SmartStyle Area Supervisor, noted that on September 20, 2011 a letter was sent to Petitioner from Darcy Musack ("Ms. Musack"), Regis Claim Manager, regarding transitional duty work that would begin on September 26, 2011. PX1 at 7. Petitioner failed to report to work on that date. *Id.* Ms. Towne noted inclusion of Petitioner's work schedule and indicated that if she did not report to work as scheduled she would be in violation of the company's attendance policies. *Id.* Ms. Towne also noted that if she did not hear from Petitioner by 5:00 p.m. on October 7, 2011, they would take appropriate measures regarding Petitioner's employment status. *Id.*

On October 3, 2011, Petitioner presented for an initial evaluation at the Chicago Pain Clinic. RX1 at 53-56. The handwritten records are not signed by any physician. *Id.* The notes reflect Petitioner's report of cervical pain at a level of 8/20, low back pain at a level of 8/10, and pins and needles as well as numbness and weakness in the right hand. *Id.* Petitioner offered into evidence a note placing her off work for 14 days by an unidentified physician from "Physicians Plus, Ltd" also dated October 3, 2011. PX1 at 8, 18.

A progress evaluation dated October 10, 2011 from Dr. Mark Cohen ("Dr. Cohen") indicated that Petitioner began hot and cold treatment as well as electrical stimulation recommended for the neck three times per week

that began on October 3, 2011. RX1 at 57. As of October 17, 2011, Dr. Cohen noted that Petitioner was to undergo an EMG/NCV. RX1 at 58. Petitioner underwent the EMG on October 20, 2011. RX1 at 59-60. The interpreting chiropractic neurologist, Carlos Halwaji, D.O. ("Dr. Halwaji") found that the EMG showed a peripheral neuropathy affecting the median and ulnar nerves on the right and a radiculopathy affecting the L4-S1 bilaterally. *Id.* He recommended that Petitioner continue with chiropractic care, physical therapy, rehabilitation and prescribed medication. *Id.*

Petitioner returned to Dr. Cohen for continued chiropractic care on October 21, 2011 through February 7, 2012. RX1 at 61-63, 66-70, 75-81, 84-95. Petitioner offered notes placing her off work for 30 days each by an unidentified physician from "Physicians Plus, Ltd" dated October 17, 2011 and November 15, 2011. PX1 at 9-10.

In the interim, Petitioner underwent a lumbar MRI as ordered by Dr. Cohen at American MRI on October 6, 2011. PX1 at 13, 19. The MRI was interpreted by John Aikenhead, D.C., noting a disc bulge at L5-S1 with a central protrusion effacing the thecal sac with an annular tear. *Id.*

Petitioner also saw Ernesto Padron, M.D. ("Dr. Padron") at South Pulaski Surgical on October 26, 2011. RX1 at 64-65. Dr. Padron diagnosed Petitioner with a lumbar disc herniation, lumbar radiculopathy due to disc displacement, low back pain, sacral disorder, and sacroiliitis. *Id.* He performed a bilateral sacroiliac joint arthrogram, bilateral sacroiliac joint injections, and attempted a caudal epidural steroid injection that was unsuccessful. *Id.*

Dr. Padron appears to also work through the Chicago Pain Center. RX1 at 71-72. Petitioner saw him there on November 16, 2011. *Id.* He noted that Petitioner denied radiculopathy, and that she had "positive findings on MRI." *Id.* Dr. Padron indicated in conjunction with Petitioner's report that she had good response to the SI injections. *Id.* He recommended another attempt at a caudal epidural steroid injection with a different needle. *Id.* On December 28, 2011, Petitioner returned to Dr. Padron at the Chicago Pain Center. RX1 at 82-83. Dr. Padron noted that Petitioner followed up after a caudal steroid injection and a second bilateral sacroiliac joint injection. *Id.*

Petitioner then saw Mark Lorenz, M.D. ("Dr. Lorenz") for an evaluation on February 23, 2012. RX1 at 96-99; PX1 at 14-15. She provided a history that she bent over to pick up an item from the floor on September 21, 2010 and struck her head on a cabinet. *Id.* Petitioner reported that she "lost consciousness. She developed neck pain and back pain. Since that time she had gone through a long course of cervical care including injections. She is coming in for a surgical consultation. She has been off work since May 2011. She states her neck pain is 8/10. She gets occasional numbness in her right arm. She has back pain which is 9/10 and occasional numbness in her left thigh. She denies any bowel or bladder incontinence, no night pain, night sweats, or weight loss." *Id.*

Dr. Lorenz noted his review of a lumbar MRI from October 6, 2011 showing an annular tear essentially at L5-S1 with a very tiny central disc protrusion. *Id.* Petitioner's cervical x-rays were normal. *Id.* On physical examination, Petitioner was very guarded going from sitting to standing, she had pain with rotation of her spine in neutral plane, pain with axial loading of her neck, negative straight leg raise testing, and numbness in the left arm and left thigh. *Id.* Dr. Lorenz diagnosed cervical pain with myofascial component as well as a central disc herniation and annular tear at L5-S1. *Id.* He indicated that Petitioner was a very poor surgical candidate and he recommended that she follow up with her pain service. *Id.* Dr. Lorenz kept Petitioner off work until then. *Id.*

On March 22, 2012, Petitioner went to ATI Physical Therapy for a functional capacity evaluation as ordered by Dr. Lorenz. RX1 at 101-108; RX4 (Dep. Exh. 6); Tr. at 71-72. The evaluating physical therapist noted that Petitioner's results were invalid due to inconsistencies with grip dynamometry, heart rate, and weights achieved. *Id.* It was further noted that Petitioner's results "generally represent a manipulated effort by the client." *Id.*

Petitioner underwent a third functional capacity evaluation at ATI Physical Therapy on April 27, 2012 as ordered by Dr. Lorenz. RX1 at 109-115; RX4 (Dep. Exh. 7). The evaluating physical therapist found the results were valid and released Petitioner back to work at the sedentary demand level. *Id.*

Section 12 Examination Addendum Report – Dr. Andersson

On May 1, 2012, Dr. Andersson authored an addendum report after reviewing Petitioner's functional capacity evaluations with invalid results. RX4 (Dep. Exh. 4). Dr. Andersson opined that, based on the mechanism of injury and his review of Petitioner's medical records, "her current complaints of the lower back are in no way related to the accident in question. She did not injure her lower back and had no complaints from the lower back. She had a completely normal physical examination of the lower back when examined by me." *Id.* He further opined that, "[b]ased on the patient's independent medical evaluation and the two failed functional capacity evaluations, I believe Ms. Aguirre should return to work full duty as a hair stylist." *Id.*

Continued Medical Treatment

On May 7, 2012, Dr. Lorenz referred Petitioner to Dr. Jain for pain management. PX1 at 16.

Second Section 12 Examination – Dr. Shapiro

On September 6, 2011, Petitioner submitted to a medical evaluation at Respondent's request with David Shapiro, M.D. ("Dr. Shapiro"). RX5 (Dep. Exh. 2). Petitioner gave a history of accident that a brush fell to the floor and she bent over to pick it up when she struck her head on the counter. *Id.* She reported that she had immediate numbness in her right arm and dizziness. *Id.* At the time of this examination, Petitioner reported low back pain, neck, left-sided leg pain, numbness and tingling throughout the left leg, pain in the right arm, low back pain that was worse than her leg pain, and neck pain that was worse than her arm pain. *Id.* Dr. Shapiro also conducted a physical examination and reviewed various medical records including a personal review of Petitioner's cervical and lumbar x-rays as well as her cervical MRI, which were all normal. *Id.* Dr. Shapiro also reviewed Petitioner's lumbar MRI from October 6, 2011, which showed a minor disc bulge at L5-S1 with an annular tear at L5-S1. *Id.* With regard to the interpreting radiologist's reading of the lumbar MRI showing a central protrusion, Dr. Shapiro indicated that the MRI was "over-read." *Id.*

Ultimately, Dr. Shapiro diagnosed Petitioner with low back pain due to degenerative disc disease as evidenced by the annular tear at L5-S1 and he indicated that he was "unable to document an organic reason for her neck complaints give the normal MRI and her examination." *Id.* He opined that there was no connection between either her neck or low back pain to the accident at work. *Id.* Dr. Shapiro noted that there was a significant amount of time (several months) between her complaints of neck pain and accident at work, and an even later onset of low back pain. *Id.* "Therefore, without any consistent history of the onset of those symptoms in direct relationship to the accident, there is no relationship between her accident and the current symptoms, which she was complaining on this visit." *Id.*

Dr. Shapiro indicated that the physical therapy and chiropractic treatment Petitioner received had been reasonable, but there was no indication for injection therapy given that Petitioner showed no demonstrable nerve compression in the MRI. *Id.* He also indicated that Petitioner could return to work full duty and that she had reached maximum medical improvement. *Id.*

Deposition Testimony – Dr. Shapiro

On February 28, 2013, Respondent called Dr. Shapiro to give testimony at an evidence deposition. RX5. Dr. Shapiro testified that he is a board certified orthopedic surgeon. RX5 at 4-7; RX5 (Dep. Exh. 1). Dr. Shapiro testified consistent with the information contained in his report and explained his opinions. *See generally* RX5.

Dr. Shapiro testified in depth about his physical examination of Petitioner. RX5 at 9-13. He explained that Petitioner exhibited subjective symptoms on examination of the neck and low back that did not correlate to objective findings. *Id.* Dr. Shapiro also noted that Petitioner exhibited five of five Waddell's signs on examination of the low back, and he noted that the findings should not be taken as an intent to defraud; rather, that the signs were nonorganic or unrelated to the low back. RX5 at 12-13, 32.

Dr. Shapiro also testified in depth about Petitioner's three functional capacity evaluations. RX5 at 19-26. He noted that it was interesting that her third functional capacity evaluation was deemed to be valid consistent with the sedentary demand level. RX5 at 25. Specifically, Dr. Shapiro noted that Petitioner was noted to be able to lift only up to six pounds in the valid test whereas she was noted to be able to lift up to 10 pounds and nine pounds in her first and second invalid tests, respectively. RX5 at 25. He also noted that Petitioner's capabilities in terms of overall work hours and hours that Petitioner could sit, stand or walk in a day were higher in the invalid tests than on her valid functional capacity evaluation test. RX5 at 25-26.

Dr. Shapiro also testified consistent with the opinions in his report that Petitioner's neck and low back conditions were not causally related to her accident at work, that she was at maximum medical improvement, and that, after reviewing Petitioner's job description, she was capable of returning to her prior job as a hair stylist. RX5 at 27-29.

Deposition Testimony – Dr. Andersson

On April 17, 2013, Respondent called Dr. Andersson to give testimony at an evidence deposition. RX4. Dr. Andersson testified that he is a board certified orthopedic surgeon. RX4 at 4-6; RX4 (Dep. Exh. 1). Dr. Andersson testified consistent with the information contained in his reports and explained his opinions. *See generally* RX4.

Dr. Andersson testified that Petitioner's medical records reflect that she first complained of neck pain approximately eight months after her accident in the emergency room at St. Joseph's Hospital on May 6, 2011. RX4 at 9. He also testified that she first reported low back pain approximately 10 months after her accident in July of 2011. *Id.*

In line with the opinions indicated in his report, Dr. Andersson concluded that Petitioner's neck and low back complaints were not causally related to her injury at work. RX4 at 11-12. He explained that "first of all, she didn't have an accident involving the neck and the lower back. And, secondly, she had no complaints from the neck and lower back. She saw several physicians some of whom specialize in neck and back disorders and never had a complaint." RX4 at 12. Dr. Andersson maintained that Petitioner's physical examination was

normal, that she did not require further care or medical treatment for the neck or low back, and that Petitioner could return to her job as a hair stylist given his examination of Petitioner on September 6, 2011. RX4 at 13-14; RX4 (Dep. Exh. 3).

Dr. Andersson was also presented with Petitioner's functional capacity evaluation report from April 27, 2012. RX4 at 19-20; RX4 (Dep. Exh. 7). The results of the functional capacity evaluation were valid. *Id.* However, Dr. Andersson testified that physical capabilities noted in Petitioner's valid functional capacity evaluation on April 27, 2012 were less than those noted in her invalid functional capacity evaluation from March 22, 2012. RX4 at 20-21. Dr. Andersson testified that the results of the functional capacity evaluations did not impact his opinions because the tests were administered five weeks apart and "[i]t is inconceivable to me that you would lose function in five weeks." RX4 at 21, 24.

On cross examination, Dr. Andersson acknowledged that a hairdresser position would likely require a person to stand most of the time, and that the valid functional capacity evaluation released Petitioner to work at the sedentary level. RX4 at 25-26.

Additional Information

Regarding her current condition, Petitioner testified that she is not the same as she was before her accident. Tr. at 44-45. She explained that she feels emotional and she cannot do what she used to love to do, which was styling hair and training others to do the same. Tr. at 45. Petitioner also explained that she does not have relationships like she used to have and she feels sad and experiences pain in her back. Tr. at 45-46. Petitioner described the pain in her back as if she had needles and fire in her back and in her neck she feels a sensation as though a needle is burning in her neck. Tr. at 46. After an injection in the back, Petitioner also testified that she cannot use the bathroom normally and she sometimes experiences incontinence. Tr. at 46. Petitioner also testified that she experiences anger and she has been instructed that when she feels that way she should try to relax. Tr. at 48.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being is related, in part, to her accident at work. Specifically, the Arbitrator finds that Petitioner's neck and low back conditions are not causally related to her accident at work as opined by Respondent's Section 12 examiners, Dr. Andersson and Dr. Shapiro.

First, the mechanism of injury reported by Petitioner at trial varies from those reported in the medical records. At trial, Petitioner consistently reported that she hit her left temple while standing back up from picking up a brush that fell to the floor. However, she testified that she also fell backwards and hit her low back. This complaint is not supported by the contemporaneous medical records of Dr. Papaeliou or Dr. Gulati. Indeed, Dr. Gulati's records from November 10, 2010 also reflect Petitioner's report that she did not fall on the date of accident.

In addition, Petitioner testified that she reported symptoms in the neck and low back to all of her treating physicians, but the medical records do not corroborate her testimony. To the contrary, Dr. Gulati's initial treatment notes reflect Petitioner's specific denial of any neck symptoms. Her first complaint of neck pain was in late July of 2011 to Meridian Medical Associates. In the interim, her physical examinations with Dr. Papaeliou and Dr. Gulati were also normal despite her subjective complaints at the time or the subjective complaints she testified that she reported at the time. The medical records simply do not reflect any report of neck or low back pain or symptoms and Petitioner disputes the accuracy of any such records. She testified that she reported neck pain, low back pain, symptoms in the legs, and/or pain all over the body to every physician she saw. Dr. Papaeliou and Dr. Gulati's records over the first 7½ months after her accident do not corroborate Petitioner's testimony, but these are not the only medical records with which Petitioner takes issue.

On May 6, 2011, approximately 7½ months after her accident at work, the medical records first reflect a report by Petitioner of neck pain when she went to the emergency room at Provena St. Joseph Hospital. As with the records of Dr. Papaeliou and Dr. Gulati, Petitioner disputed the accuracy of the emergency room medical records. She testified that she also reported low back pain at this time. No such report is contained in the hospital records and no physical examination was performed of the low back.

Petitioner's affected body parts continued to increase as her medical treatment progressed. The records of Meridian Medical Associates on July 18 and 20, 2011 reflect Petitioner's report of head, neck and back pain with limited movement as noted by Maribel Rosinski, whose position with Meridian Medical Associates is unknown. On August 3, 2011, Petitioner returned to Meridian Medical Associates and saw Dr. Kuo. Dr. Kuo noted Petitioner's report that "[i]nitially, there was pressure to the shoulder area and around March, she started having more pain." RX1 at 39-41. Petitioner specifically denied low back pain and was unable to localize her pain. Dr. Kuo noted that "[w]hen I asked her to be more specific where her pain is, she states that it is everywhere over her neck and her shoulders but she does not give me any more specifics. She denies any back pain or radicular type symptoms." *Id.* Nonetheless, Dr. Kuo examined Petitioner's neck and low back noting

no specific areas of tenderness, tension or spasm, no tenderness in the lumbar spine and an otherwise unremarkable physical examination with the exception of guarding and grimacing with movement of the neck.

Petitioner's diagnostic tests were also normal with limited exception and her performance during functional capacity evaluations to determine her physical abilities was questionable. Petitioner underwent a cervical MRI on August 5, 2011, which was normal. She then underwent her first functional capacity evaluation as ordered by Dr. Kuo, which was invalid. The evaluating physical therapist noted that Petitioner failed 7 of 7 validity criteria for upper extremity hand and pinch grip testing indicating a sub-maximal effort was given and that cross reference testing was unable to be performed because Petitioner self terminated the FCE. Notably, Petitioner also reported low back pain, bilateral shoulder pain and bilateral cervical pain at the time of this FCE. The normal cervical MRI and invalid functional capacity evaluation results occurred within a period of treatment for reportedly severe neck pain and low back pain treated by a chiropractor and pain management physicians without any relief or objective basis correlating the subjectively reported pain to Petitioner's accident at work. Petitioner underwent a low back MRI on October 6, 2011, which the chiropractic radiologist read to show a disc bulge at L5-S1 and an annular tear. Neither Petitioner's orthopedic physician, Dr. Lorenz, nor Respondent's Section 12 examiners read the MRI to show as much.

Eventually, Petitioner came under the care of Dr. Lorenz on February 23, 2012. At this time, Petitioner reported yet another version of her injury involving loss of consciousness. She reported neck and back pain and Dr. Lorenz examined Petitioner. He also reviewed her lumbar MRI of October 6, 2011, which he believed showed a very tiny central disc protrusion. Dr. Lorenz determined that Petitioner was not a surgical candidate and he ordered a functional capacity evaluation. Petitioner failed this second evaluation on March 22, 2012 at ATI. When she returned to Dr. Lorenz, he ordered another functional capacity evaluation. Petitioner returned to ATI on April 27, 2012 and the evaluating physical therapist found that the results were valid. Notably, however, Petitioner was able to perform even less physical activity than at the time of her failed evaluation three weeks earlier. Respondent's Section 12 examiners took issue with the validity determination of the latest evaluation.

During her medical treatment, Petitioner was also evaluated by two physicians at Respondent's request. Dr. Andersson and Dr. Shapiro ultimately determined that Petitioner's neck and back conditions were not causally related to her accident at work. The Arbitrator finds the opinions of Dr. Andersson and Dr. Shapiro to be plausibly reached given the facts in this case and, thus, persuasive.

Dr. Andersson noted that Petitioner's cervical MRI of August 5, 2011 was completely normal, that she made no complaints regarding the neck for many months after her accident, and that she was repeatedly evaluated by her own physicians who found no evidence of cervical symptoms. Dr. Andersson also reviewed Petitioner's functional capacity evaluations and commented on her reported mechanism of injury throughout the year after her accident including the allegedly affected body parts. Ultimately, he opined that Petitioner's low back complaints were in no way related to her accident at work noting that the mechanism of injury did not involve the neck or low back and that she first reported neck pain almost eight months after her accident and low back pain about 10 months after her accident. In sum, Dr. Andersson concluded that Petitioner's neck and low back complaints were not causally related to her accident. In his own analysis, Dr. Shapiro agreed.

Dr. Shapiro diagnosed Petitioner with low back pain due to degenerative disc disease as evidenced by the annular tear at L5-S1. Like Dr. Andersson, Dr. Shapiro indicated that he was unable to identify an organic reason for Petitioner's neck complaints and he opined that there was no connection between either Petitioner's neck or low back pain to the accident at work. Dr. Shapiro also noted that there was a significant amount of time (many months) between Petitioner's complaints of neck pain and the accident at work, and an even later

onset of low back pain. Dr. Shapiro also testified in depth about Petitioner's three functional capacity evaluations. He found the results of those evaluations to be incongruent. Specifically, Dr. Shapiro questioned how Petitioner would be able to lift only up to six pounds in the third, valid functional capacity evaluation whereas she was able to lift more (up to nine pounds) in the second, invalid evaluation three weeks earlier. Dr. Shapiro also noted that Petitioner's capabilities in terms of overall work hours, and the hours that she could sit, stand or walk in a day, were rated higher in the invalid tests than during her most recent functional capacity evaluation test taken only three weeks after her second invalid evaluation.

Interestingly, Dr. Shapiro also noted that Petitioner exhibited five of five Waddell's signs on examination of the low back, but he noted that the findings should not be taken as an intent to defraud; rather, that these signs were nonorganic or unrelated to the low back. Dr. Andersson also noted minimal Waddell's findings at the time of his examination. These conclusions suggest that, while Petitioner's reports are not corroborated from an orthopedic or neurological standpoint to the extent alleged by Petitioner, , Dr. Gelbort's neuropsychological conclusion that Petitioner sustained an emotional reaction to a mild physical trauma is supported by the record and is consistent with the opinions of Respondent's Section 12 examiners.

Based on all of the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is related, in part, to her accident at work and adopts the opinions of Dr. Andersson and Dr. Shapiro finding that Petitioner's neck and low back conditions are not causally related to her accident at work.

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

As explained more fully above, the Arbitrator finds that Petitioner's claimed current conditions of ill-being in the neck and low back are not causally related to her accident at work in reliance on the opinions of Dr. Andersson and Dr. Shapiro.

"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).

The medical bills submitted into evidence totaling $63,530.76 are for treatment related to the neck and low back. AX1 & PX2. Accordingly, the Arbitrator finds that these medical bills are not for reasonable or necessary medical treatment related to the injury sustained by Petitioner at work. Petitioner's claim for payment of these medical bills is denied.

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

Petitioner claims entitlement to temporary total disability benefits commencing October 13, 2010 through December 24, 2010 and commencing May 5, 2011 through September 15, 2015. AX1. Respondent stipulates

to Petitioner's entitlement to benefits from October 13, 2010 through December 24, 2010 only. *Id.* Thus, such benefits are awarded and Respondent will receive credit for such benefits paid totaling $6,216.25 pursuant to the parties' stipulations. AX1.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm.*, 201 Ill. App. 3d 880, 886, 559 N.E.2d 526 (1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Mechanical Devices v. Industrial Comm.*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added).

The medical records reflect that Petitioner's medical treatment beginning May 5, 2011 related to her neck and low back conditions. As explained above, Petitioner has failed to prove that her neck and low back conditions are causally related to her accident at work. Moreover, the medical records of Petitioner's other treating physicians, including the neuropsychological evaluation report of Dr. Gelbort, indicate that Petitioner would benefit from an eventual full duty return to work prior to May 5, 2011.

Based on the foregoing, the Arbitrator finds that Petitioner has failed to establish her entitlement to temporary total disability benefits from May 5, 2011 through September 15, 2015 based on an inability to work due to a condition that is causally related to her accident at work. Thus, Petitioner's claim for temporary total disability benefits from May 5, 2011 through September 15, 2015 is denied.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injuries, the Arbitrator finds the following:

Based on the record as a whole—reflecting that Petitioner sustained a mild traumatic injury to her head requiring diagnostic evaluation and conservative medical treatment resulting in subjectively perceived pain and ongoing symptomatology, which is supported by the evaluation of Dr. Gelbort and the opinions of Dr. Shapiro and Dr. Andersson that Petitioner did sustain some injury that resolved—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 7.5% loss of use of the person as a whole pursuant to Section 8(d)(2).

In support of the Arbitrator's decision relating to the issue of attorney's fees the Arbitrator finds the following:

The Commission's mainframe records reflect that Petitioner was previously represented by counsel. The Arbitrator takes judicial notice of the Commission's mainframe records (available through the Commission's website), which indicate that a petition to dismiss Petitioner's first attorney was filed on October 17, 2011 and granted on November 3, 2011. A petition for attorney's fees was filed on October 21, 2011. It is unclear from the Commission's records who this attorney was or whether the petition for attorney's fees was entered and continued to final disposition of the case. Thereafter, a stipulation to substitute attorneys was filed on November 29, 2011 and February 28, 2012.

Petitioner's case was dismissed on September 15, 2014 and reinstated on December 10, 2014. On that date, Petitioner was present and indicated that she wished to represent herself and did not wish to have Mr. Durham represent her going forward in the case. Mr. Durham was dismissed as Petitioner's counsel. Then on March 16,

2015, Mr. Durham appeared with Petitioner and Respondent on Mr. Durham's petition for attorney's fees, which was entered and continued to disposition of the case. On June 8, 2015, Respondent's attorney was present by phone and Petitioner appeared with another attorney who indicated that he would not be filing an appearance on Petitioner's behalf. No such appearance was entered. The Petitioner and Respondent's Attorney were instructed to discuss exchange of evidence as appropriate by September 4, 2015 with a final trial date set for September 15, 2015. Petitioner and Respondent's attorney appeared for trial, which was held on September 15, 2015. Mr. Durham had been given notice of the hearing and did not appear, but he was contacted on the morning of the hearing and acknowledged receiving notice of the hearing on June 8, 2015. Tr. at 4-5.

Based on the evidence adduced at trial showing that Mr. Durham represented Petitioner for approximately three years during which time he represented Petitioner in two physicians' depositions in preparation of her case, the Arbitrator finds that Mr. Durham is entitled to 15% in accordance with Section 16Λ of the Act plus costs for his services. Payment of the awarded benefits in this case shall be made by Respondent in accordance with 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	X None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melissa Grischow

Petitioner,

vs.

No. 11 WC 22574

Canon Business Solutions, Inc.
Som Po Japan Insurance Company of America and
Crawford and Company/ Broadspire,

17IWCC0541

Respondents.

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(h) AND 8(a)

Timely Petitions for Review under sections 19(h) and 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of further medical benefits, and permanent disability and being advised of the facts and law, denies both petitions for the reasons set forth below.

On June 13, 2013, the Arbitrator filed a decision awarding permanent disability benefits corresponding to 20 percent loss of the use of Petitioner's right leg as the result of the work injury of January 27, 2011. Neither party appealed the Arbitrator's decision.

On December 7, 2015, Petitioner timely filed a petition for review under sections 19(h) and 8(a) asking the Commission to find that Petitioner is entitled to the further medical treatment recommended by Dr. Schroeder, including physical therapy and repeat viscosupplementation. In her brief on review, Petitioner additionally asks the Commission to award a medical bill in the amount of $356.00 for treatment by Dr. Schroeder for services rendered on July 14, 2016.

Petitioner injured her knee in a fall at work on January 27, 2011. Petitioner missed no

17IWCC0541

work as the result of this injury. The evidence shows that Petitioner completed therapy and did not receive any further treatment for her right knee for almost three years, between December 13, 2012 and when she returned to Dr. Schroeder on November 21, 2015. At that appointment, Petitioner reported to Dr. Schroeder that she had experienced the insidious onset of right knee pain over the past two months. Dr. Schroeder recommended physical therapy which was denied by the workers' compensation carrier.

On Respondent's request Petitioner underwent a Section 12 examination on May 10, 2016 by Dr. Cohen. Petitioner reported to Dr. Cohen that she had been doing very well until the summer of 2015 when she was doing repetitive squatting and kneeling while on a family vacation at Disney World. Petitioner testified at hearing that having two young, growing children has exacerbated her knee condition. Petitioner testified at hearing that she has more heat and throbbing in the knee and feels symptoms when she carries her three- year- old child.

Dr. Cohen stated the opinion in his report that Petitioner had chondromalacia patella. Dr. Schroeder noted that Petitioner had no abnormal findings on examination, with the exception of a mild patellar click, which was bilateral. While Dr. Cohen finds that Dr. Schroeder's treatment recommendations are reasonable they are not related to the work incident of January 27, 2011.

The Commission relies on the opinion of Dr. Cohen and denies Petitioner's Section 8(a) petition. With regard to the 19(h) petition, the Commission likewise finds that any increase in disability would not be related to the work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petitions under Sections 8(a) and19(h) are denied.

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

The 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: SEP 6 - 2017
o-10/19/16
SM/msb
44

Stephen Mathis

David L. Gore

Kevin Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRISCHOW, MELISSA
Employee/Petitioner

Case# **11WC022574**

17IWCC0541

CANON BUSINESS SOLUTIONS INC SOM PO
JAPAN INSURANCE COMPANY OF AMERICA
CRAWFORD AND COMPANY/BROADSPIRE
Employer/Respondent

On 6/13/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

CRAWFORD & COMPANY/BROADSPIRE
PO BOX 681519
SCHAUMBURG, IL 60168

17IWCC0541

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Melissa Grischow
Employee/Petitioner

v.

Canon Business Solutions, Inc.
Som Po Japan Insurance Company of America;
Crawford and Company / Broadspire
Employer/Respondent

Case # **11** WC **22574**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **April 26, 2013**. By stipulation, the parties agree:

On the date of accident, **January 27, 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 **$57,496.92**, and the average weekly wage was **$1,105.71**.

At the time of injury, Petitioner was **34** years of age, ***married*** with **0** dependent children.

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

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 **$663.43**/week for a further period of **43** weeks, as provided in Section **8(e)(12)** of the Act, because the injuries sustained caused **the 20% loss of the right leg as provided in the Act**.

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

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

Deborah L. Simpson
Signature of Arbitrator

June 13, 2013
Date

JUN 13 2013

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA OQUENDO,

Petitioner,

vs. NO: 11 WC 36858

RESURRECTION HEALTH CARE,

17IWCC0556

Respondent,

DECISION AND OPINION ON REVIEW

Petitioner filed a Petition for Review on the issues of causation, temporary total disability, medical expenses, and nature and extent. However, we find that Petitioner's Petition was not filed timely and we no longer have jurisdiction.

At the hearing, the parties agreed to waive receipt of the Arbitrator's decision by certified mail and consented to receive the decision by electronic mail. (T.9, 11). Both parties agreed that their e-mail addresses are listed on the Request for Hearing form. (Id.) The decision was filed on February 2, 2016 and sent to both parties via e-mail on February 3rd. Petitioner did not file a Petition for Review until March 31, 2016, well beyond the 30-day time limit required under §19(b) of the Act. On the Petition, Petitioner indicated that the decision was filed on February 2, 2016, but that it was received on March 23, 2016.

Pursuant to Commission procedure, decisions are e-mailed with a delivery receipt and read receipt requested. The delivery receipt is generated automatically when the e-mail is successfully transmitted to the recipient's e-mail address. The read receipt is generated when the e-mail is opened but we note that it is possible for this receipt to be manually prevented by the receiving party. Commission records indicate that Respondent's attorney sent a read receipt on February 3rd, but Petitioner's attorney did not send a read receipt until March 24th.

Petitioner's brief indicates that the decision was e-mailed to an attorney who subsequently left the firm and that this e-mail address was not being monitored by the office manager. Without citing anything in support, Petitioner claims that, "It has been the understanding of the undersigned that the decision is not considered to be received until receipt

17IWCC0556

is acknowledged by the opening of the e-mail." (P-brief at 1). The Commission does not know what the basis of this alleged "understanding" could have been but it is not accurate.

This situation is similar to a party receiving a certified letter via USPS but choosing not to read it. We find that Petitioner's attorney's law firm had an affirmative duty to review all of the e-mails sent to the former attorney's e-mail address and/or inform the Arbitrator of a change in e-mail address. Therefore, we find that Petitioner's Petition for Review was not timely filed and that the "date of receipt" of the decision is the date that the decision is e-mailed unless the party proves that it was not received, such as when the decision was sent to an e-mail address that is different than the one specified on the Request for Hearing form. To find otherwise would allow too much opportunity for the 30-day deadline to be subverted by simply waiting indefinitely to read any e-mails from the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review is hereby dismissed for lack of jurisdiction.

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

DATED: SEP 7 - 2017

Charles J. DeVriendt

Kevin W. Lamborn

Joshua D. Luskin

SE/
O: 7/26/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OQUENDO, MARIA
Employee/Petitioner

Case# **11WC036858**

17IWCC0556

RESURRECTION HEALTH CARE
Employer/Respondent

On 2/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
RACHEL L BECISH
ONE N LASALLE ST 26TH FL
CHICAGO, IL 60602

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

17IWCC0556

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

Maria Oquendo
Employee/Petitioner
v.
Resurrection Health Care
Employer/Respondent

Case # **11 WC 36858**

An *Application for Adjustment 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 **November 19, 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 _____

17IWCC0556

FINDINGS

On **April 5, 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 **$21,932.20**; the average weekly wage was **$421.60**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **no** dependent children.

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

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

ORDER

Respondent shall pay for all medical services rendered through July 21, 2011, as provided in Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of **$252.96**/week for **10** weeks, because the injuries sustained caused the **2%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

February 1, 2016
Date

ICArbDec p. 2

FEB 2 - 2016

FINDINGS OF FACT

Petitioner's native language is Spanish, and she testified through an interpreter. Tr. 13-15 Petitioner testified that on April 5, 2011 she was employed by Respondent as a patient transporter. Tr. 16 Petitioner testified her job involved moving patients from one floor to any other floor in the hospital. Tr. 27 Petitioner testified that on any given shift she may transport as many as 10 patients. Tr. 28

Petitioner testified that on April 5, 2011 "We were transferring the patient from my stretcher to the patient's bed, since the patient was big, the stretcher was spreading, it was moving away from her bed and my stretcher. And she became like stuck in between beds. And I had to strain myself and use a lot of force because it was moving away. And that strength, all of that is what affected me, it affected my back, all of the strength and the straining." Tr. 16-17 Petitioner testified that she told her co-worker that she "felt something very strange, I hurt myself". Tr. 17 Petitioner testified that she could not recall the exact time this injury occurred, but that it was early, and that she didn't know if it was in the morning or at noon. Tr. 28 Petitioner testified that following the injury she continued to work her entire shift. Tr. 28

Petitioner testified that she saw her physician, Dr. Manual Dominguez, who had her undergo an MRI, prescribed physical therapy, and then referred her to a specialist, Dr. Lichtenbaum. Tr. 20 Petitioner testified that she continued to work full duty without restrictions. Tr. 29-30

The records of Dr. Dominguez were submitted. The first indication of treatment following April 5, 2011 was on April 8, 2011. The handwritten notes from those medical records are not very legible and are not very decipherable. PX1, p2 Petitioner testified that she told Dr. Dominguez about an accident at work and that she did not tell him she had back pain for three years. Tr. 32

Petitioner testified she provided notice of the accident to her supervisor Lori Campos and then filled out an accident report on April 11, 2011. Tr. 17-19 Petitioner's written accident report was submitted. PX9

Petitioner returned to Dr. Dominguez on April 14, 2011 and May 2, 2011 PX1, p5

Petitioner presented to St. Mary of Nazareth for an MRI of the lumbar spine on April 18, 2011. Results indicated degenerative disk disease at L5-S1 characterized by disc dehydration and a right paracentral bulge. There was minimal effacement of the thecal sac and there was no significant compromise of the central spinal canal or of either neural foramen. There was no significant change in the appearance of the lumbar spine since a previous study obtained on June 16, 2007. PX2, p1

Petitioner testified that when she saw Dr. Dominguez she told him that she was in too much pain that she couldn't take it anymore and that is when he sent her to a specialist, Dr. Lichtenbaum. Tr. 44

The records of Dr. Lichtenbaum were submitted. Those records show that Petitioner presented to Dr. Roger Lichtenbaum on referral from Dr. Dominguez on June 2, 2011. PX3, p1 The patient insurance sheet states that Petitioner has had low back pain for two years, had silicone injected into her back several years ago which helped, had burning radiating pain as of the month prior into the left leg, and pain had improved since then. PX3, p3

Petitioner testified that she did not comment to Dr. Lichtenbaum about low back pain for two years. Tr. 34 Petitioner further testified that she did not tell Dr. Lichtenbaum that her back pain had improved. Tr. 35

Dr. Lichtenbaum's impression was that Petitioner had chronic low back pain and a temporary incident of lower extremity radiculopathy on the left but only mild degenerative changes on her MRI. Dr. Lichtenbaum did not recommend any neurosurgical intervention. He referred Petitioner for therapy and noted that if her pain persisted beyond therapy she could consider an epidural steroid injection. PX3, p1

Petitioner's testimony on cross-examination about her prior back complaints and prior accident was not responsive. Tr. 35-41 Petitioner eventually testified under cross-examination that she did have a history of back pain as of April 2011. Tr. 45

Petitioner attended therapy sessions at St. Mary & Elizabeth Medical Center from June 22, 2011 through July 21, 2011. PX2, pp3-15 At her initial evaluation, Petitioner provided a history of accident consistent with her testimony at trial, and noted a past medical history of a prior back injury. PX2, p11 A physical therapy discharge summary dated July 21, 2011 indicated that Petitioner had met her goals of decreasing pain and increasing strength, and that Petitioner needed to practice her home exercise program. PX2, p3

Petitioner testified that between April 2011 and September 2011 she worked full duty. Tr. 43

Petitioner returned to Dr. Dominguez on August 23, 2011 and September 9, 2011. PX1, pp3-4

Petitioner began treating with Dr. Mark Gerber on September 19, 2011. Petitioner complained of severe pain and limitation of motion in the low back with pain radiating into the left leg. Petitioner provided a history that on April 5, 2011 she was lifting a patient when she felt severe pain in the low back. Her past medical history was noted to be "unremarkable". PX4, p1 Dr. Gerber recommended that Petitioner undergo an MRI of the lumbar spine, be evaluated by Dr. Richard Kiang for pain management and physical rehabilitation, and continue physical therapy 3 times per week. PX4, p2 Dr. Gerber released Petitioner to a10 pound lifting restriction with no pushing or pulling until October 3, 2011, and he prescribed anti-inflammatory and analgesic medication. PX4, p3

Petitioner indicated in her cross-examination testimony that she did not tell Dr. Gerber about her prior history of back problems. Tr. 42-43

A lumbar spine MRI from Niles Open MRI was obtained on September 20, 2011. The MRI revealed mild disc bulging at L3-L4 and a mild to moderate disc protrusion at L5-S1 eccentric toward of the right neural foramen. PX5, pp2-3

Petitioner attended physical therapy at Fullerton Drake Medical Center from September 19, 2011through October 28, 2011. PX4, pp4-36

Petitioner began treating with Dr. Kiang on September 29, 2011. PX6, p1 Dr. Kiang performed an EMG, and his impression was acute moderately severe left L5 radiculopathy. PX6, p5 On October 5, 2011 Petitioner underwent a left L5 epidural steroid injection and a nerve root block administered by Dr. Kiang. PX7, p1 On October 14, Petitioner underwent a left L5 epidural steroid injection and a nerve root block administered by Dr. Kiang. PX7, pp2-3

On October 20, 2011 a note from Dr. Gerber stated that Petitioner had improved sufficiently enough from physical therapy so she could return to work as of October 21, 2011, with the restrictions of work excuses

on October 26, 2011 and October 27, 2011 for epidural steroid injections, and no lifting more than 20 pounds or excessive bending or twisting of the low back until November 4, 2011. PX4, p 28

On October 26, 2011 Petitioner underwent a left L5 epidural steroid injection and a nerve root block administered by Dr. Kiang. PX7, p4

On October 31, 2011 Dr. Gerber noted that Petitioner had improved sufficiently that she could return to work as of November 7, 2011 with the restriction of no pushing or pulling of the stretchers, but that she could push and pull wheelchairs, and that the restrictions would apply until November 16, 2011. PX4, p37

Petitioner attended physical therapy at Fullerton Drake Medical Center from October 31, 2011 through November 21, 2011. PX4, pp37-51

Petitioner returned to Dr. Dominguez on November 3, 2011. PX1, p4

On November 21, 2011 a note from Dr. Gerber stated that Petitioner remained under his care for her "work-related injury of the low back", that Petitioner attempted to return to work full duty but her work activities aggravated her condition and that her low back pain has become intolerable, and that therefore Petitioner cannot work and is totally disabled until December 1, 2011. Dr. Gerber stated that Petitioner required a functional capacity evaluation to assess her current functional capacity. PX4, pp50-52

Petitioner attended physical therapy at Fullerton Drake Medical Center from November 21, 2011 through December 14, 2011. PX4, pp50-65

On December 14, 2011 Dr. Gerber released Petitioner to full duty from December 15, 2011 through December 28, 2011. Dr. Gerber noted that Petitioner required a functional capacity evaluation as well as continued physical therapy three times per week. PX1, pp65-66

On December 20, 2011 a note from Dr. Gerber stated that Petitioner remained under his care, that Petitioner attempted to rework to work full duty but that her work activities caused intolerable pain, and that therefore she was totally disabled and unable to work and will remain so until January 3, 2012. Dr. Gerber restated that Petitioner required a functional capacity evaluation. PX1, p67

A functional capacity evaluation was obtained on December 23, 2011 at Best Practice Physical Therapy. The report summary states that Petitioner could return to work in the light strength category. PX8, p4 The clinician comments recite that Petitioner's results were valid and reliable. PX8, p5

On December 29, 2011 Dr. Gerber ordered a course in work conditioning at Best Practice Physical Therapy 5 times per week for 4 weeks to assist Petitioner with reaching her return to work goals. Petitioner was taken off work until January 13, 2012. PX4, p71

On January 13, 2012 Dr. Gerber released Petitioner to full duty and advised her to continue therapy as needed. PX4, pp78-79

On January 16, 2012, Petitioner returned to Dr. Gerber, who took Petitioner off all work and referred her to a neurosurgeon, Dr. Sean Salehi. PX4, p80

On January 26, 2012, Petitioner returned to Dr. Gerber, who released Petitioner from care with a permanent 25 pound lifting restriction and no excessive bending or twisting of the low back. PX4, p84

Petitioner returned to Dr. Dominguez on February 9, 2012. PX1, p6

Respondent obtained a Section 12 examination with Dr. Andrew Zelby on September 10, 2012. Dr. Zelby provided an AMA Impairment rating in his report. RX1, p 6, Dep. Ex. 2 The evidence deposition of Dr. Zelby was taken on March 11, 2014.

Dr. Zelby testified that Petitioner reported a two year history of back pain that was usually mild. He testified that Petitioner told him she was transferring a patient on April 5, 2011, who she estimated weighed 300 pounds, from one bed to another pushing this patient while a coworker was pulling this patient and that she felt low back pain which became immediately worse, although she continued to work. RX1, pp7-8 Dr. Zelby testified that the physical examination was normal. RX1, p12 Dr. Zelby opined that Petitioner had easily reached MMI for any condition arising as a consequence of her work injury almost 18 months earlier. RX1, p19

CONCLUSIONS OF LAW

CAUSATION

The main issue is whether or not Petitioner's present condition of ill-being is related to her April 5, 2011 accident.

Petitioner's testimony on cross-examination about her prior back complaints and her prior accident was extremely unresponsive and evasive. Petitioner lacks credibility on the causation issue.

Dr. Dominguez's medical records consist of his handwritten notes. This Arbitrator cannot read Dr. Dominguez's handwriting. Dr. Dominguez's medical records are given no weight.

Dr. Lichtenbaum's medical records state that Petitioner had had low back pain for two years, had silicone injected into her back several years ago which helped, had burning radiating pain as of the month prior into the left leg, and pain had improved since then. Dr. Lichtenbaum's impression was that Petitioner had chronic low back pain and a temporary incident of lower extremity radiculopathy on the left. He referred Petitioner for therapy and noted that if her pain persisted beyond therapy she could consider an epidural steroid injection. Because Dr. Lichtenbaum's medical records include an actual history of the previous back pain and were made within two months of the accident, the Arbitrator finds them to be persuasive.

Dr. Gerber's medical records state that Petitioner's past medical history was "unremarkable". It is a reasonable inference that Petitioner did not tell Dr. Gerber about her prior history of low back pain. More importantly, Petitioner indicated in her cross-examination testimony that she did not tell Dr. Gerber about her prior history of back problems. Because Dr. Gerber's medical records do not contain an accurate medical history, they are unhelpful on the causation issue.

Dr. Zelby testified that Petitioner reported a two year history of back pain that was usually mild and that while she was transferring a patient on April 5, 2011 when she felt low back pain which became immediately worse, although she continued to work. The Arbitrator finds Dr. Zelby's medical testimony to be helpful on the causation issue.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained a minor aggravation of a pre-existing chronic low back condition and that her current condition of ill-being, to the extent of that minor aggravation, is causally related to the accident.

MEDICAL

Petitioner attended therapy sessions at St. Mary & Elizabeth Medical Center from June 22, 2011 through July 21, 2011. A physical therapy discharge summary dated July 21, 2011 indicated that Petitioner had met her goals of decreasing pain and increasing strength, and that Petitioner needed to practice her home exercise program. Petitioner testified that she worked full duty during that period. The physical therapy was consistent with Dr. Lichtenbaum's persuasive medical impression.

Dr. Gerber's subsequent medical treatment was based on an inaccurate history. As a result, his opinions on the issue of medical treatment are not helpful.

Based upon the foregoing, the Arbitrator finds all medical care provided through the July 21, 2011 discharge from physical therapy to be reasonable, necessary, and related to the work injury. The Arbitrator further finds all that all medical care provided after July 21, 2011 is not related to the work injury.

TEMPORARY TOTAL DISABILITY

Petitioner testified she lost no time from work from the date of the accident April 5, 2011 through the first date of treatment with Dr. Gerber on September 19, 2011. Petitioner claims temporary total disability beginning September 21, 2011. Petitioner was first authorized off of work by Dr. Gerber. However, he was treating Petitioner based upon an inaccurate medical history.

Based upon the foregoing, the Petitioner's claim for temporary total disability is denied.

NATURE AND EXTENT

Both parties have proposed that Petitioner has sustained a permanent disability.

Dr. Zelby provided an AMA impairment rating. However Petitioner's accident preceded the September 1, 2011 effective date of Section 8.1b. The substantive rights of the parties were set on the April 5, 2011 accident date. Therefore, the AMA impairment rating is given no consideration on the issue of the nature and extent of the injury.

Based upon the totality of the medical evidence, the Arbitrator finds that Petitioner has sustained a minor aggravation of a pre-existing chronic low back condition.

Accordingly, the Arbitrator finds that Petitioner has sustained a 2% loss of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REGINA GONZALEZ,

Petitioner,

vs. No. 12 WC 12473

FRESENIUS KABI,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Motion to Reinstate. A hearing was scheduled for August 29, 2017 before Commissioner Simpson in Chicago. Only counsel for Respondent appeared and requested the matter be continued.

The underlying claim was dismissed for want of prosecution by Arbitrator Williams on March 2, 2016. Petitioner filed a Motion to Reinstate on May, 26, 2016 to be heard by Arbitrator Williams. The Motion to Reinstate was not heard by Arbitrator Williams nor any other arbitrator. Rather, on May 22, 2017, Petitioner filed the Motion to Reinstate before the Commission. Such a motion must be ruled on by an Arbitrator before coming before the Commission. If either party wants the Arbitrator's decision on reinstatement reviewed, such party can file a Petition to Review that decision. Until then the Commission does not have jurisdiction to rule on this motion. Therefore, the instant motion is dismissed and the matter will be assigned to an Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Reinstate is hereby dismissed and the matter will be assigned to an Arbitrator.

DATED: SEP 7 - 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
R-8/29/17
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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

Art Moss,
Petitioner,

v.

NO: 12 WC 01903

Illinois Secretary of State,
Respondent.

17IWCC0578

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent disability, and being advised of the facts and law, affirms the Arbitrator's finding Petitioner failed to prove a repetitive trauma injury manifesting on November 15, 2011 but applies different reasoning to reach its conclusion.

Initially, the Commission notes Petitioner's Statement of Exceptions indicates there is a heightened burden of proof for repetitive trauma claims: "it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including frequency, duration, manner of performing, etc." The Commission emphasizes this is an incorrect statement of the law and reiterates a claimant seeking to recover for a repetitive trauma injury is held to the *same standard of proof* as any other claimant under the Act. *Durand v. Industrial Commission*, 224 Ill. 2d 53, 64, 862 N.E.2d 918 (2006) (Emphasis added).

Analysis:

The record contains opinions from two physicians, Dr. Greatting and Dr. Williams, both of whom are board certified with an added qualification in hand surgery. Dr. Greatting testified regarding the records of Petitioner's initial presentation to the clinic on December 13, 2011, as

well as his first evaluation of Mr. Moss on January 18, 2012. PX5, p.9. Dr. Greatting's records demonstrate Petitioner reported chronic symptoms of numbness and tingling in the ulnar nerve distribution of both arms and gave a history of working as a supervisor in a mail and shipping room for approximately 30 years. PX5, p.9-10. Petitioner stated he had increasing symptoms while working and advised the doctor his work was about six hours a day of keyboarding activities; Petitioner described his body mechanics while typing as elbows bent about 45 to 60 degrees, resting his forearm and elbow on the desk, and he indicated his symptoms increased during that activity. PX5, p.10. Later in his deposition, when questioning turned to causation, Dr. Greatting was presented with the job description quote from Dr. Williams' report pursuant to Section 12 of the Act:

> Mr. Moss has worked for the State of Illinois since 3/21/1983. At the time of the IME his title was that of an Executive II, where he said his job duties involve him sorting and inserting mail. He types where he makes out reports. He does phone calls. He does some delivery. He does some truck loading. He does stapling and unstapling for which he uses both hands; this is intermittent, maybe less than 15 minutes a day. He does some truck loading maybe half an hour a day. Delivery he does maybe an hour a day. Typing or making out reports he dose (sic) maybe 2 hours a day. Sorting and sometimes does inserts he might do for 3 hours a day. He said there is mechanical, which does inserting and sorting. He does some grabbing of mail, where it comes out of the inserter and then sorts and puts it into a 2-foot postal tray and you have to feed the machine. He said his job is Monday through Friday. He works from 7 a.m. to 3:30 p.m. He said there is a 1 hour lunch, two 15-minute breaks in the a.m. and p.m. and they are on call on the weekends. PX5, DepX3.

In comparing that document with what Petitioner stated to him, Dr. Greatting testified, "it sounds like he didn't do keyboarding as much as he told me, but the other activities more and keyboarding less." PX5, p.14. Dr. Greatting was then asked whether, based on the history, examination findings, operative findings, and the job description from Dr. Williams' report, Petitioner's job could or might have caused or aggravated his bilateral cubital tunnel syndrome, and Dr. Greatting responded, "I don't think I could say that it caused it, but I certainly feel that based on his history provided to me and my understanding of his work now that it would be an aggravating factor at a minimum." PX5, p.15. As to what specific job duties in Dr. Williams' report were causative, Dr. Greatting stated,

> Well, he would hold his elbows partially flexed for periods of time. He would put pressure on the back part of his elbows, resting them on a hard surface, and then it sounds like he did various other repetitive activities including stapling, unstapling, loading a truck, doing delivery type things, sorting mail, and also feeding mail or removing mail and sorting it out of a machine. I think a combination of all those things over time would contribute to this. PX5, p.15-16.

Dr. Greatting conceded Petitioner possessed multiple risk factors for development of cubital tunnel syndrome, including diabetes, obesity, and being a chronic smoker (PX5, p.18-20) but testified the existence of such factors did not alter his opinion Petitioner's employment was an aggravating factor in his development of cubital tunnel syndrome. PX5, p.28, 31.

Dr. Williams reached the opposite conclusion. Dr. Williams testified a significant portion of his evaluation of Petitioner was spent discussing job duties. RX1, p.9. Dr. Williams then discussed Petitioner's medical history, including his obesity, history of hypertension as well as his onset of Type II diabetes. Dr. Williams explained obesity and hypertension placed Petitioner at an increased risk for peripheral neuropathy. RX1, p.9-10, 13. Dr. Williams also highlighted the onset of Petitioner's diabetic condition roughly correlated with his symptoms and noted Petitioner complained of numbness in his feet, which is typical of someone with diabetic neuropathy. RX1, p.9-10, 15. Dr. Williams also observed his opinion is consistent with the blood tests contained in Dr. Greatting's records, which document Petitioner had significantly elevated blood glucose. RX1, p.17-18. Dr. Williams also identified Petitioner's 30-year smoking history as a further risk factor. RX1, p.13. Dr. Williams concluded Petitioner's work activities did not contribute to or aggravate his condition, and this was based on the other risk factors, the job duties, as well as his conversation with Petitioner describing the job duties he performed. RX1, p.19. Later in his deposition, Dr. Williams again testified Petitioner conveyed his job duties to him as well as the time frames he would be performing the various tasks then reiterated his opinion Petitioner was not performing those tasks for a sufficiently long enough time to cause or aggravate the cubital tunnel:

> I do not think he was. Even if you look at the OWN physical ability requirement sheet where it fills out the job duties and how often he did those - - which I reviewed with him and he found no discrepancy - - that under activities it has a space for typing nonstop, and it specifically says that he did not do that. It says not applicable...So I think the chances of him developing that from an ergonomic situation where he did not stay at that position for a significant period of time is pretty low. RX1, p.25.

Dr. Williams further explained even if Petitioner typed for six hours a day, he would still need to do that "over a significant period of time, not just a day here or a day there." RX1, p.26.

An employee who alleges injury based on repetitive trauma must "show [ ] that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987). "There is no requirement that a certain percentage of time be spent on a task in order for the [claimant's work] duties to meet a legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 194, 825 N.E.2d 773 (1987). In repetitive trauma cases, the claimant "generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502 (1987). The question whether a claimant's work activities are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory must

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be decided on a case by case basis upon the particular facts presented in each case. *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 210-11, 614 N.E.2d 177 (1993).

Both physicians agreed cubital tunnel syndrome requires exposure to prolonged elbow flexion. Dr. Greatting testified cubital tunnel syndrome is typically linked to where "the elbow is flexed significantly for long periods of time or where there is pressure on the posterior part of the elbow where the nerve is for significant periods of time." PX5, p.14-15. Dr. Williams offered a similar explanation:

> So the more common reason people develop a cubital tunnel or cubital tunnel is aggravated is by keeping the elbow held flexed. Flexion and extension actually relaxes the tension on the nerve every time that elbow is extended...
> So flexion and extension, no. Held the elbow in the flexed position for a long period of time, yes. RX1, p.26-27.

Both physicians agree Petitioner's typing activities were insufficient to cause cubital tunnel syndrome. Where the physicians' opinions diverge is regarding whether Petitioner's varied work activities would aggravate the condition. The Commission finds Dr. Williams' opinion more persuasive.

Dr. Greatting's initial causation opinion was predicated on Petitioner typing six hours per day and was therefore flawed. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) However, when presented with the more accurate description of Petitioner's varied work duties, Dr. Greatting did not alter his opinion, stating, "those activities over that period of years could aggravate this problem, yes." PX5, p.30. While Dr. Greatting testified those activities were repetitive enough to aggravate Petitioner's condition, the doctor failed to explain how Petitioner would have been exposed to prolonged elbow flexion while performing any of those enumerated activities, *i.e.*, sorting mail, loading trucks, delivery, phone calls, and stapling/unstapling. The Commission finds Dr. Greatting's opinion is incompatible with Petitioner's description of his body mechanics while working. For instance, Petitioner testified when he utilized the automated sorter, he "would reach out, grab the mail, put it in a tray" (T.13-14) or, in the Howlett building, "it's an extension. You are up against a machine and these automated trays come through there and then you reach out, grab the mail and pull it back and set it in a tray up above your head." T.14-15. Certainly, the activities described by Petitioner require reaching and grabbing, the mechanics of which involve repetitive flexion and extension of the elbow, however there is no evidence those activities involved the requisite prolonged elbow flexion which both physicians testified was necessary for causation. Moreover, Dr. Williams, whose testimony and conclusions the Commission finds more credible, specifically denied repeated flexion and extension causes or aggravates cubital tunnel syndrome.

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Based on the above, the Commission finds the preponderance of the evidence established Petitioner's cubital tunnel syndrome is a result of his comorbidities, and his varied work tasks did not aggravate his condition. The Commission affirms the Arbitrator's finding Petitioner failed to prove he sustained a repetitive trauma injury manifesting on November 15, 2011.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 2016 as modified is hereby affirmed.

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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: SEP 25 2017

L. Elizabeth Coppoletti

LEC/mck

Charles J. DeVriendt

O: 8/2/17

Joshua D. Luskin

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOSS, ART
Employee/Petitioner

Case# **12WC001903**

ST OF IL SECRETARY OF STATE
Employer/Respondent

17IWCC0578

On 9/20/2016, 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 0.50% 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:

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

SEP 20 2016

DONALD A. DORAN, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0578

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

Art Moss
Employee/Petitioner

v.

State of Illinois, Secretary of State
Employer/Respondent

Case # 12 WC 01903

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 **June 30, 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 November 15, 2011, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $81,829.00; the average weekly wage was $1,573.63.

On the date of accident, Petitioner was 59 years of age, married with 0 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 is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

The Arbitrator concludes the Petitioner did not sustain an accident that arose out of or in the course of petitioner's 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

9/9/16
Date

SEP 20 2016

I. STATEMENT OF FACTS

Petitioner began working for the State in 1983. Initially he worked for CMS for thirteen years and since then for the Illinois Secretary of State. He was an Executive 3. As an Executive 3 he was involved with inventory, warehousing, mail processing and typing. The amount of typing he did varied from a couple of hours up to 6 hours per day. Petitioner testified the primary goal was to make sure that all of the messengers were out delivering, picking up and making sure the mail got delivered.

As to the warehousing, on occasion he would have to haul, transport, load, unload and deliver supplies primarily boxes of copy paper.

In addition to the above, Petitioner did mail sorting. This required him to reach for the mail and put it in a tray. Petitioner testified he would arrive at the Howlett Building at 7 o'clock and would have the sorting done by 8:00 or 8: 30 so the messengers could start delivery. Petitioner indicated most of the time he would do this for an hour or two a day. On occasion, it could be an all-day process Petitioner worked from 7:00 a.m. – 3:30 p.m. with two 15 minute breaks and sometimes an hour for lunch. Petitioner testified in 2011 his elbows would get a painful sensation which woke him up in the middle of the night from sleeping.

Petitioner saw Dr. Trudeau on November 15, 2011. Petitioner's chief complaint was difficulty in his upper extremities especially the left. Petitioner's history was increasing symptomatology in the left upper extremity and even more lately in the right. Dr. Trudeau noted Petitioner, who is right handed, notes his symptoms are worse on the left side.

Interestingly, there is absolutely no reference in Dr. Trudeau's report about Petitioner's job or complaints or issues while performing his job.

Petitioner went to Dr. Greatting's office on December 13, 2011 for an evaluation of bilateral elbows and forearms. Petitioner gave a history of having bilateral arm pain and numbness and tingling for about the past 4-5 years with the left side being worse even though he is right hand dominant. Petitioner conveyed his symptoms were worse with computers, sorting objects, gripping and grasping. Petitioner told Dr. Greatting's physician's assistant he was going to file this as a workman's compensation case even before seeing Dr. Greatting. The note on that date further reflects:

> He does work for the State of Illinois. He is a supervisor of mailing and shipping and has been there 29 years. He does a lot of computer work, sorting and gripping activities which definitely aggravate the numbness, tingling and pain in his elbows and into his hand.

The assessment was bilateral cubital tunnel syndrome.

Petitioner returned to Dr. Greatting to follow up on January 18, 2012.

Dr. Greatting's note on that date reflects per Petitioner:

> He works as a supervisor in a mailing and shipping room for the Secretary of State. He has done this for about 30 years. He does get some increasing symptoms while working but also get symptoms at night. He says about 6 hours of his work per day now is keyboarding activities. He says when doing this, his elbows will be bent about 45-60 degrees, and he will rest his forearms and elbow areas on a tabletop of desk surface He will get increasing symptoms when doing these activities.

Based on the above, Dr. Greatting opines, "It does sound, based on his history, that his work activities at least aggravate his symptoms."

On February 14, 2012 Dr. Greatting released the ulnar nerve of the left elbow. On March 13, 2012, Dr. Greatting released the ulnar nerve of the right elbow.

On May 2, 2012, post-operatively, Petitioner returned to Dr. Greatting. Dr. Greatting's note indicates:

> Numbness has resolved in both hands. He has little tenderness in his left-sided incision. Strength is good in the ulnar nerve distribution bilaterally. His incisions are well healed.
>
> He can use the arms without restrictions or limitations. He is released from care. He is at maximum medical improvement. He will be seen back on an as-needed basis only.

Petitioner has not seen Dr. Greatting since that date.

Petitioner testified he works on the family farm of 160-170 acres of crops and 80 acres of pasture for beef cattle.

II. CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that he sustained accidental injuries arising out of and in the course of his employment with the Respondent, and failed to prove that his bilateral cubital tunnel syndrome conditions were causally related to his work duties with the Respondent.

The Petitioner has the burden of proof with regards to the issues of accident and causation. Petitioner testified he did many tasks including loading and unloading trucks, mail sorting, typing, delivering mail, and working at the warehouse.

As indicated, Petitioner told Dr. Greatting on January 18, 2012 that "6 hours of his work per day now is keyboarding activities." PX5.

Petitioner's counsel submitted the following job description during the evidentiary deposition of Dr. Greatting.

> Mr. Moss has worked for the State of Illinois since 3/21/1983. At the time of the IME his title was that of an Executive II, where he said his job duties involve him sorting and inserting mail. He types where he makes out reports. He does phone calls. He does some delivery. He does some truck loading. He does stapling and unstapling for which he used both hands; this is intermittent, maybe less than 15 minutes a day. He does some truck loading maybe half an hour a day. Delivery he does maybe an hour a day. Typing or making out reports he dose [sic] maybe 2 hours a day. Sorting and sometimes does inserts he might do for 3 hours a day. He said there is mechanical, which does inserting and sorting. He does some grabbing of mail, where it comes out of the inserter and then sorts and puts it into a 2-foot postal tray and you have to feed the machine. He said his job is Monday through Friday. He works from 7 a.m. to 3:30 p.m. He said there is a 1 hour lunch, two 15-minute breaks in the a.m. and p.m. and they are on call on the weekends. PX5, Ex. 3.

Obviously, there's a significant discrepancy in the amount of hours he conveyed to the doctor he spent typing and the amount of hours conveyed to the doctor he spent typing during Dr. Greatting's deposition.

During cross examination of Dr. Greatting, the following exchange occurred:

> Q. And you testified, doctor, that in fact you didn't see him on the first visit, that it was your physician's assistant, Ms. Lukac, is that correct?
> A. Correct.
> Q. So the history conveyed in that particular note about his job was not conveyed to you, that was just a note that she took down?
> A. Correct.
> Q. And you do discuss a little bit his job in the second visit on January 18, 2012; and the history he gave you is that six hours per day he is doing keyboarding and when he is doing that, he's got his elbows bent 45 to 60 degrees and he rests his forearms on a table top when he is doing that activity, is that accurate?
> A. Yes.
> Q. And, in fact, when he conveyed that history to you about his job duties, that's in part the reason that you conveyed today that you feel work might have been an aggravating factor for the development of his cubital tunnel?

A. I think if that were correct, yes, I would feel that way. But I think the other activities he does sound to be sufficiently repetitive in the job description that, either way, I don't think it would change my opinion.
Q. If in fact he wasn't doing the activities conveyed or there is some inaccuracy in the job description and the history he gave you about his job duties, that might or could lead you to change the opinion that you have rendered here today that his duties aggravated his condition?
A. It could if it was significantly different from these things.
Q. So if he wasn't keyboarding six hours a day or if he wasn't resting his elbows on the table six hours a day, that might or could lead you to change your opinion that you rendered here today?
A. Yeah, I would have to know what he was doing the other time.
Q. In fact, you don't know the number of hours or the minutes that he is engaged in the sorting of the mail, the delivering of the mail, the keyboarding, other than what he conveyed to you on the January 18, 2012 note, is that correct?
A. When I saw him and, yeah, did that note, that's all I understood about his work activities.
PX5, p. 20-22.

Respondent had Petitioner examined by a board certified orthopedic surgeon, Dr. Williams. During cross examination, Petitioner testified he answered all of Dr. Williams' questions truthfully to the best of his ability.

Unlike Dr. Greatting, Dr. Williams had a significantly better understanding of Petitioner's job duties.

The following exchange occurred during the deposition of Dr. Williams.

Q. And did you discuss his job duties with him on that date?
A. I did, sir.
Q. And what did he tell you about his job on that date?
A. He explained to me that he had worked at the present time as an Executive II where his job duties involved him sorting and inserting mail.

He said he made out reports which he typed. He did phone calls. He did some delivery, some truck loading. He did stapling and unstapling, for which he used both hands, which was intermittent, less than fifteen minutes a day.

He said if he did truck loading it was half an hour on a given day. He said if he did delivery it was maybe an hour a day. Typing was maybe two hours a day. Typing was maybe two hours a day. Sorting and sometimes doing inserts he might do for maybe three hours a day.

He did some grabbing of mail where it came out of the inserter and he sorted it and put it into a two, two-foot postal tray. He had to feed, and they you have to feed the machine.

He said his job was Monday through Friday, 7 a.m. to 3:30 p.m. with a one-hour launch [sic] and two fifteen-minute breaks, and there were some on-call weekends.
Q. Do you believe inquiring about his job duties is important for you?

A. It is, Rick. I don't know how else you're to determine whether someone's job is related or not unless you know exactly what they do.
Q. And so you spent a significant portion of your time discussing his job duties with him. Is that a fair statement?
A. I did, sir.
Q. And you had him also fill out a medical questionnaire?
A. I did, Rick.
Q. And then you also took a medical history from him?
A. I did.

The Arbitrator believes what was conveyed to Respondent's physician, Dr. Williams, more clearly mirrors Petitioner's duties based on his testimony.

Based on the above Dr. Williams' impression was:

> He underwent bilateral carpal and cubital tunnel releases. Obviously, Dr. Greatting is a capable physician and felt the patient was having some symptoms of carpal tunnel, I guess, and thus performed carpal and cubital tunnel releases, although I do not have those operative reports; that is only from the patient, with the dates of surgery coming from the patient. The patient appears to be doing well following those surgeries. Obviously, he does have type 2 diabetes. He does state he is also getting occasional numbness and tingling in his feet, which would indicate that maybe the diabetes is even worsening. Of note, he also has hypertension. He also, of note, per his own history, works with livestock. He also works with mechanical things including hammer drills, wrenches, and screwdrivers, which he has done his whole life, as well as he hunted using a gun and bow, which he has not done for some time. Obviously, I feel that the patient's carpal and cubital tunnel syndrome on the right and left sides would be more likely related to his type 2 diabetes, his hypertension, his increased body mass index, his 1-per-pack-per day smoking history for 30 years, as well as his hobby that of using hammer drills, wrenches, and screwdrivers, all of which he has done his whole life according to him, and I believe those would be more likely contributory than would be his work duties which he has explained to me as well as which I have explained and noted from the job descriptions of which I reviewed with him, of which he found no significant discrepancy, which do not note any significant vibration, impact, and/or sustained forcible repetitive gripping and/or pinching in any of the activity of which he did, so I feel that the surgeries of which the patient underwent, being a left carpal and left cubital tunnel release on 2/14/12, as well as the right carpal and right cubital tunnel release of which was done by Dr. Greatting on 03/15/2012, would be more so related to his medical problems and his hobbies and his smoking history than would be from any work-related issues.
>
> I do not feel his job is either aggravating and/or causative of any of the problems which he suffered, for which he eventually underwent operative treatment.

Dr. Greatting was also of the opinion that patients with diabetes are at an increased risk of ulnar nerve symptoms. Dr. Greatting also testified there is a higher incidence of developing cubital tunnel syndrome with chronic smokers.

The Petitioner told Dr. Williams he smoked a pack a day for 30 years in July 2012. During cross-examination, he testified he quit approximately a month before the hearing. Petitioner smoked almost a quarter of a million cigarettes - 20 per pack x 365 days x 34 years = 247,520. Both Doctors testified this extensive smoking history could be contributory for the condition Petitioner developed.

Further, Dr. Greatting was unaware of Petitioner's farming activities. PX5, p. 23.

Also, Dr. Greatting could not state to a reasonable degree of medical certainty that work caused his cubital tunnel syndrome:

> Q. And it would be speculative for you, would it not, to state if the cause of his condition is from work versus diabetes versus some other risk factor?
> A. I don't think I ever said work caused it.
> Q. So that would be - - you wouldn't be able to state to a reasonable degree of medical certainty that work was a cause over one of the other risk factors that he had for the development of cubital tunnel?
> A. I never stated that work caused it.
> Q. And, in fact, it is your opinion that work did not cause this or you can't state to a reasonable degree of medical certainty that work caused his cubital tunnel, is that a fair statement?
> A. That's what I said earlier, yes.

PX5, p. 28.

Another issue is somewhat concerning to the Arbitrator. As previously noted, it does not appear as if Petitioner even discussed work with Dr. Trudeau.

On his first visit to Dr. Greatting, before even having a physician discuss whether or not his job may be contributory, he advises Dr. Greatting's physician assistant he plans to file this as a workman's compensation case.

Based on the above, the Arbitrator believes Petitioner has failed to meet his burden of proof establishing an accident occurred arising out of his employment and his bilateral cubital tunnel syndrome is from his employment. Therefore, all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Johnston,

Petitioner,

vs.

NO: 12 WC 2910

17IWCC0583

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 18, 2016, is hereby affirmed and adopted.

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

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

17IWCC0583

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

DATED: SEP 26 2017
TJT:yl
o 9/18/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

17 IWCC0058

JOHNSTON, LARRY
Employee/Petitioner

Case# **12WC002910**

12WC019337
12WC011599

CATERPILLAR INC
Employer/Respondent

On 10/18/2016, 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 0.47% 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:

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

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

17IWCC0583

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Larry Johnston
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # **12** WC **02910**

Consolidated cases: **12 WC 19337**
12 WC 11599

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

FINDINGS

On the date of accident, **March 3, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,019.70**; the average weekly wage was **$875.41**.

On the date of accident, Petitioner was **50** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$49,270.66** for other benefits, for a total credit of **$49,270.66**.

Respondent is entitled to a credit of **$27,309.45** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on March 3, 2011 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to the alleged 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.

Nancy Lindsay
Signature of Arbitrator

October 13, 2016
Date

ICArbDec19(b)

OCT 18 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to medical records, in a letter dated January 22, 2001 Dr. Kurt J. Heimbrecht, a doctor affiliated with Family Medical Care of Decatur, stated that Petitioner had been experiencing back pain ever since he fell at work in 1994. Petitioner was noted to have symptoms of sciatica down his leg. He added, "With the slightest lifting or trauma there is recurrence of his back pain." The doctor went on to note a four day exacerbation for which he was recommending medication and physical therapy. (PX 1, dep. ex. 2)

In an August 7, 2001 Post Offer Medical-Factory Exam form from Respondent Petitioner denied any prior back pain, back surgery or numbness/tingling in his legs/feet; however, he acknowledged having consulted with a doctor about a back strain. (RX 1)

Petitioner completed a Post Offer Medical Questionnaire for Respondent on May 20, 2003. He denied any prior back surgery of any kind. He denied any prior back pain or injury. (RX 1)

Petitioner underwent a "Vehicle Operator Exam" for Respondent on December 11, 2003. He denied any chronic low back pain. (RX 1)

In March of 2006 Petitioner was treated at Decatur Memorial Hospital for gallstones. (RX 4)

In October of 2006 Petitioner was seen at Prairie Cardiovascular regarding cardiac issues. (RX 4)

Petitioner presented to Dr. Heim on August 5, 2008 regarding back pain. Petitioner gave a history of low back pain that "worsened acute[ly]" on August 1, 2008 when he stepped off a ladder and twisted, which "unfortunately messed up his back." Petitioner was reportedly unable to walk very well and noted pain radiating into his anterior thighs. Petitioner could not put his shoes on. He was using Skelaxin and Advil with minimal relief and was not sleeping well nor could he work for the last two days. Petitioner was observed walking very slowly with tenderness to his low back. Straight leg lifting pulled significantly into his low back at only 20 degrees. He was unable to perform FABER. Petitioner was taken off work from August 4, 2008 through August 7, 2008 and told to use heat and/or ice and perform exercises. He was to call if no better. (PX 4, pp. 62-63; PX 5)

Petitioner returned to see Dr. Heim on August 13, 2008 in regard to his "right sciatica" which was no better. The right anterior thigh discomfort had moved distally to the right lateral calf as well as to the foot which felt numb. Petitioner denied any left leg weakness but was so uncomfortable that he couldn't walk very well. Petitioner had been using Prednisone for five days which helped with discomfort but the tapering had not done so. He had also been using Tylenol as needed. Petitioner continued to move very slowly and with discomfort. He had mild tenderness to his right low back. Straight leg lifting was positive at 20 degrees of movement on the right side. He did not tolerate much extension of the right leg. Petitioner was instructed in a Prednisone regimen. An MRI of the lumbar spine was ordered and Petitioner was taken off work. FMLA papers were to be completed. (PX 4, pp. 60-61; PX 5)

Petitioner underwent lumbar spine x-rays at Decatur Memorial Hospital, per Dr. Heim, on August 19, 2008. According to the radiologist's report, Petitioner presented with a history of low back and right leg pain along with right leg numbness. The radiologist's impression was a large extruded herniated disc to the right of midline at L4-5, indenting upon the thecal sac at and medial to the origin of the right-sided nerve root sleeve while extending inferiorly to rest behind the posterior aspect of the L5 vertebral body on the right, posterior disc bulging at L5-S1, and L4-5, foraminal encroachment by disc bulge most evident on the right at L5-S1 and greater than at any other lumbar levels, and degenerative changes. (PX 5; RX 4)

After the MRI, Petitioner was advised of an appointment with Dr. Chu on August 25, 2008. (PX 5, notations on MRI report)

On September 8, 2008 Petitioner completed a Patient Profile Form. Petitioner indicated he was being seen for both back and right leg pain, with the back being more bothersome than the leg. Petitioner stated that his back pain had begun three weeks prior to August 1, 2008 but he noticed an increase in his pain on August 1, 2008. Petitioner was noted to have morning pain in his ankle and right buttock and numbness in the top of his right foot and his right big toe. He was taking Advil on a daily basis. Petitioner denied an injury or accident, marking that the back problem began "spontaneously." On the pain drawing, he marked lower back pain which was moderate in nature and staying the same. Petitioner reported that walking, standing, and sitting made his pain worse and that his leg felt weak from the knee down. Petitioner could only sit and stand comfortably for thirty minutes. He slept comfortably for two hours and could not walk comfortably whatsoever. Petitioner reported being unable to work since August 4, 2008 and that the following activities were limited because of his pain: dressing; light household chores; heavy household chores; social life; and travel. He had given up walking, swimming, and bike riding due to his pain. (PX 5)

Petitioner was examined by Dr. Chu on September 8, 2008. Dr. Chu felt Petitioner had a large herniated disc at L4-5. Petitioner told the doctor he had experienced back pain prior to August 1, 2008 but it was "not very significant." Petitioner told Dr. Chu that he started experiencing severe pain radiating down his ankle with numbness in his right foot, big toe and on top of his right foot all of which began on August 1, 2008. Petitioner described his pain as constant and moderate to severe since that time. Petitioner was uncertain as to whether he wished to proceed with surgery and he was instructed to return in two weeks with his MRI film which the doctor wished to review. (RX 2 – res. ex. 2, p. 2)[1]

Petitioner returned to see Dr. Chu two weeks later, advising him he did not wish to proceed with surgery as he wished to treat with a chiropractor instead. (RX 2 – res. ex. 2, p. 2)

Petitioner treated with a chiropractor, Dr. Eric Niehaus from September 25, 2008 through March 11, 2009. (RX 2 – res. ex. 2, p.2)[2]

On January 9, 2009 Dr. Niehaus released Petitioner to return to work with a 25 lb. lifting restriction which was to remain in effect until March 11, 2009 or until Petitioner was re-evaluated. (RX 1) Petitioner was cleared by Respondent to return to work on that date. (RX 1)

According to Respondent's company medical records Petitioner was seen on February 2, 2009 in follow-up for chiropractic care for spinal decompression. Petitioner had been released to return to work with restrictions for lower back pain. He was noted to have a herniated disc at L4-5. Petitioner denied any

[1] The actual records of Dr. Chu are not a part of the record.
[2] The actual records of Dr. Niehaus are not a part of the record.

further low back pain and was not taking any narcotics. He had been off work since August 4, 2008. He denied any numbness, tingling, or weakness in his lower extremity. He had normal range of motion with bilateral lower extremity strength and sensation. Petitioner was advised to return to see the company medical department once cleared for return to work at regular duty. (PX 3; RX 1)

According to Respondent's medical department records, Petitioner was seen in the medical department on February 20, 2009 for a herniated disc. There is a reference to Incident # 81752. He had last worked on August 3, 2008 and had returned to work on February 2, 2009. Petitioner had undergone a spinal decompression. Petitioner denied weakness, numbness, or tingling in his lower extremity. He was not on any medication and was no longer having lower back pain. There is reference to an incident date/procedure date of December 3, 2008. (PX 3)

Petitioner returned to Respondent's medical department on May 4, 2009 reporting he had been in physical therapy at his chiropractor's office and his back was good. He denied any more pain, numbness, tingling, or weakness. The assessment was "much improved lower back pain" and Petitioner was told to continue with his restrictions and return to see the company medical department once he was released to regular duty. (PX 3; RX 1)

Petitioner was examined by Dr. Heim on June 9, 2009 regarding his medications. He had last been seen in November of 2008. Petitioner reported his back was doing "very well." He had a herniated disc that was treated with decompression therapy and he had done well. Petitioner was on a 25 lb. weight lifting restriction at work without any problems and the doctor felt he should continue with that to keep his back healthy. Petitioner was noted to still be under some stresses and he was out of work, at least until August. Petitioner was taking a half tablet of Celexa daily. (PX 4, pp. 56- 57)

Dr. Heim re-examined Petitioner on October 19, 2009 regarding Petitioner's low back pain which had improved with Prednisone. Petitioner had also borrowed a piece of medical equipment called a Lumbar Home Trac that utilized a stretching of his lumbar spine. Petitioner reported that previous lumbar traction had helped and he wished to have his own medical equipment. He denied any leg weakness but was still on his Prednisone that began on October 16, 2009. A script for a Saunders Lumbar Home Trac was given based upon a diagnosis of sciatica. He was off work as of October 15, 2009 but the doctor felt he could return to work as of October 19, 2009. (PX 4, pp. 50-51)

Petitioner was seen at Decatur Memorial Hospital on November 18, 2009 for lower back pain that had begun in August of 2008. Dr. Heim had issued a script for Saunders Lumbar traction and Petitioner was being instructed in its use. (RX 4, pp. 123-132)

Petitioner returned to Dr. Heim on February 1, 2010 for a medication check. Petitioner reported occasional left anterior chest discomfort with more of a pleuritic component. No back complaints were noted or discussed. (PX 4, pp. 46-47)

Dr. Heim re-examined Petitioner on April 23, 2010 regarding his low back pain for which Petitioner reported he was "doing well." Petitioner was doing low back exercises, walking on a daily basis, keeping his weight under control and managing with a 25 pound weight restriction at work for which he needed "reaffirmation." He denied any discomfort down his legs and avoided lifting a lot of heavy objects at home. His back was non-tender and everything looked negative. Straight leg raising was negative. FABER did not pull into his back. He had normal deep tendon reflexes to his legs. Petitioner was advised to continue his medications, home physical therapy and weight loss. A note was given regarding his permanent 25 lb. weight restriction at home and at work. (PX 4, pp. 44-45; RX 1, p. 88)

Petitioner was re-examined in Respondent's medical department on April 26, 2010 regarding a "non-occ back check-up." Petitioner was noted to have 2 years of L5 disc discomfort. He was status post decompression surgery. Petitioner completed a pain drawing showing "pain" in the mid lower back region just above his buttocks. There is a reference to "Dr. Niehaus over 4 mo." And "LWT 6 mo – 2008." Petitioner wasn't taking any pain pills beyond Advil and didn't require a TENS unit. Petitioner reportedly could lift up to 10 lbs. "okay." His condition was described as "non-occ L5 lumbar disc disease" and he was to continue with Dr. Heim's restriction of 25 lbs. Petitioner was to return in a year for a review. (PX 3; RX 1)

According to Respondent's medical records, Petitioner was seen in the Medical Department on July 26, 2010 after undergoing a kidney stone lithotripsy on July 9, 2010 (Incident # 93036)(PX 3; See also RX 4, pp. 70 – 121). Petitioner had last worked on July 6, 2010 and was returning to work on July 26, 2010. He was given no new restrictions but was to continue his 25 lb. lifting restriction per Incident # 81752. (PX 3) Petitioner was cleared by Respondent's medical department to return to work on July 26, 2010. (RX 1, p. 95)

Respondent's Progress Notes from its medical department dated January 3, 2011 show that Petitioner had undergone surgery for an umbilical hernia on November 30, 2010. Petitioner was released to return to work with his previous 25# lifting restriction to remain in effect. (RX 1; RX 4, pp. 46- 69)

Petitioner presented to Dr. Heim on March 4, 2011 for a "workers' Comp" injury. Petitioner gave a history of right back pain radiating to his right flank area that had begun the day before. He also complained of a headache and desired some Avapro samples. Petitioner reported working at a work station for the last four days which he had not been stationed at for the better part of a year or so. The company had reportedly tried to make the work station more feasible for Petitioner with different wenches and tackle but he had to maneuver some heavy pieces of building equipment with his arms, upper body and trunk muscle which resulted in significant worsening after work. Petitioner was unable to go to work on the 4th and didn't feel he could work on the 5th due to muscle spasms to the right thoracic muscles radiating around the right mid chest. He denied any leg pain or sciatica. Advil wasn't helping. Petitioner moved around slowly with tenderness around the lower aspect of the right parascapular area along with tenderness to the right mid thoracic muscles and right mid chest wall. Straight leg raising was negative. FABER pulled into the right thoracic muscles. There was no tenderness across the lower back. Petitioner was taken off work as of March 4th but told he could resume work on March 7th. He was given a Prednisone taper and told to use heat and ice. Range of motion exercise was encouraged. Petitioner advised the doctor that "in the course of rotating work stations he will not be on the same work station for a long time. If he is not able to work on Monday '[he is] to get in touch [with the doctor.]'." (PX 4, pp. 35-36)

On March 8, 2011 Petitioner completed a Caterpillar Employee Incident Report regarding an accident on March 3, 2011 while working in Department 8336 Building B67C. Petitioner stated:

> Work in in dept. 8336 on load stand, load and unloading fixtures. dept. has a manual hoist in this area. I was pushing and pulling on parts on hoist all day, also large lifting device is hard on me whey [sic] putting it on and off the parts. Back was a little sore when I left work. I just thought this was normal because I have not done this job in about

4 yrs. I woke up Thursday night with bad pain in my mid back right

side. (PX 3; RX 1)

Petitioner reported a sharp dull pain in his right mid back. In response to the question "Have you had a prior injury to the affected body part/parts?" Petitioner replied "Yes" and stated "I have had a lower back injury." (PX 3) Petitioner further indicated that he was treating with Dr. Heim. The record notes the incident number as "99750." (PX 3) Petitioner completed a pain drawing showing right mid-back "minimal to mild" pain. Petitioner denied any radiating pain complaints and described his level of pain as "3/10." According to the narrative, "Petitioner injured back while running load stand." (PX 3)

Petitioner was examined by Respondent's nurse on March 8, 2011 in conjunction with incident number 99750. The nurse noted Petitioner had injured his right mid-back while running the load stand. (PX 3)

Petitioner was seen by the Medical Department on March 8, 2011 and a "Progress Note" was entered. Petitioner was complaining of mid-back pain spasms radiating to the "right side" that had awaken him. He had a history of a herniated disc at L5-S1 and permanent 25 # lifting restrictions (since 2008). Petitioner had undergone a spinal decompression in the past. Petitioner's back was reportedly feeling better that day. He had seen a doctor who put him on Prednisone and Skelaxin. Petitioner reported doing okay with getting in and out of a chair and going up steps or stairs and squatting. He could cross his legs. Petitioner's condition was described as lumbago. Petitioner was released to return to work with his 25# restriction and was to return if needed. (PX 3)

Petitioner completed another Caterpillar Employee Incident Report on March 30, 2011 after he fell backwards onto way covers in "4449" when his left foot caught on a wire cable. Petitioner noted right wrist, left shin, and right lower back injuries. He further mentioned "bruised." He denied receiving any medical care outside of Respondent at that time. (PX 3) Petitioner was seen by Respondent's nurse that same day regarding incident #100317. Petitioner's wrist was noted to be beginning to bruise. He was given ice for the wrist and antibiotic ointment and a band-aid for his shin. He was released to return to work. This was recorded as Incident # 100317. (PX 3)

According to Respondent's Medical "Progress Note" dated March 30, 2011 Petitioner was being seen for the first time after a fall that day at work. Petitioner complained of bruises and abrasions to his right wrist, left shin, and right buttocks. On exam, Petitioner's right wrist had some shallow abrasions on the radial side and was tender. There was no deformity, however. Petitioner also had abrasions on his left shin but no deformity. Petitioner buttock's area revealed tenderness with no other abnormalities. Petitioner was advised to use Advil, and ice. He was released to his regular job and told to come back the next day. (PX 3; RX 1) Petitioner completed a pain drawing showing achiness and minimal pain in his right lower back/buttocks region. (PX 3)

Petitioner was examined by Dr. Fabrique at Respondent's Occupational Health and Wellness Center on March 30, 2011. He was complaining of bruises and abrasions of his right wrist, left shin, and right buttock after falling at work earlier that day. His pain drawing was referenced (showing pain at the right wrist, left shin, and right lower back/hip region). Petitioner was noted to have a shallow abrasion on the radial side of his right wrist with tenderness but no deformity, an anterior medial abrasion of the left shin with tenderness but no bony deformity, and tenderness in the right mid-buttock without any other abnormalities. Petitioner was advised to use Advil and apply ice to the sore areas. He was able to return to work but was told to come back the next day. (PX 3; RX 1)

Petitioner returned to Respondent's medical department on March 31, 2011 as instructed. He reported being stiff and sore. His right wrist was sore and bruised and he had iced it the previous evening. Petitioner's right knee was sore also. Petitioner's range of motion for his back was normal. He was kept on his regular job and told to return on April 6, 2011. (PX 3; RX 1)

Petitioner was re-examined by Dr. Fabrique on March 31, 2011 and reported ongoing stiffness and soreness. His right knee was sore. Some swelling of the ulnar side of the right wrist was noted. He had full active range of motion. Dr. Fabrique's assessment was occupation contusion/abrasions of the right wrist, left leg, and right buttock. He was advised to return on April 6, 2011. (PX 3; RX 1)

Petitioner did not return to Respondent's Medical Department or Dr. Fabrique on April 6, 2011 as instructed. (PX 3)

Petitioner did, however, return to see Dr. Heim on April 11, 2011, to discuss medications as the Avapro (for his headaches) was too expensive. No low back or leg complaints were noted. (PX 4, p. 31)

Petitioner presented to Dr. Heim on July 20, 2011 due to a "flare-up" of his sciatica. According to the doctor's note the last time Petitioner had a flare-up was in 2008 and it was right sciatica. Petitioner was now reporting left sciatica explaining that he had been experiencing low back pain for the last month with worsening left sciatica in the preceding last five days. Petitioner had been utilizing his lumbar traction machine at home which helped minimally. He had been taking Advil as needed which helped minimally and, rarely, using Vicodin. Petitioner had not worked the 19th or 20th due to progressing pain. Petitioner moved around slowly. He had no significant tenderness across his low back. Straight leg raising was positive on the left and FABER pulled subtly into his left low back as well. Petitioner was started on Prednisone and told to continue the Vicodin as needed. He could use his lumbar traction. Petitioner was advised he could return to work on July 26, 2011 unless an extension was needed in which case he should call. (PX 4, pp. 29-30)

Petitioner returned to see Dr. Heim on August 15, 2011 regarding persistent back pain. His left sciatica was reportedly no better. The Prednisone was of minimal benefit. Petitioner had not worked since July 19, 2011 "when this all started." Petitioner commented that his right-sided sciatica had resolved after six months and he had seen the back specialist who did not highly suggest any surgical procedures. Petitioner had been using his inversion table with some improvement noted and Skelaxin helped decrease muscle spasms and walk better. Standing and lying down seemed to help his pain a lot. He denied any left leg weakness. Petitioner was able to walk a little more easily that day with some slight tenderness to the left low back being noted. Straight leg raising was positive on the left and FABER pulled slightly into the left low back. His legs were normal neurovascularly. Petitioner was to continue the Prednisone and return to work on September 20, 2011 but the doctor wanted to see him on the 19th. Petitioner was to resume Advil after the Prednisone was finished. They elected to hold off on the MRI for the time. (PX 4, pp. 27-28; RX 1)

As instructed Petitioner return to Dr. Heim on September 19, 2011 reporting about thirty percent improvement but with his work schedule and duties he didn't feel he could return to work at the present time. Petitioner noted he was looking for another job that would be less physically demanding on his body. Dr. Heim suggested Petitioner try the inversion t.i.d. which he had been using at home. The Prednisone had reportedly helped. Dr. Heim also noted that it had previously taken about six months for his sciatica to fully resolve. Petitioner was noted to be moving slowly with some tenderness to his low back. Straight leg lifting pulled significantly into the left back and was positive on the left side for sciatica. Petitioner's exam was essentially unchanged from the 15th of August. Dr. Heim provided

Petitioner with another ten day Prednisone course and kept him off work until October 19th. (PX 4, pp. 25-26; PX 7)

Petitioner returned to see Dr. Heim on October 17, 2011 as previously instructed. Petitioner reported that his left-sided sciatica improved and bout two weeks earlier was noted to be gone but the right-sided sciatica with calf discomfort had begun. He did not feel he could return to work. On exam, he moved very slowly. Standing and walking seemed to help the most. He had some mild tenderness to the lower lumbar muscles. Straight leg lifting was negative bilaterally but pulled into both sides of his low back. He was kept off work as of "July 19, 2011" through November 23, 2011. An MRI was ordered. Petitioner was to return on November 21, 2011. (PX 4, pp. 23-24; PX 7; RX 1)

Petitioner underwent a lumbar spine MRI on October 21, 2011 at Decatur Memorial Hospital. The impression was: (1) Foraminal encroachment on the right side at L5-S1, mildly impinging upon the right-sided nerve root sleeve within the foramen and (2) Degenerative changes of the lumbar spine, mild to moderate in appearance. (PX 4, p. 132; PX 5; RX 1; RX 4)

Petitioner presented to DMH Millennium Pain Center on October 31, 2011 regarding his low back pain. By history, Petitioner reported low back pain since 2008 which had worsened in August. He reported having a herniated disc and denying any accident or injury to his back, stating "just woke up in the morning and was in a lot of pain." Petitioner reported some days he was okay and some days he just couldn't move. He reported some numbness and tingling in his legs, more so on the left than the right. The pain would radiate down the back of his leg and into the thigh area. Petitioner also reported that he has some ankle pain and that it feels like it's broke. Petitioner was on Advil, having previously taken Vicodin and Prednisone. Advil seemed to work better than Vicodin. The doctor's assessment was a herniated disc at L4-5 and L5-S1 along with facet arthropathy, SI joint pain, and myofascial pain. An L4-5 ESI was recommended. (PX 8; RX 4)

Petitioner presented to DMH Millennium Pain Center on November 1, 2011 reporting no changes since his last visit of October 31, 2011. Petitioner underwent an L4-5 LESI. (PX 8; RX 4)

Petitioner reported back to Dr. Heim on November 11, 2011 regarding epidural injections. He had undergone one on November 1, 2011 and noticed some changes thereafter. The epidural helped significantly as the right sciatica resolved. His low back pain spasms and arthritic symptoms were still present, however. He was to return to the Pain Clinic next week. Dr. Heim noted, "Did also review that previously in 2008 he had a herniated disc at L4-5 and now he has continued herniation at L4-5 with some bulging discs that are worse at L5-S1." (PX 4, pp. 21-22)

As of November 21, 2011 Dr. Heim noted that Petitioner continued to have low back pain with some left sciatica, minimally occurring at present. The right sciatica had resolved with an injection. Petitioner stated that his pain had been ongoing since July 11, 2011 and he wished to see a surgeon. He was referred to Dr. Pencek and kept off work through January 17, 2012 at which time the doctor wished to re-examine him. (PX 4, p. 19; PX 7)

In anticipation of his upcoming appointment with Dr. Pencek, Petitioner completed a Questionnaire for the doctor on December 13, 2011. In it, he stated he was being seen for lower back pain and left leg pain. He didn't not state whether or not his injury was work-related (leaving the question unanswered) but denied it was related to an auto accident. He also did not address whether he had a lawsuit pending. (PX 5)

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 2910 on December 27, 2011 alleging an accident date of March 4, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX 5[3])

On January 10, 2012 Petitioner was examined by Dr. Pencek at St. Mary's in Decatur in regard to his left sciatic pain. Petitioner reported low back pain and left hip pain. At times, he noted bilateral hip pain. Petitioner also reported numbness and tingling in his left foot and the inability to bend or twist with pain or the ability to ride in a car for long distances. Petitioner reported injuring his back at work in 2008 at which time he was examined by Dr. Chu. Petitioner reported electing not to pursue surgery at that time preferring, instead, to be treated by a chiropractor. Petitioner, a machinist for Respondent, further reported that his pain was tolerable until March of 2011 when his workload at work increased and his symptoms progressively worsened. Petitioner had been off work since July 17, 2011. Petitioner further reported increased pain by leaning forward as it would result in a "shocking feeling" up his spine and out to the sides. Lying down would help as would steroids which Dr. Heim had prescribed to him. He had not done any therapy since 2008. He hadn't seen a chiropractor recently either. Petitioner had undergone an epidural steroid injection in November of 2011 which relieved his left leg pain but resulted in urinary incontinence for two weeks. Dr. Pencek noted some tenderness to palpation at the L5 region. Strength was 5/5 bilaterally with a steady gait and no need for assistance. He toe walked without difficulty. Heel walk reportedly caused pain as did flexion of the knee with resistance. Petitioner had positive straight leg raising at 30 degrees bilaterally with low back pain. Dorsiflexion while performing straight leg testing only increased pain on the right. Petitioner's MRI from 2011 revealed "black discs" at L4-5 and L5-S1. At L4-5 there was disc bulging mildly flattening the anterior aspect of the thecal sac. The neural foramen was patent. At L5-S1 there was moderate foraminal encroachment from a bulging disc on the right mildly impinging upon the right-sided L5 nerve root. Dr. Pencek recommended physical therapy. He noted a discogram might be necessary in the future. (PX 5)

Dr. Heim re-examined Petitioner on January 17, 2012. Petitioner's left sciatica was reportedly no better. Indeed, Petitioner felt they were sores. He had seen a neurosurgeon who ordered physical therapy for thirty days but it was not scheduled to begin until February 1, 2012. If physical therapy did not help a discogram was being recommended. In the meantime Petitioner was to remain off work. A prescription for lidocaine patches was given since they had helped before. On exam, Petitioner walked slowly around the office. He would sometimes sit on the exam table and sometimes not due to back discomfort. Petitioner had muscle spasms and tenderness around the low back. Straight leg lifting was positive. Petitioner was kept off work through March 13, 2012 ("tentatively"). (PX 4, pp. 17-18; PX 7)

Petitioner underwent four sessions of physical therapy beginning in mid-February of 2012. In conjunction with the initial examination he gave a history of onset in March of 2011 when he was pushing a hoist at work and noticed increased pain that evening. (PX 5; RX 4)

Petitioner followed up with Dr. Pencek on February 21, 2012 at which time he reported no improvement from the physical therapy. Dr. Pencek noted Petitioner had a large extruded disc at L4-5 on the right. A lumbar discogram was ordered. Petitioner was reporting low back pain, right hip pain, and right knee pain, worse since the discogram. (PX 5)

Petitioner underwent a brief course of physical therapy in February and March of 2012. (PX 5)

[3] Petitioner's counsel advised at trial that the original accident date alleged in the Application for Adjustment of Claim was March 4, 2011. It was subsequently amended to allege an accident date of March 3, 2011.

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 11599 on March 12, 2012 alleging an accident date of March 30, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX6)

Petitioner returned to see Dr. Heim on March 13, 2012 reporting he was scheduled for a discogram on March 29, 2012 and anticipated undergoing a lumbar laminectomy and spinal fusion. Petitioner remained unable to work with a limited level of activity although the doctor encouraged as much activity as possible. He also recommended trying to lose some weight before surgery. Medications were refilled. He was kept off work through June 14, 2012 and was to return for a visit on June 13, 2012. (PX 4, pp. 15-16)

Petitioner underwent a discogram on March 29, 2012 at St. Mary's Hospital in Decatur. The discogram, performed by Dr. Furry, was performed at three levels: L3-4, L4-5, and L5-S1. Dr. Furry noted the discogram was positive at L4-5. (PX 5)

Petitioner returned to see Dr. Heim on April 27, 2012 regarding his left sciatica which was continuing to be a significant problem. Petitioner had done more research and wished to be seen by Dr. Kovalsky in Mt. Vernon who was performing lumbar surgery with disc replacements rather than fusions. He was referred for a consultation. (PX 4, pp. 11-12)

Petitioner was examined by Dr. Kovalsky on May 16, 2012. According to the doctor's notes, Petitioner was a self-referral for evaluation of chronic low back pain. Petitioner reported being injured in 2008 and then re-injured himself in March of 2011. Petitioner had not been working since July of 2011. Petitioner initially tripped over a large part lying on the floor and grabbed a chain to keep from falling. He then twisted his back in the process and injured his back. Petitioner then re-injured his back lifting in March of 2011. Petitioner's primary complaint was low back pain. His secondary complaint was referred pain into his legs. Petitioner's back pain was reportedly constant and worse with activity. His leg pain was described as intermittent and worse on the left than the right. Dr. Kovalsky concluded that Petitioner was suffering from degenerative lumbar disc disease at L4-5 and L5-S1 along with a central disc herniation at L4-5 and a right central disc herniation at L5-S1. He felt Petitioner was a candidate for a two-level total disc arthroplasty at L4-5 and L5-S1. The doctor recommended a twenty pound weight loss prior to surgery. Once surgery was approved by workers' compensation the doctor recommended he be evaluated by Dr. Shores, his "access surgeon." In the interim he recommended continuing with medication per his family doctor. He remained unable to work. (PX 6)

On May 25, 2012 Petitioner signed his Application for Adjustment of Claim in case number 12 WC 19337 (AX 4). Petitioner alleged an accident date of August 1, 2008 when he was "injured at work." (AX 4)

Dr. Heim re-examined Petitioner on June 13, 2012 regarding his medications. Petitioner reported being scheduled for a two level lumbar laminectomy on August 28th, as his surgeon had undergone a hip replacement recently and would be unable to perform any surgeries until the end of August. Petitioner remained uncomfortable. He was kept off work as of July 19, 2011 with an anticipated return to work on October 8, 2012. He was to return to see the doctor sometime after his surgery and before the 8th. (PX 4, p. 10)

Petitioner returned to see Dr. Heim on October 1, 2012 noting his back surgery had been cancelled. Petitioner's surgery "was in arbitration" and he didn't know which surgery he would be undergoing. Petitioner reported decreased sleeping lately due to low back pain. He was having a lot of low back muscle spasms and throbbing at the present along with intermittent bilateral right and left leg sciatica issues. His left leg felt a little weak that day. Petitioner was not working. He was taking some Vicodin at

bedtime. He was told to resume a ten day course of Prednisone. Petitioner was to return the first week of January. He remained off work. (PX 4, p. 8)

Dr. Heim re-examined Petitioner on January 2, 2013 for his back. He was no better and his case was presently in a "review mode" which might take up to 180 days. Petitioner was still in a lot of discomfort and was using his Vicodin as needed. The Prednisone helped but only for a short while. He was to return to see the doctor on April 22, 2013 for an anticipated April 24th return to work. (PX 4, pp. 5-6)

Petitioner returned to see Dr. Heim on April 22, 2013 for a medication check-up. Petitioner reported significant low back pain. His appeal for low back surgery had been denied and his lawyer was working on other possibilities. Petitioner reported a lot of stress in his life for which he was taking some medication. His weight was down six pounds. He moved slowly around the office due to low back pain. He remained off work and his medications were continued. Petitioner was to return in four months for a recheck. (PX 4, pp. 3- 4)

Dr. Heim re-examined Petitioner on November 20, 2013 regarding his medications. Petitioner reported ongoing significant problems with his sciatica. His surgery had been denied. Dr. Heim was scheduled for a deposition. Petitioner had experienced right kidney stones which the doctor felt accounted for some ongoing right flank pain. Petitioner's weight was up a few pounds. He remained off work with a possible resumption date of April 2, 2014. (PX 4)

Deposition of Dr. Dennis Heim

The deposition of Dr. Dennis Heim was taken on December 10, 2013. (PX 1) Dr. Heim is board certified in family medicine. Dr. Heim testified consistently with his office notes discussed above. He testified that when he saw Petitioner on March 4, 2011 he did so due to significant low back pain that had begun on March 3rd and kept Petitioner from being able to work that day. Petitioner denied any prior significant pain in his low back. Dr. Heim testified that Petitioner had related to him that his job required him to move heavy pieces of building equipment with his arms, upper body and trunk muscles when he noticed the back discomfort. Dr. Heim recommended Petitioner not work for a few days and prescribed some Prednisone and Skelaxin to help with inflammation, swelling, and muscle spasms. Dr. Heim further acknowledged seeing Petitioner again on April 6 and April 11, 2011. He did not testify that these visits dealt with Petitioner's back. (PX 1, pp. 1-9)

Dr. Heim also testified that Petitioner returned to see him on July 20, 2011 regarding a flare-up in his left-sided sciatica. Petitioner's physical examination was consistent with left-sided sciatica (or pinching of a nerve) and the doctor again recommended Prednisone and Vicodin along with use of his home lumbar traction machine. He was taken off work. As of August 15, 2011 Petitioner's left sciatica was no better, his exam reflected mild tenderness in the left lower back, positive straight leg raising on the left, and a positive Faber on the left lower region of Petitioner's back. Petitioner told the doctor he had not been working since July 19, 2011 and the doctor kept him off work. He then re-examined Petitioner on September 19, 2011 noting the same complaints with some general improvement. Petitioner didn't feel he could return to work at that time. Dr. Heim examined him and felt he should remain off work. (PX 1, pp. 9- 12)

Dr. Heim further testified that when he examined Petitioner on October 17, 2011 Petitioner's left-sided sciatica had improved but he was now complaining of right-sided symptoms down his right leg. His use of the inversion therapy had not helped. He remained off work and the doctor ordered an MRI. Dr. Heim testified that he again saw Petitioner on November 11, 2011 at which time Petitioner was discussing the epidural steroid injections he was receiving and which had helped on the right side but not the left. Dr.

Heim testified that the MRI report revealed a herniated disc at L4-5 and a worsening bulging disc at L5-S1. Dr. Heim kept him off work. As of November 21, 2011 the right sciatica had resolved. The doctor testified that when he saw Petitioner on January 17, 2012 Petitioner felt his left-sided sciatica was getting worse. Petitioner was examined and felt to be unable to work. Lidoderm patches were prescribed for pain management. As of March 13, 2012 Petitioner was reporting that his activity level remained quite limited and he was scheduled for a discogram. Dr. Heim kept him off work. (PX 1, pp. 12 -18)

Dr. Heim testified that in April of 2012 he and Petitioner discussed a consultation with Dr. Kovalsky and the doctor referred Petitioner to him. Thereafter, Dr. Kovalsky examined him and subsequently recommended a two level fusion. Dr. Heim further testified that he saw Petitioner on October 1, 2012 noting Petitioner was upset that his surgery had been cancelled and he wasn't sleeping well because of his low back pain. Petitioner reported bilateral sciatica issues for which he was taking Vicodin. Petitioner also reported left leg weakness. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 18-20)

Dr. Heim testified that he again examined Petitioner in January and April of 2013 with ongoing back complaints and discomfort being noted. Petitioner was taking Vicodin as needed. In April Petitioner was complaining of stress because of his appeal for low back surgery being denied and he was having some other issues as well. Petitioner was moving very slowly due to his low back pain and remained unable to work. (PX 1, pp. 20-22)

Dr. Heim testified that he last saw Petitioner on November 20, 2013 for a medication check. Petitioner was still complaining of low back pain and issues with sciatica. Petitioner was also passing kidney stones, using his Skelaxin, Norco, and Lidoderm intermittently. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 22-23)

Dr. Heim was of the opinion that Petitioner had ongoing herniated discus and bulging discs which needed surgical repair. When asked if the injury Petitioner described to him could have caused or aggravated Petitioner's condition of ill-being, Dr. Heim testified that based upon the history he was provided on March 4, 2011 Petitioner had been doing well, returned to work, and had an injury at his work station that had resulted in a painful back with sciatica. He recommended the surgery proposed by Dr. Kovalsky noting that Petitioner has multiple level disc disease which would not benefit from being repaired at solely one level as it would be highly probable that adjacent levels would destabilize to the point of requiring a second surgery. (PX 1, pp. 23-25)

On cross-examination Dr. Heim testified that he has treated Petitioner since April 15, 1996. The doctor was unaware that Petitioner sustained a fall at work in 1994 that resulted in back pain. Dr. Heim also did not know if Petitioner had periodically been seen by Dr. Heimbrecht. Dr. Heim acknowledged correspondence from Dr. Heimbrecht dated January 22, 2001 noting a history of Petitioner having low back pain since a fall at work in 1994 which had resulted in sciatica that significantly impacted his ability to be mobile. (PX 1, pp. 25-28)

Dr. Heim also acknowledged seeing Petitioner on August 5, 2008 at which time Petitioner reported an acute worsening of his low back pain after stepping off a ladder and twisting. He also agreed that Petitioner then underwent an MRI in August of 2008 that showed a herniated disc at L4-5 and degenerative discs at L4-5 and L5-S1. (PX 1, pp. 28-30) On further cross-examination Dr. Heim also acknowledged that on August 14, 2008 he signed off on a two page disability form for Respondent at which time he indicated Petitioner's low back condition was not work-related. (PX 1, pp. 30-31)

Based upon the foregoing, Dr. Heim agreed that Petitioner had degeneration of his low back with a herniated disc and sciatica on two occasions prior to March of 2011. He also agreed that Petitioner's complaint on March 4, 2011 was thoracic pain radiating around his right mid chest. The doctor had no recollection of how high or low on Petitioner's thoracic spine or chest those pain complaints were. The doctor further agreed that Petitioner denied any leg or sciatic complaints at that time. Dr. Heim also agreed that when he saw Petitioner on April 6, 2011 he was complaining of left anterior chest discomfort which would have nothing to do with Petitioner's mid-back or low back. He also acknowledged that Petitioner voiced no low back complaints nor did he comment upon back pain at that visit. He also didn't mention anything about sciatica. Dr. Heim further testified that at the April 11, 2011 visit Petitioner told him his earlier back pain had resolved and he mentioned no sciatic complaints. (PX 1, pp. 31-34)

Dr. Heim also testified on cross-examination that Petitioner presented on July 20, 2011 with sciatic complaints that Petitioner associated with back pain for the preceding month and that the sciatica complaints had worsened in the previous five days. Dr. Heim further testified that Petitioner told him, at that time, that he had last experienced sciatica in 2008. Dr. Heim further testified that Dr. Heimbrecht had completed a Respondent disability form in July of 2011 and indicated Petitioner's condition was not related to his work. (PX 1, pp. 34-37) Dr. Heim also agreed that the first recorded complaint in 2011 of sciatica occurred on July 20, 2011. Dr. Heim also testified that when he saw Petitioner on March 4, 2011 Petitioner was not specifically talking about a sciatica issue. He also agreed that Petitioner's MRI in 2011 showed disc degeneration and sciatica issues and that those findings were also present in 2008 but the "wording was different." (PX 1, p. 38) He stated that his causal relationship opinion was based on an assumption that Petitioner had ongoing back pain or sciatica symptoms from March forward, which is not recorded anywhere in any of the records that he has or has been provided. (PX 1, pp. 34-40)

On redirect examination Dr. Heim testified that he has seen Petitioner for approximately 17 years, including occasions prior to March 4, 2011. As of March 4, 2011 he agreed Petitioner's back was "generally stable." He also agreed that prior to that visit they had not discussed a referral to a neurosurgeon. He also agreed that maneuvering heavy pieces of building equipment with one's arms, upper body and trunk muscles could aggravate or cause a disc herniation or degenerative disc disease leading to the necessity of a fusion. He also agreed that left foot tingling could be a sign of sciatica, disc herniation or an aggravation of degenerative disc disease. Dr. Heim also agreed that lumbago could indicate pain in one's lower back. Dr. Heim further agreed that one can have some low back pain and that as time progresses that pain increases in the low back and down one's leg. When asked if that could or might have been what happened to Petitioner, Dr. Heim replied it was possible that a person could have degenerative low back arthritis that could progress to cause sciatica and he believed that the type of injury Petitioner described to him could have aggravated his particular condition. (PX 1, pp. 40-44)

On further cross-examination, Dr. Heim agreed that tingling in one's left food can be caused by a variety of things. (PX 1, p. 45)

At the request of Respondent, Petitioner underwent an examination on February 4, 2014 with Dr. Sergey Neckrysh. In a letter to Respondent's attorney dated February 17, 2014 Dr. Neckrysh summarized his evaluation. (RX 2 – RX 2) In his report Dr. Neckrysh noted Petitioner gave a history of having sustained his first injury around August 1, 2008. At that time Petitioner was sent over by his supervisor to receive training and he fell into a hole in the ground. As he was falling down, he grabbed the chain hanging from the hoist and twisted his body in a "funny way" and he started complaining of left foot pain. Petitioner then presented to Dr. Heim on 8/5/08 who noted a history of back pain for one month

and an acute exacerbation while stepping off a ladder. Petitioner, thereafter, underwent an MRI on August 19, 2008. He followed up with Dr. Chu on September 8, 2008. While surgery for a right-sided disc herniation was discussed Petitioner decided not to undergo surgery, preferring, instead, to try chiropractic treatment. Petitioner did, in fact, undergo chiropractic treatment, from September 25, 2008 through March 11, 2009. He then followed up with Dr. Heim on August 14, 2008 and the doctor signed off on a disability form.

Dr. Neckrysh further noted in his report that Petitioner was subsequently seen by Dr. Bahrainwala, Respondent's company doctor, in February of 2009 who felt Petitioner had non-occupational low back pain. There were some additional visits in May of 2009 and Petitioner was eventually released to return to work with a 25 pound weight restriction. At that time Petitioner denied any numbness, tingling, or weakness.

According to Dr. Neckrysh's report Petitioner's next injury occurred after returning to work and working with a 2000 pound part that had a manual hoist which he had to attach the part to and then push the part along the production line. He would also have to stop the movement of the part by pulling with his body. He felt it was beyond his restrictions but his attempts to bring it to the company's attention were ignored. Then, on "March 3, 2011" Petitioner got his right foot caught and fell backwards experiencing back and right leg pain which the doctor noted was the primary issue of the evaluation that day. Dr. Neckrysh reviewed the Decatur Plant medical site notes along with Dr. Heim's records of that time. Dr. Neckrysh noted that Respondent's medical records reflected that Petitioner caught his left foot on a cable on March 30, 2011 and that Petitioner then fell backwards bruising his right wrist, left shin and right lower back. As of March 31, 2011 Petitioner had no focal abnormalities of his low back and his active range of motion was normal. The doctor further noted Dr. Heim's April 11, 2011 office visit which was silent regarding any lower back complaints and Dr. Heim's July 20, 2011 visit noting a "flare-up" in Petitioner's sciatica. Dr. Neckrysh noted that Petitioner was seen by Dr. Kurt Heimbrecht on July 20, 2011 who signed off that there was a causal relationship between the accident Petitioner had reported and the left sciatica. (RX 2 – RX 2, p. 3) Petitioner also told Dr. Neckrysh he had been referred for epidural injections but due to the side effects of the first one, he only underwent one injection.

Dr. Neckrysh also noted that Petitioner had resolved sciatica in the right leg as of November 21, 2011 but ongoing left sciatica as of January 17, 2012 when he was referred to Dr. Pencek. Dr. Neckrysh noted Petitioner's history to Dr. Pencek of having injured his back in 2008. Dr. Neckrysh also reviewed Petitioner's discogram. Petitioner had then been seen by Dr. Kovalsky who recommended surgery in the form of a two level disc arthroplasty but approval was denied. Since then Petitioner has been in a "holding pattern" as nobody will pay for his surgery.

Included in the doctor's report was a comment that Petitioner told him during the examination that his pain has always been in his left foot; however, the doctor noted various medical records documenting lower right foot pain. (RX 2 – res. ex. 2, p. 3)

On physical examination Petitioner was noted to walk in the room with "significant pain, grimacing on his face, jerking his right foot, claiming that it is still impossible for him to walk without support, and that he is using a walker." Examination of Petitioner's lower extremities was very limited due to Petitioner's subjective complaints of pain. He admitted to tenderness of the lumbar spine in the midline and upon palpation of bilateral sacroiliac joints. He did not display objective weakness on exam but every motor task in the lower extremities bilaterally was very limited due to pain complaints. Right side straight leg raising was positive at 40 degrees and crossed over to his left leg; left leg at 60 degrees. Petitioner could dorsiflex his feet but did so very dramatically. No films were available for the doctor to review.

Dr. Neckrysh was of the opinion that Petitioner had degenerative disease of his lumbar spine with complaints of right leg pain unsupported by any current imaging studies. The doctor further opined that Petitioner's current condition had "nothing to do" with Petitioner's performance of job duties on August 1, 2008, March 4, 2011 or March 30, 2011. He felt the timing of Petitioner's reported symptoms was inconsistent with work-related exacerbations or aggravations but more consistent with flare-ups of degenerative disc disease. He felt the MRI showed no surgical pathology but, rather, age appropriate disc degeneration at L4-5 and L5-S1 which still don't require surgery. Dr. Neckrysh acknowledged that the discograms reportedly showed annular tears at L4-5 and L5-S1 but discography is a highly controversial matter and he wouldn't base his clinical or surgical decisions on the results of a discogram. He further felt that Petitioner had fully recovered from his acute disc herniation in 2008.

Dr. Neckrysh was also of the opinion that Petitioner was at maximum medical improvement as a result of any of the injuries; however, further work-up of his degenerative disc disease and right leg pain would be warranted. If he were the treating doctor he would have Petitioner undergo an EMG to verify any radiculopathy. He would also try a diagnostic block at L4-5 on the right and send him to a neurosurgeon who specializes in spinal cord stimulation. He felt a two level disc arthroplasty was an unnecessary procedure as there is no data to support the benefits of such a procedure. He noted that Petitioner has complaints of right leg pain which such a procedure would not even potentially help. Finally, the doctor felt Petitioner needed no work-related restrictions and he couldn't verify Petitioner's complaints of leg pain. In his report the doctor noted that Petitioner was, on the day of his exam with him, stating that his pain was always in the left foot; however, the doctor noted multiple treating records surround the accident on August 1, 2008 show treatment for right foot pain. (RX 2 – RX 2)

Petitioner returned to see Dr. Heim on March 21, 2014 regarding his medications. Overall, Petitioner was not doing very well. He was still having significant problems with his sciatica and had been unable to walk very much because of it and bad weather. His case was in the legal system with depositions having been taken. He had undergone an examination with an independent physician who, in Petitioner's words, "did not really do anything that was of any objective unbiased examination." He was taking Norco 1 or 2 tablets a day and had had no further kidney stones since his last visit. His weight was up. Dr. Heim noted Petitioner could not do a lot of outdoor exercising because he was being monitored and watched by his work comp people so his exercise was limited. The doctor suggested he walk inside the house. Petitioner's ability to work was not addressed. (PX 4)

Petitioner was re-examined by Dr. Heim on April 25, 2014. No back complaints were noted. His weight was stable. The visit was for medications. (PX 4)

Dr. Heim again examined Petitioner regarding his back pain and medications on June 6, 2014. Petitioner was feeling more relaxed with Librium. He has been doing a little bit more walking and had been up to twenty minutes until his back significantly flared up with the walking. The back pain was so bad and the sciatica so bad (left leg) that he had to resume Prednisone for a short while. The sciatica was improving but not resolved. Petitioner's attorney was working on his case. He was noted to be moving slowly due to back and leg pain. Petitioner was to return in three months for blood pressure. No off work status was noted. (PX 4)

Deposition of Dr. Sergey Neckrysh

The deposition of Dr. Sergey Neckrysh was taken on September 4, 2014. (RX 2) Dr. Neckrysh testified consistent with his earlier written report. He was of the opinion that Petitioner's condition as of the date

of his examination was not causally related in any way to the incidents of August 1, 2008, March 4[4], 2011, or March 30, 2011. (RX 2, p. 11) Dr. Neckrysh acknowledged on cross-examination that he only examined Petitioner on one occasion. Dr. Neckrysh was also asked about some 2001 records he reviewed and he agreed that nothing in them suggested Petitioner needed back surgery or an MRI at that time or showed positive findings for sciatica, positive straight leg raising. (RX 2, pp. 25-27) Dr. Neckrysh agreed that, in general terms, one could herniate a disc or aggravate a pre-existing herniated disc stepping off a ladder and twisting. (RX 2, p. 28) He further agreed that if one fell backwards landing on their buttocks, it could aggravate a herniated disc. (RX 2, p. 29) He also acknowledged that Petitioner's symptoms improved somewhat after using his traction machine. He also testified that Dr. Niehaus' records suggested that Petitioner had a herniated disc and right leg pain for which surgery had been recommended but Petitioner decided not to pursue it. (RX 2, p. 31) He did not have an opinion as to whether or not Petitioner still needed surgery in March of 2009 because he did not undergo another MRI and the doctor didn't know if he still had right leg pain. He did acknowledge that Dr. Bahrainwala saw Petitioner on February 2, 2009 and noted Petitioner had no more pain, numbness, tingling or weakness. (RX 2, pp. 32-33)

Dr. Neckrysh was also asked to assume that on "May 3, 2011" Petitioner reported pushing and pulling on large fixtures all day and experiencing some back pain and then questioned whether such an activity could aggravate degenerative disc disease. Dr. Neckrysh replied "Yes and no. I mean, it could cause a temporary flare-up of the muscle pain, facet pain which usually are a very self-limiting event. (RX 2, p. 34) He was also asked to assume that on March 30, 2011 Petitioner fell and landed on his buttocks and then asked whether that event could aggravate the degenerative disc disease. Dr. Neckrysh replied that any fall or excessive physical load on the spine may produce soft tissue injury or symptoms but it will not effect in any way degeneration. (RX 2, p. 35) He did not believe such an injury could make asymptomatic degenerative disc disease symptomatic. (RX 2, pp. 35-37) He did acknowledge that a fall or trauma could trigger "an investigation" but one would need objective evidence of an injury on imaging studies or clinical exam by a neurosurgeon. Thus, the doctor agreed that a fall such as the one Petitioner had on March 30, 2011 would aggravate degenerative disc disease but it could cause a disc condition such as a herniation but absent objective evidence of a disc change, there would be no connection between the two. Back spasms after such a fall would indicate a soft tissue injury. (RX 2, p. 38) He also agreed that right buttock pain could be indicative of a number of things. (RX 2, p. 40)

Dr. Neckrysh testified that the discogram ordered by Dr. Pencek was positive at L4/5 which meant there was disruption or inflammation or pathology within the L4/5 disc which, for some surgeons, is sufficient to recommend surgery. However, Dr. Neckrysh, personally, would not recommend a fusion since there was no concordant level of pain. (RX 2, pp. 44-45)

On redirect examination Dr. Neckrysh acknowledged that the May 4, 2009 report of Dr. Bahrainwala suggested that Petitioner had fully recovered from his disc herniation noted in 2008. (RX 2, p. 52) He also agreed that the January 22, 2001 report from Family Medical Care noted back pain and sciatica, the latter of which indicated irritation to a nerve root. (RX 2, pp. 53-54) The doctor also agreed that the October 21, 2011 MRI did not indicate any new disc injury or herniation in Petitioner's lumbar spine. (RX 2, p. 54) On further cross-examination the doctor acknowledged that he only read the MRI report and did not actually read the film. (RX 2, p. 55)

Petitioner was re-examined by Dr. Heim on September 15, 2014 but the record is incomplete and any history and treatment plans were not provided. (PX 4)

[4] The date of accident was subsequently amended from March 4th to March 3rd

Deposition of Dr. Don Kovalsky

The deposition of Dr. Don Kovalsky was taken on October 14, 2015. (PX 2) Dr. Kovalsky is an orthopedic spine specialist board certified in orthopedic surgery with a subspecialty in spinal surgery. Dr. Kovalsky testified regarding his first visit with Petitioner in 2012 at which time Petitioner reported having back problems intermittently and then injuring himself in March of 2011. Petitioner told the doctor he was a machinist and had tried to work for a few months but then stopped working in July of 2011. Petitioner told the doctor he tripped over a large object or some sort of metallic part on the floor, tried to grab a chain to keep from falling and twisted his back in the process of doing so. He believed the original date of injury was 2008 followed by a re-injury in March of 2011 when he lifted a heavy object resulting in an increase in back pain as of March. When Dr. Kovalsky saw Petitioner in May of 2012 Petitioner was also reporting bilateral leg pain. Dr. Kovalsky testified that Petitioner's physical examination was consistent with mechanical back pain combined, possibly, with discogenic pain or disc disease. He felt Petitioner might have low grade instability due to the amount of pain he had with extension which would also be consistent with some facet arthritis. Dr. Kovalsky reviewed Petitioner's x-ray and MRI and felt they showed moderate narrowing of the L5-S1 disc space which would typically be a degenerative process as well as mild narrowing with the L4-5 disc space. The spine itself was stable. He also had some facet arthritis on the oblique views of his spine. He felt the MRI showed fairly significant narrowing of the L5-S1 disc space which would not be an acute finding. He also had a diffuse disc herniation at L5-S1 (more right than left sided) and he had mild disc dehydration (central disc herniation) at L4-5 that wasn't causing any significant nerve compression. There was some mild internal derangement of that disc which would be age related. He also had some facet arthritis at L4-5 and L5-S1. In summary Dr. Kovalsky felt Petitioner had pre-existing degenerative disc disease and discogenic pain that was aggravated by the work injury in 2011 when he tripped over a part. (PX 2, pp. 1- 10) Dr. Kovalsky testified that he has recommended an anterior fusion at L5-S1 and a disc replacement at L4-5. However, before doing so, he would need to see a new MRI and updated x-rays. (PX 2, pp. 10-14)

Dr. Kovalsky was asked to assume that on March 3, 2011 Petitioner was loading and unloading fixtures that required him to push and pull on parts on a hoist all day and that there was a "large lifting device" that was "hard on him" when he was putting on and off the parts and that while doing these activities Petitioner noticed back pain. Based upon that assumption Dr. Kovalsky testified that such an event could be the straw that broke the camel's back but not the sole cause of Petitioner's problem. (PX 2, pp. 14-15)

On cross-examination Dr. Kovalsky acknowledged that the only MRI he saw was from October 21, 2011. He further acknowledged being unfamiliar with Dr. Heim's records as he didn't review them. When shown Dr. Heim's March 4, 2011 office note he acknowledged that it did not refer to any lumbar complaints, only thoracic. He also acknowledged that the April 6, 2011 note of Dr. Heim didn't reflect any back complaints. He next acknowledged that Dr. Heim's July 20, 2011 office note records a history of low back pain for one month with a recent flare-up of sciatica. Finally, he acknowledged that Dr. Heim's note of August 15, 2011 suggests that all of Petitioner's complaints (low back and sciatica complaints) began on July 19, 2011 when he stopped working. (PX 2, pp. 16-20)

Dr. Kovalsky also agreed that Petitioner's degenerative disc disease at L4-5 and L5-S1 pre-dated the events of 2011. The doctor was then asked whether the histories as shown in Dr. Heim's records suggested that the condition for which Petitioner presented to him were no longer related to any work-related exacerbation in March of 2011 and the doctor said it was hard to say completely because in the July note there was no reference to actually when Petitioner was injured but Dr. Kovalsky acknowledged

that he didn't treat Petitioner at that time and the records certainly don't document an injury occurring in March. He testified, "It's a much more vague history than – he was having symptoms when that doctor saw him in July, but there was again no mention of a very specific date of onset." (PX 2, pp. 20-21) He further agreed that if one assumed the history in the July 2011 office note of an onset thirty days earlier that would not relate to an event in March. He further agreed that when Petitioner was seen by Dr. Heim in March he wasn't really complaining of lumbar pain; rather he had thoracic pain. (PX 2, p. 21)

Dr. Kovalsky testified that it would be impossible for him to say whether Petitioner's lumbar pain was related to any work incident. He testified, "I can't speak for Dr. Heim but, you know, based upon this [his records] he has no evidence in his records of a specific lumbar injury which occurred in March of 2011." (PX 2, p. 23) Dr. Kovalsky also testified that based upon his training and expertise Petitioner's pre-existing degenerative condition would be the kind of condition subject to exacerbation of back pain with normal activity or any sort of minor event that happens in everyday life. (PX 2, p. 23) He further added that with such disease one will have flare-ups and those flare-ups can become more frequent as the condition progresses resulting in increased pain and length. (PX 2, p. 23) Dr. Kovalsky also agreed that in light of Petitioner's pre-existing condition and Dr. Heim's July 20, 2011 office note, Petitioner had an onset in June of 2011 without any history of an aggravating event and that such an onset could be consistent with the natural progression of his degenerative disc disease. (PX 2, p. 24)

Dr. Kovalsky testified that Petitioner's radicular symptoms as of May 16, 2012 were mild, not severe, and he had no weakness, no sensory deficits, and no reflex changes. His straight leg raising test on the right was equivocal and mildly positive on the left as was the Valsalva test. He testified that nothing in Petitioner's clinical presentation indicated to him that Petitioner's radicular symptoms were traceable to L5-S1 rather than L4-5. He further added that Petitioner has an asymmetrical contained disc herniation on the right at L5-S1 and a small central disc herniation at L4-5 which doesn't appear to be causing any nerve compression whatsoever. He agreed that the positive results on clinical exam were on the left side, not the right side. Based upon the doctor's training and experience he did not feel Petitioner was a surgical candidate due to his radicular pain. (PX 2, pp. 24-29)

Dr. Kovalsky further acknowledged that he initially recommended a possible disc replacement at L5-S1 but he has stopped doing that because so many patients were starting to see problems. He was still recommending surgery at two levels so that L4-5 can act as a buffer zone. He is recommending the disc replacement at L4-5 rather than a fusion because patients are less likely to develop adjacent segment disease with the replacement as one is still allowing for motion. Dr. Kovalsky felt that if he fused Petitioner at L4-5 he had a 35 to 40 % chance of developing a surgical condition at L3-4. Dr. Kovalsky also testified that he would need to do additional imaging on Petitioner to determine if there has been any progression of Petitioner's facet arthritis such that he would need a fusion and not a disc replacement. He felt a disc replacement at L5-S1 for Petitioner was "out of the question" given the doctor's philosophical change and the fact Petitioner is much older and has facet arthritis dating back three years. (PX 2, pp. 29-43)

On redirect examination Dr. Kovalsky testified that Petitioner told him he had been having back pain since the March 2011 and that he had been experiencing episodes of back pain even before that which were usually self-limited. He further testified that if Petitioner had low back pain after the "March 11th" event and was never symptom free thereafter, it would support an aggravation theory. However, if he developed a symptom free interval thereafter, it would only be another exacerbation. "If he had symptoms in March and improved and then had recurrent of symptoms later on and it wasn't a work related episode, then you would chalk that flare up to exacerbation of a preexisting condition. So in

order for me to feel that this is work related those symptoms had to have started and remained persistent indefinitely after that specific period of pain." (PX 2, pp. 43-44)

Dr. Kovalsky was further asked to assume that at the time of the March 3, 2011 event Petitioner had to stop the movement of the 2,000 lb. part by pulling it with his body. Based upon that assumption, Dr. Kovalsky testified that such activities could exacerbate low back pain in someone with pre-existing degenerative disc disease. (XP 2, pp. 45-46)

Deposition of Dr. Kimberly Terry

The deposition of Dr. Kimberly Terry was taken on May 9, 2016. (RX 3) Dr. Kimberly Terry testified that she is a board certified neurosurgeon practicing in San Antonio, Texas. (RX 3) She testified that a two-level disc replacement was not medically necessary based on the records she reviewed and the ODG standards. (RX 3) She testified that disc arthroplasty is indicated for single-level degenerative disc disease and that multiple level disc arthroplasty would be outside of FDA indications. (R's E. 3) She prepared a supplemental report based on the subsequent suggestion of a fusion of L5-S1 and a disc replacement at L4-5. (RX 3) In reviewing this, she cited to another nationally recognized treatment guideline besides ODG; namely, the ACOEM which indicates that this proposed procedure was not medically necessary. (RX 3) She testified further that, again, the FDA indications for artificial disc replacement were inconsistent with this proposal as there is multi-level degenerative disc disease and there is little in the literature to support the efficacy and safety of this sort of procedure. (RX 3) She did concede that a radicular type of pain can be an indication that a fusion is medically necessary. (RX 3) Likewise, a positive straight leg raise would be one indication that a fusion might be medically necessary. (RX 3) She testified that it is "possible" that Petitioner could meet a standard of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies although she noted that he had a normal examination per the note of Dr. Kovalsky. (RX 3) There was no objective evidence of radiculopathy, only the subjective report of pain radiating down the leg. (RX 3) "Spinal segment collapse" under ODG would be significant degeneration of the disc space. (RX 3) When she cites to ACOEM regarding "severe and disabling lower leg symptoms," she is talking about the clinical findings on examination, such as reflexes, strength, and those kinds of things. (RX 3) She bases her opinions on the procedure that is proposed and she was asked if he needs a particular type of surgery. (RX 3) She stated that she would have to re-review everything, but Petitioner might be a candidate for a lumbar fusion. (RX 3)

The 19(b) Arbitration Hearing

Petitioner's three cases against Respondent proceeded to arbitration on August 18, 2016. They were consolidated for purposes of trial with separate decisions to issue. The issues in dispute in case # 12 WC 19337 were accident, causal connection, medical bills, temporary total disability, prospective medical, and the statute of limitations. The disputed issues in case # 12 WC 02910 were accident, causal connection, medical bills, temporary total disability, and prospective medical care. The disputed issues in case # 12 WC 11599 were causal connection, medical bills, temporary total disability benefits, and prospective medical care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was employed by Respondent on August 1, 2008, as a CNC machinist. In this job, he unloaded fixtures, kept machines running, changed tooling, performed quality inspections, and washed and readied parts for shipping. On August 1, 2008 Petitioner went from Section 8334 to Section 8336 to train another employee on the job at that location. He testified that as he was doing so, he was at a computer control panel and he stepped backward, at which time his foot went inside a part that

had been placed on the floor, unbeknownst to Petitioner. Petitioner testified that he started to fall over and he grabbed the chain of a hoist "real hard" to keep from falling. He testified that this jerked him and twisted him and he injured his back.

Petitioner testified that he went to Dr. Heim and was given a twenty-five pound lifting restriction.

Petitioner also testified that he filled out a weekly disability benefits form for Respondent on which he marked that an accidental injury was not involved. (PX 1, Dep. Ex. 4) Petitioner acknowledged that he didn't fill out an incident report. He indicated at arbitration that this was suggested by a supervisor since he was in line for a promotion.

Petitioner testified that he had some history of "muscle problems" in his back in the past, but denied that he had ever had nerve pain or sciatica before August 1, 2008. He denied having ever seen a Dr. Heimbrecht. He denied ever having nerve pain that radiated down his legs to his feet.

Petitioner acknowledged seeing a chiropractor and being released by same in February/March of 2009.

Petitioner acknowledged that he had been seen a few times by the doctors at the Caterpillar medical department after August 1, 2008.

Petitioner further testified that he was employed as a CNC machinist by Respondent at its Decatur facility on March 3, 2011. Petitioner testified that he was assigned to Section 8334 but was reassigned to Section 8336, which he claimed was outside of his lifting restrictions. Petitioner testified that he filed a grievance regarding the reassignment but was ultimately re-assigned to the section as he was told he would not have to work beyond his restriction. Petitioner testified that as of March 3, 2011 he was required to push a part that was well over 1,000 pounds on a manual jib hoist. He also testified that he had to pull 70 to 80 pound parts out of a tub down at floor level, bending at the waist in order to do that; however, he stated that when he injured his back, he was moving the part on the jib hoist. He introduced photographs, including a photograph of a large part on a hoist. (PX 10, p. 1) Petitioner indicated that he would have to slow down the part (acting like a brake) and, that as he was doing so, he noticed discomfort in his low back.

Petitioner testified that he sought medical treatment on March 4, 2011 with Dr. Heim.

Petitioner then testified that on March 30, 2011, he was inside a machine cleaning up chips when he stepped backward and his left foot caught on a wire, causing him to fall backward onto the side of the machine. He testified that he had pain in the lower and mid part of his back after this event. Petitioner testified that, thereafter, he returned to see Dr. Heim on July 20, 2011.

Petitioner testified that he hasn't worked since July 20, 2011 when Dr. Heim took him off work. Petitioner further testified that he has continued to treat with Dr. Heim who has referred him to both Dr. Pencek and Dr. Kovalsky. Petitioner testified that Dr. Kovalsky has recommended surgery and Petitioner would like to proceed with the surgery if the doctor still feels it is necessary.

Petitioner testified that as of the time of arbitration, his back always hurts and he is in pain. He indicated that he could not bend and could not do simple tasks around the house. He needed to lie down afterward if he did work outside. His back would get stiff and he could not function. Petitioner testified that his back was different after March 3, 2011 explaining that as long as he was following his

restrictions he didn't have a lot of issues. He acknowledged some occasional pain prior thereto but nothing like what he currently experiences.

Petitioner was asked if he treated for his back between March of 2009 and 2011 to which he replied that he had a home decompression unit that he used for treatment. Petitioner denied having a lifting restriction before August 1, 2008.

Petitioner also acknowledged that he reported mid-back pain to Respondent on March 8, 2011 and to Dr. Heim on March 4, 2011. When asked if he denied any low back or leg pain at that time he testified he was "sure they talked about it."

Petitioner also acknowledged working his regular job between March 30, 2011 and July 18, 2011 (Section 8334). He could not recall if he had any low back or leg complaints by March 31, 2011. Petitioner also testified that he filled out another disability form when he went off work as of July 20, 2011. Petitioner acknowledged seeing Dr. Kovalsky on one occasion in 2012.

On redirect examination Petitioner testified that he injured his low back on March 3, 2011; however, he didn't know why the records only referred to his mid-back as his lower back "has been an issue since 2008." Petitioner also testified that after the early March incident his back progressively worsened.

Petitioner's medical bills are found in PX 9. Included in PX 9 is a bill from Elite Care, LLC. In the amount of $8,853.65 for treatment rendered to Petitioner between September 25, 2008 and March 11, 2009.[5]

The Arbitrator concludes:

Issue (C): Did an accident occur on March 3, 2011 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove he sustained an accident to his low back on March 3, 2011 that arose out of and in the course of his employment with Respondent. This conclusion is based upon Petitioner's lack of credibility, generally, and a lack of corroboration for Petitioner's allegation and testimony that he injured his low back at work on March 3, 2011.

Petitioner has the burden of proving, by a preponderance of the credible evidence, all of the elements of his claim. *Parro v. Industrial Commission*, 250 Ill.App.3d 551, 553, 630 N.E.2d 860 (1993), *affirmed*, 167 Ill.2d 385 (1995). To obtain compensation under the Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b). Petitioner testified that on March 3, 2011, he was pushing a large part on a manual hoist weighing at least 1,000 pounds, which he would have to push and stop. He claimed at arbitration that he noticed discomfort in his low back while he did so. He introduced a photograph of a part similar to the one he was moving being moved on the hoist. (Exhibit 10A) He indicated that after the March 3, 2011 incident, his back condition "changed." As noted above, the Arbitrator does not find Petitioner's testimony credible.

While Petitioner did report right flank pain to Dr. Heim on March 4, 2011, Dr. Heim's exam (and deposition testimony) only referenced mid-thoracic pain and no low back pain.

[5] No office notes or records for these visits is a part of the record.

Additionally, Petitioner did not fill out an incident report at Respondent's medical department until March 8, 2011. (RX 1, p. 23) Thus, whatever occurred on March 3, 2011 was not so severe or significant so as to warrant the need to immediately report it or seek medical attention. When he did report to the medical department Petitioner indicated that his right mid-back was sore. (RX 1, p. 23) He was seen by a nurse practitioner, Jackie Clayton, who noted mid-back pain with spasms radiating to the right side which "woke him up." (RX 1, p. 26) There is no reference to low back pain or complaints by history or by illustration in Petitioner's pain drawing. At most, Petitioner was experiencing some mid-back/chest soreness that day which he associated with job activities. Petitioner was released to return to work that day with no restrictions attributable to the alleged incident. He then sought no further medical treatment for alleged low back complaints until March 30, 2011.

Petitioner was not forthright regarding his back problems prior to August of 2008 or even his date of employment with Respondent. In his early post-offer questionnaire with Respondent he either minimized the extent of any prior back problems or completely denied them. During the arbitration hearing Petitioner denied a long-standing history of sciatica and indicated that he had never seen a Dr. Heimbrecht. Evidence was introduced at arbitration, specifically January 22, 2001 correspondence of Dr. Heimbrecht, indicating that Petitioner had back pain ever since he fell at work in 1994, that he had symptoms of sciatica with straight leg raise testing being positive and radiation of the pain down the leg prior to August 1, 2008, and that with the slightest lifting or trauma, he had recurrence of his back pain. (PX 1, Dep. Ex. 2) Petitioner provided no credible explanation as to how or why he forgot this prior history. While it appears Petitioner's records of earlier treatment with Dr. Chu and Dr. Niehaus were available to both parties it is disturbing that Petitioner did not include them in the record or discuss them during his testimony.

Based on the sum total of the evidence, the Arbitrator concludes that Petitioner, given multiple inconsistencies and a lack of credibility, generally, has failed to prove he sustained an accident to his low back arising out of and in the course of the employment on March 3, 2011.

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

Even assuming, arguendo, that Petitioner sustained an accident on March 3, 2011, Petitioner failed to prove that his current condition of ill-being is causally related to that injury.

To obtain compensation under the Act, a Petitioner must prove that some act or phase of his or her employment was a causative factor in the ensuing injuries. *Land and Lakes Company v. Industrial Commission*, 359 Ill.App.3d 582, 592, 834 N.E.2d 583 (2005).

Petitioner testified at arbitration that in pushing a large part on a hoist on March 3, 2011, he suffered low back pain and discomfort. He referred to his job duties including reaching for parts in tubs, but specifically identified that pushing and stopping the large parts on the hoist as causing him to have pain in his low back. However, when Petitioner made an incident report at Respondent's plant medical department, he only complained of pain in his right mid-back. (RX 1, p. 23) When he saw the nurse practitioner, Jackie Clayton, he only complained of mid-back pain with spasms radiating to the right side which woke him up. (RX 1, p. 26)

Petitioner saw his primary care physician, Dr. Heim, on the following day, March 4, 2011, and complained of muscle spasms in the right thoracic muscles radiating around to his right mid chest. (PX

4, p. 14) He denied any leg pain or sciatica symptoms. (PX 4, p. 14) He was next seen by Dr. Heim on April 6, 2011, and only had complaints of anterior chest pain. (PX 2, Dep. Ex. 4). On April 11, 2011, he told Dr. Heim that his back pain he had experienced earlier in the month had resolved. (PX 1)

When Petitioner next saw Dr. Heim on July 20, 2011, he indicated that he was experiencing a flare-up of sciatica on the left. He stated that he had been having low back pain for the last month, but in the last five days, his sciatica had worsened. (PX 4, p. 17) When he followed up with Dr. Heim on August 15, 2011, he indicated that he had not been at work since July 19, 2011 "when this all started." (PX 4, p. 19) He indicated to Dr. Rehman, who provided him with an injection, that he had back pain since 2008, but the pain seemed to get worse back in August; he denied any accident or injury to his back and "just woke up in the morning and was in a lot of pain." (PX 8, p. 6)

As noted above under Issue "C" Petitioner denied, at arbitration, that he had ever seen a Dr. Heimbrecht. The medical evidence reflects that Dr. Heimbrecht had Petitioner as a patient as of January 22, 2001. (PX 1, Dep. Ex. 2). Dr. Heimbrecht noted at that time that Petitioner had a history of back pain ever since a fall at work in 1994. (PX 1, Dep. Ex. 2) He indicated that as of that time, Petitioner had sciatica with radiating pain down the leg and a positive straight leg raise test, and that with the slightest lifting or trauma, there is recurrence of his back pain. (PX 1, Dep. Ex. 2) Dr. Heimbrecht subsequently noted that Petitioner's subsequent off-work period beginning July 19, 2011, was not related to his work at Caterpillar. (PX 1, Dep. Ex. 5)

Dr. Heim testified at his deposition that the "injury that Mr. Johnston described" could have aggravated or caused his condition of ill-being. (PX 1) However, he stated that that opinion was based on the history he took on March 4, 2011, that Petitioner had an injury at his work station and "since that time, his back has been painful and he's had sciatica." (PX 1) He stated that it would be fair to say that any causal relationship opinion he offered was based on an assumption that Petitioner had ongoing back pain or sciatica symptoms from March forward, which he acknowledged was not recorded anywhere in any of the records that he had or had been provided. (PX 1) Furthermore, the Arbitrator concurs with Dr. Heim's assessment that the medical records fail to reflect ongoing back pain or sciatica from March of 2011 forward. Petitioner sought no treatment for his low back in May, June, or a substantial part of July in 2011. When he did resume treatment on July 20, 2011 Petitioner did not suggest that his visit that day was related to his March 3, 2011 incident. Rather he noted a "flare-up" of one month's duration and sciatica for the preceding last five days. He later told Dr. Heim that his lower back pain and sciatica began on July 19, 2011.

Dr. Don Kovalsky testified that, working on the assumption that on March 3, 2011, Mr. Johnston noticed back pain after pushing and pulling parts on a hoist all day, such activities like that can be the "straw that breaks the camel's back" and ultimately lead to a flare-up of back pain which never resolves. (PX 2) However, after reviewing the notes of Dr. Heim from March 4, 2011 through August 15, 2011, he stated that "it's hard to say" whether the condition, complaints and symptoms that he had when he presented to him were no longer related to any sort of work-related act or exacerbation based on the history on March 4 of thoracic pain radiating around to the chest without lumbar complaints or sciatica. (PX 2) He testified that he would agree that if the onset of symptoms is as reflected in his July visit, the symptoms would be unrelated to any sort of event in March although he had no knowledge personally of what Petitioner had done and the records were not "100% clear" as to when those symptoms actually started. (PX 2)

Respondent offered the opinion of Dr. Sergey Neckrysh, the Chief of Spine Surgery at University of Illinois at Chicago, that Petitioner's degenerative disease of the lumbar spine had nothing to do with Mr. Johnston's work duties or a specific accident on March 3, 2011. (RX 2) He felt that Petitioner had complaints of chronic back pain consistent with degenerative disease of the lumbar spine without any relationship to the alleged accidents. (PX 2) Pushing and pulling on large fixtures all day would produce symptoms related to other soft tissue surrounding the spine, and would not cause under any circumstances anything more than a temporary flare up of muscle and facet pain. (RX 2) Further, Petitioner did not have any verifiable complaints of leg pain and Neckrysh felt the back pain was mechanical in nature without quasi-discogenic components. (RX 2) It should be noted in this context that Dr. Neckrysh noted that Petitioner was walking around the room at the time of the examination with a significant amount of pain, jerking of the right foot, and using a walker because, purportedly, it was impossible for him to walk without support. (RX 2) None of these presentations were consistent with Petitioner's presentation in the hearing room at arbitration.

Based upon the sum total of the evidence, the Arbitrator concludes that Petitioner failed to meet his burden of proving that his current condition of ill-being with respect to his low back was causally related to an accident occurring on March 3, 2011. Petitioner's claim for compensation is denied and no benefits are awarded.

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 Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to the payment of medical expenses as outlined in Petitioner's Exhibit 9. No medical benefits are awarded.

Issue (K): Is Petitioner entitled to any prospective medical care?

Based upon the Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, above, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to the payment of future medical as outlined in the deposition of Dr. Kovalsky, his most recent treating surgeon. (PX 2) Petitioner has failed to prove that any such medical care would be causally related to an accident arising out of and in the course of the employment on or about March 3, 2011.

As a further basis of the Arbitrator's decision in this respect, the Arbitrator finds that Petitioner has failed to prove medical necessity of the surgical procedures proposed by Dr. Kovalsky. Dr. Kovalsky first proposed a two-level disc arthroplasty contingent upon any technical complications at the L5-S1 level. (PX 6, pp. 1-2) At his deposition, he amended this recommendation to a recommendation for a one-level fusion at L5-S1 and a disc arthroplasty at L4-5. (PX 2) He then opined that if Petitioner, on repeat radiographs had extensive facet arthritis, he might change the recommendation again to a two-level fusion with a disc arthroplasty at L3-4. (PX 2)

Respondent presented utilization review evidence by Dr. Terry establishing that nationally recognized treatment guidelines indicate that neither the two-level disc replacement originally proposed, nor the hybrid procedure of a fusion at L5-S1 and a disc arthroplasty at L4-5 were medically necessary or indicated. (RX 3) Dr. Terry noted that not only do the nationally recognized treatment

guidelines ODG and ACOEM indicate against the procedures alternatively proposed by Dr. Kovalsky, that FDA indications for lumbar disc replacement are for single-level degenerative disc disease which Petitioner did not have. (RX 3) This was true of both of the procedures recommended by Dr. Kovalsky. (RX 3). Beyond this, Dr. Neckrysh, the Chief of Spine Surgery at the University of Illinois at Chicago, indicated that the two-level disc arthroplasty proposed was an unnecessary procedure which had no data to support it and a lumbar arthroplasty does not have a remote potential of helping leg pain assuming that Petitioner had it. (RX 2, Dep. Ex. 2) Only when there is a confirmed diagnosis of discogenic back pain by discography and no other degenerative findings on the images or clinically, would a disc replacement be indicated. (RX 2) It appears that the statement that it was "absolutely necessary" was a typographical. (PX 2) Based upon the sum total of the evidence, given Dr. Kovalsky's admission that his originally planned procedure produced less than optimal results and his vagueness regarding what procedures would actually be performed, and the opinions of Dr. Terry and Dr. Neckrysh that the procedures proposed by Dr. Kovalsky were not consistent with nationally recognized treatment guidelines, FDA standards, or the circumstances under which such a procedure might be contemplated, the Arbitrator finds that Petitioner has failed to prove medical necessity for such a procedure. Prospective medical is, therefore, denied.

Issue (L): What temporary total disability benefits are in dispute – TTD?

Based upon the Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to temporary total disability benefits as claimed. The Arbitrator finds that the evidence fails to establish that Petitioner's condition of ill-being with respect to his low back was causally related to an accidental injury arising out of and in the course of the employment on or about March 3, 2011. Compensation for temporary total disability benefits is, therefore, denied.

Further, Dr. Neckrysh credibly testified that he could not recommend any work-related restrictions as of his IME of February 4, 2014, given Petitioner's unverifiable complaints. (PX 2) No doctor has certified him off work after the IME. (PX 7) This forms an additional basis for the denial of TTD after February 4, 2014.

****

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

Larry Johnston,

Petitioner,

vs. NO: 12 WC 11599

17IWCC0584

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 18, 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.

17IWCC0584

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: SEP 26 2017
TJT:yl
o 9/18/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

JOHNSTON, LARRY
Employee/Petitioner

Case# **12WC011599**

12WC019337
12WC002910

CATERPILLAR INC
Employer/Respondent

17IWCC0584

On 10/18/2016, 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 0.47% 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:

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

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

17IWCC0584

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Larry Johnston
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # **12** WC **11599**

Consolidated cases: **12 WC 19337**
12 WC 02910

An *Application for Adjustment 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 **August 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

17IWCC0584

FINDINGS

On the date of accident, **March 30, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,145.54**; the average weekly wage was **$859.10**.

On the date of accident, Petitioner was **50** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$49,270.66** for other benefits, for a total credit of **$49,270.66**.

Respondent is entitled to a credit of **$27,309.45** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being is causally connected to his injury of March 30, 2011. Petitioner further failed to prove he is entitled to payment of medical bills, temporary total disability benefits, or prospective medical care as a result of his injury of March 30, 2011. 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

October 13, 2016
Date

ICArbDec19(b)

OCT 18 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to medical records, in a letter dated January 22, 2001 Dr. Kurt J. Heimbrecht, a doctor affiliated with Family Medical Care of Decatur, stated that Petitioner had been experiencing back pain ever since he fell at work in 1994. Petitioner was noted to have symptoms of sciatica down his leg. He added, "With the slightest lifting or trauma there is recurrence of his back pain." The doctor went on to note a four day exacerbation for which he was recommending medication and physical therapy. (PX 1, dep. ex. 2)

In an August 7, 2001 Post Offer Medical-Factory Exam form from Respondent Petitioner denied any prior back pain, back surgery or numbness/tingling in his legs/feet; however, he acknowledged having consulted with a doctor about a back strain. (RX 1)

Petitioner completed a Post Offer Medical Questionnaire for Respondent on May 20, 2003. He denied any prior back surgery of any kind. He denied any prior back pain or injury. (RX 1)

Petitioner underwent a "Vehicle Operator Exam" for Respondent on December 11, 2003. He denied any chronic low back pain. (RX 1)

In March of 2006 Petitioner was treated at Decatur Memorial Hospital for gallstones. (RX 4)

In October of 2006 Petitioner was seen at Prairie Cardiovascular regarding cardiac issues. (RX 4)

Petitioner presented to Dr. Heim on August 5, 2008 regarding back pain. Petitioner gave a history of low back pain that "worsened acute[ly]" on August 1, 2008 when he stepped off a ladder and twisted, which "unfortunately messed up his back." Petitioner was reportedly unable to walk very well and noted pain radiating into his anterior thighs. Petitioner could not put his shoes on. He was using Skelaxin and Advil with minimal relief and was not sleeping well nor could he work for the last two days. Petitioner was observed walking very slowly with tenderness to his low back. Straight leg lifting pulled significantly into his low back at only 20 degrees. He was unable to perform FABER. Petitioner was taken off work from August 4, 2008 through August 7, 2008 and told to use heat and/or ice and perform exercises. He was to call if no better. (PX 4, pp. 62-63; PX 5)

Petitioner returned to see Dr. Heim on August 13, 2008 in regard to his "right sciatica" which was no better. The right anterior thigh discomfort had moved distally to the right lateral calf as well as to the foot which felt numb. Petitioner denied any left leg weakness but was so uncomfortable that he couldn't walk very well. Petitioner had been using Prednisone for five days which helped with discomfort but the tapering had not done so. He had also been using Tylenol as needed. Petitioner continued to move very slowly and with discomfort. He had mild tenderness to his right low back. Straight leg lifting was positive at 20 degrees of movement on the right side. He did not tolerate much extension of the right leg. Petitioner was instructed in a Prednisone regimen. An MRI of the lumbar spine was ordered and Petitioner was taken off work. FMLA papers were to be completed. (PX 4, pp. 60-61; PX 5)

Petitioner underwent lumbar spine x-rays at Decatur Memorial Hospital, per Dr. Heim, on August 19, 2008. According to the radiologist's report, Petitioner presented with a history of low back and right leg pain along with right leg numbness. The radiologist's impression was a large extruded herniated disc to the right of midline at L4-5, indenting upon the thecal sac at and medial to the origin of the right-sided nerve root sleeve while extending inferiorly to rest behind the posterior aspect of the L5 vertebral body on the right, posterior disc bulging at L5-S1, and L4-5, foraminal encroachment by disc bulge most evident on the right at L5-S1 and greater than at any other lumbar levels, and degenerative changes. (PX 5; RX 4)

After the MRI, Petitioner was advised of an appointment with Dr. Chu on August 25, 2008. (PX 5, notations on MRI report)

On September 8, 2008 Petitioner completed a Patient Profile Form. Petitioner indicated he was being seen for both back and right leg pain, with the back being more bothersome than the leg. Petitioner stated that his back pain had begun three weeks prior to August 1, 2008 but he noticed an increase in his pain on August 1, 2008. Petitioner was noted to have morning pain in his ankle and right buttock and numbness in the top of his right foot and his right big toe. He was taking Advil on a daily basis. Petitioner denied an injury or accident, marking that the back problem began "spontaneously." On the pain drawing, he marked lower back pain which was moderate in nature and staying the same. Petitioner reported that walking, standing, and sitting made his pain worse and that his leg felt weak from the knee down. Petitioner could only sit and stand comfortably for thirty minutes. He slept comfortably for two hours and could not walk comfortably whatsoever. Petitioner reported being unable to work since August 4, 2008 and that the following activities were limited because of his pain: dressing; light household chores; heavy household chores; social life; and travel. He had given up walking, swimming, and bike riding due to his pain. (PX 5)

Petitioner was examined by Dr. Chu on September 8, 2008. Dr. Chu felt Petitioner had a large herniated disc at L4-5. Petitioner told the doctor he had experienced back pain prior to August 1, 2008 but it was "not very significant." Petitioner told Dr. Chu that he started experiencing severe pain radiating down his ankle with numbness in his right foot, big toe and on top of his right foot all of which began on August 1, 2008. Petitioner described his pain as constant and moderate to severe since that time. Petitioner was uncertain as to whether he wished to proceed with surgery and he was instructed to return in two weeks with his MRI film which the doctor wished to review. (RX 2 – res. ex. 2, p. 2)[1]

Petitioner returned to see Dr. Chu two weeks later, advising him he did not wish to proceed with surgery as he wished to treat with a chiropractor instead. (RX 2 – res. ex. 2, p. 2)

Petitioner treated with a chiropractor, Dr. Eric Niehaus from September 25, 2008 through March 11, 2009. (RX 2 – res. ex. 2, p.2)[2]

On January 9, 2009 Dr. Niehaus released Petitioner to return to work with a 25 lb. lifting restriction which was to remain in effect until March 11, 2009 or until Petitioner was re-evaluated. (RX 1) Petitioner was cleared by Respondent to return to work on that date. (RX 1)

According to Respondent's company medical records Petitioner was seen on February 2, 2009 in follow-up for chiropractic care for spinal decompression. Petitioner had been released to return to work with restrictions for lower back pain. He was noted to have a herniated disc at L4-5. Petitioner denied any

[1] The actual records of Dr. Chu are not a part of the record.
[2] The actual records of Dr. Niehaus are not a part of the record.

further low back pain and was not taking any narcotics. He had been off work since August 4, 2008. He denied any numbness, tingling, or weakness in his lower extremity. He had normal range of motion with bilateral lower extremity strength and sensation. Petitioner was advised to return to see the company medical department once cleared for return to work at regular duty. (PX 3; RX 1)

According to Respondent's medical department records, Petitioner was seen in the medical department on February 20, 2009 for a herniated disc. There is a reference to Incident # 81752. He had last worked on August 3, 2008 and had returned to work on February 2, 2009. Petitioner had undergone a spinal decompression. Petitioner denied weakness, numbness, or tingling in his lower extremity. He was not on any medication and was no longer having lower back pain. There is reference to an incident date/procedure date of December 3, 2008. (PX 3)

Petitioner returned to Respondent's medical department on May 4, 2009 reporting he had been in physical therapy at his chiropractor's office and his back was good. He denied any more pain, numbness, tingling, or weakness. The assessment was "much improved lower back pain" and Petitioner was told to continue with his restrictions and return to see the company medical department once he was released to regular duty. (PX 3; RX 1)

Petitioner was examined by Dr. Heim on June 9, 2009 regarding his medications. He had last been seen in November of 2008. Petitioner reported his back was doing "very well." He had a herniated disc that was treated with decompression therapy and he had done well. Petitioner was on a 25 lb. weight lifting restriction at work without any problems and the doctor felt he should continue with that to keep his back healthy. Petitioner was noted to still be under some stresses and he was out of work, at least until August. Petitioner was taking a half tablet of Celexa daily. (PX 4, pp. 56- 57)

Dr. Heim re-examined Petitioner on October 19, 2009 regarding Petitioner's low back pain which had improved with Prednisone. Petitioner had also borrowed a piece of medical equipment called a Lumbar Home Trac that utilized a stretching of his lumbar spine. Petitioner reported that previous lumbar traction had helped and he wished to have his own medical equipment. He denied any leg weakness but was still on his Prednisone that began on October 16, 2009. A script for a Saunders Lumbar Home Trac was given based upon a diagnosis of sciatica. He was off work as of October 15, 2009 but the doctor felt he could return to work as of October 19, 2009. (PX 4, pp. 50-51)

Petitioner was seen at Decatur Memorial Hospital on November 18, 2009 for lower back pain that had begun in August of 2008. Dr. Heim had issued a script for Saunders Lumbar traction and Petitioner was being instructed in its use. (RX 4, pp. 123-132)

Petitioner returned to Dr. Heim on February 1, 2010 for a medication check. Petitioner reported occasional left anterior chest discomfort with more of a pleuritic component. No back complaints were noted or discussed. (PX 4, pp. 46-47)

Dr. Heim re-examined Petitioner on April 23, 2010 regarding his low back pain for which Petitioner reported he was "doing well." Petitioner was doing low back exercises, walking on a daily basis, keeping his weight under control and managing with a 25 pound weight restriction at work for which he needed "reaffirmation." He denied any discomfort down his legs and avoided lifting a lot of heavy objects at home. His back was non-tender and everything looked negative. Straight leg raising was negative. FABER did not pull into his back. He had normal deep tendon reflexes to his legs. Petitioner was advised to continue his medications, home physical therapy and weight loss. A note was given regarding his permanent 25 lb. weight restriction at home and at work. (PX 4, pp. 44-45; RX 1, p. 88)

Petitioner was re-examined in Respondent's medical department on April 26, 2010 regarding a "non-occ back check-up." Petitioner was noted to have 2 years of L5 disc discomfort. He was status post decompression surgery. Petitioner completed a pain drawing showing "pain" in the mid lower back region just above his buttocks. There is a reference to "Dr. Niehaus over 4 mo." And "LWT 6 mo – 2008." Petitioner wasn't taking any pain pills beyond Advil and didn't require a TENS unit. Petitioner reportedly could lift up to 10 lbs. "okay." His condition was described as "non-occ L5 lumbar disc disease" and he was to continue with Dr. Heim's restriction of 25 lbs. Petitioner was to return in a year for a review. (PX 3; RX 1)

According to Respondent's medical records, Petitioner was seen in the Medical Department on July 26, 2010 after undergoing a kidney stone lithotripsy on July 9, 2010 (Incident # 93036)(PX 3; See also RX 4, pp. 70 – 121). Petitioner had last worked on July 6, 2010 and was returning to work on July 26, 2010. He was given no new restrictions but was to continue his 25 lb. lifting restriction per Incident # 81752. (PX 3) Petitioner was cleared by Respondent's medical department to return to work on July 26, 2010. (RX 1, p. 95)

Respondent's Progress Notes from its medical department dated January 3, 2011 show that Petitioner had undergone surgery for an umbilical hernia on November 30, 2010. Petitioner was released to return to work with his previous 25# lifting restriction to remain in effect. (RX 1; RX 4, pp. 46- 69)

Petitioner presented to Dr. Heim on March 4, 2011 for a "workers' Comp" injury. Petitioner gave a history of right back pain radiating to his right flank area that had begun the day before. He also complained of a headache and desired some Avapro samples. Petitioner reported working at a work station for the last four days which he had not been stationed at for the better part of a year or so. The company had reportedly tried to make the work station more feasible for Petitioner with different wenches and tackle but he had to maneuver some heavy pieces of building equipment with his arms, upper body and trunk muscle which resulted in significant worsening after work. Petitioner was unable to go to work on the 4th and didn't feel he could work on the 5th due to muscle spasms to the right thoracic muscles radiating around the right mid chest. He denied any leg pain or sciatica. Advil wasn't helping. Petitioner moved around slowly with tenderness around the lower aspect of the right parascapular area along with tenderness to the right mid thoracic muscles and right mid chest wall. Straight leg raising was negative. FABER pulled into the right thoracic muscles. There was no tenderness across the lower back. Petitioner was taken off work as of March 4th but told he could resume work on March 7th. He was given a Prednisone taper and told to use heat and ice. Range of motion exercise was encouraged. Petitioner advised the doctor that "in the course of rotating work stations he will not be on the same work station for a long time. If he is not able to work on Monday '[he is] to get in touch [with the doctor.]'." (PX 4, pp. 35-36)

On March 8, 2011 Petitioner completed a Caterpillar Employee Incident Report regarding an accident on March 3, 2011 while working in Department 8336 Building B67C. Petitioner stated:

> Work in in dept. 8336 on load stand, load and unloading fixtures. dept. has a manual hoist in this area. I was pushing and pulling on parts on hoist all day, also large lifting device is hard on me whey [sic] putting it on and off the parts. Back was a little sore when I left work. I just thought this was normal because I have not done this job in about

4 yrs. I woke up Thursday night with bad pain in my mid back right

side. (PX 3; RX 1)

Petitioner reported a sharp dull pain in his right mid back. In response to the question "Have you had a prior injury to the affected body part/parts?" Petitioner replied "Yes" and stated "I have had a lower back injury." (PX 3) Petitioner further indicated that he was treating with Dr. Heim. The record notes the incident number as "99750." (PX 3) Petitioner completed a pain drawing showing right mid-back "minimal to mild" pain. Petitioner denied any radiating pain complaints and described his level of pain as "3/10." According to the narrative, "Petitioner injured back while running load stand." (PX 3)

Petitioner was examined by Respondent's nurse on March 8, 2011 in conjunction with incident number 99750. The nurse noted Petitioner had injured his right mid-back while running the load stand. (PX 3)

Petitioner was seen by the Medical Department on March 8, 2011 and a "Progress Note" was entered. Petitioner was complaining of mid-back pain spasms radiating to the "right side" that had awaken him. He had a history of a herniated disc at L5-S1 and permanent 25 # lifting restrictions (since 2008). Petitioner had undergone a spinal decompression in the past. Petitioner's back was reportedly feeling better that day. He had seen a doctor who put him on Prednisone and Skelaxin. Petitioner reported doing okay with getting in and out of a chair and going up steps or stairs and squatting. He could cross his legs. Petitioner's condition was described as lumbago. Petitioner was released to return to work with his 25# restriction and was to return if needed. (PX 3)

Petitioner completed another Caterpillar Employee Incident Report on March 30, 2011 after he fell backwards onto way covers in "4449" when his left foot caught on a wire cable. Petitioner noted right wrist, left shin, and right lower back injuries. He further mentioned "bruised." He denied receiving any medical care outside of Respondent at that time. (PX 3) Petitioner was seen by Respondent's nurse that same day regarding incident #100317. Petitioner's wrist was noted to be beginning to bruise. He was given ice for the wrist and antibiotic ointment and a band-aid for his shin. He was released to return to work. This was recorded as Incident # 100317. (PX 3)

According to Respondent's Medical "Progress Note" dated March 30, 2011 Petitioner was being seen for the first time after a fall that day at work. Petitioner complained of bruises and abrasions to his right wrist, left shin, and right buttocks. On exam, Petitioner's right wrist had some shallow abrasions on the radial side and was tender. There was no deformity, however. Petitioner also had abrasions on his left shin but no deformity. Petitioner buttock's area revealed tenderness with no other abnormalities. Petitioner was advised to use Advil, and ice. He was released to his regular job and told to come back the next day. (PX 3; RX 1) Petitioner completed a pain drawing showing achiness and minimal pain in his right lower back/buttocks region. (PX 3)

Petitioner was examined by Dr. Fabrique at Respondent's Occupational Health and Wellness Center on March 30, 2011. He was complaining of bruises and abrasions of his right wrist, left shin, and right buttock after falling at work earlier that day. His pain drawing was referenced (showing pain at the right wrist, left shin, and right lower back/hip region). Petitioner was noted to have a shallow abrasion on the radial side of his right wrist with tenderness but no deformity, an anterior medial abrasion of the left shin with tenderness but no bony deformity, and tenderness in the right mid-buttock without any other abnormalities. Petitioner was advised to use Advil and apply ice to the sore areas. He was able to return to work but was told to come back the next day. (PX 3; RX 1)

Petitioner returned to Respondent's medical department on March 31, 2011 as instructed. He reported being stiff and sore. His right wrist was sore and bruised and he had iced it the previous evening. Petitioner's right knee was sore also. Petitioner's range of motion for his back was normal. He was kept on his regular job and told to return on April 6, 2011. (PX 3; RX 1)

Petitioner was re-examined by Dr. Fabrique on March 31, 2011 and reported ongoing stiffness and soreness. His right knee was sore. Some swelling of the ulnar side of the right wrist was noted. He had full active range of motion. Dr. Fabrique's assessment was occupation contusion/abrasions of the right wrist, left leg, and right buttock. He was advised to return on April 6, 2011. (PX 3; RX 1)

Petitioner did not return to Respondent's Medical Department or Dr. Fabrique on April 6, 2011 as instructed. (PX 3)

Petitioner did, however, return to see Dr. Heim on April 11, 2011, to discuss medications as the Avapro (for his headaches) was too expensive. No low back or leg complaints were noted. (PX 4, p. 31)

Petitioner presented to Dr. Heim on July 20, 2011 due to a "flare-up" of his sciatica. According to the doctor's note the last time Petitioner had a flare-up was in 2008 and it was right sciatica. Petitioner was now reporting left sciatica explaining that he had been experiencing low back pain for the last month with worsening left sciatica in the preceding last five days. Petitioner had been utilizing his lumbar traction machine at home which helped minimally. He had been taking Advil as needed which helped minimally and, rarely, using Vicodin. Petitioner had not worked the 19th or 20th due to progressing pain. Petitioner moved around slowly. He had no significant tenderness across his low back. Straight leg raising was positive on the left and FABER pulled subtly into his left low back as well. Petitioner was started on Prednisone and told to continue the Vicodin as needed. He could use his lumbar traction. Petitioner was advised he could return to work on July 26, 2011 unless an extension was needed in which case he should call. (PX 4, pp. 29-30)

Petitioner returned to see Dr. Heim on August 15, 2011 regarding persistent back pain. His left sciatica was reportedly no better. The Prednisone was of minimal benefit. Petitioner had not worked since July 19, 2011 "when this all started." Petitioner commented that his right-sided sciatica had resolved after six months and he had seen the back specialist who did not highly suggest any surgical procedures. Petitioner had been using his inversion table with some improvement noted and Skelaxin helped decrease muscle spasms and walk better. Standing and lying down seemed to help his pain a lot. He denied any left leg weakness. Petitioner was able to walk a little more easily that day with some slight tenderness to the left low back being noted. Straight leg raising was positive on the left and FABER pulled slightly into the left low back. His legs were normal neurovascularly. Petitioner was to continue the Prednisone and return to work on September 20, 2011 but the doctor wanted to see him on the 19th. Petitioner was to resume Advil after the Prednisone was finished. They elected to hold off on the MRI for the time. (PX 4, pp. 27-28; RX 1)

As instructed Petitioner return to Dr. Heim on September 19, 2011 reporting about thirty percent improvement but with his work schedule and duties he didn't feel he could return to work at the present time. Petitioner noted he was looking for another job that would be less physically demanding on his body. Dr. Heim suggested Petitioner try the inversion t.i.d. which he had been using at home. The Prednisone had reportedly helped. Dr. Heim also noted that it had previously taken about six months for his sciatica to fully resolve. Petitioner was noted to be moving slowly with some tenderness to his low back. Straight leg lifting pulled significantly into the left back and was positive on the left side for sciatica. Petitioner's exam was essentially unchanged from the 15th of August. Dr. Heim provided

Petitioner with another ten day Prednisone course and kept him off work until October 19th. (PX 4, pp. 25-26; PX 7)

Petitioner returned to see Dr. Heim on October 17, 2011 as previously instructed. Petitioner reported that his left-sided sciatica improved and bout two weeks earlier was noted to be gone but the right-sided sciatica with calf discomfort had begun. He did not feel he could return to work. On exam, he moved very slowly. Standing and walking seemed to help the most. He had some mild tenderness to the lower lumbar muscles. Straight leg lifting was negative bilaterally but pulled into both sides of his low back. He was kept off work as of "July 19, 2011" through November 23, 2011. An MRI was ordered. Petitioner was to return on November 21, 2011. (PX 4, pp. 23-24; PX 7; RX 1)

Petitioner underwent a lumbar spine MRI on October 21, 2011 at Decatur Memorial Hospital. The impression was: (1) Foraminal encroachment on the right side at L5-S1, mildly impinging upon the right-sided nerve root sleeve within the foramen and (2) Degenerative changes of the lumbar spine, mild to moderate in appearance. (PX 4, p. 132; PX 5; RX 1; RX 4)

Petitioner presented to DMH Millennium Pain Center on October 31, 2011 regarding his low back pain. By history, Petitioner reported low back pain since 2008 which had worsened in August. He reported having a herniated disc and denying any accident or injury to his back, stating "just woke up in the morning and was in a lot of pain." Petitioner reported some days he was okay and some days he just couldn't move. He reported some numbness and tingling in his legs, more so on the left than the right. The pain would radiate down the back of his leg and into the thigh area. Petitioner also reported that he has some ankle pain and that it feels like it's broke. Petitioner was on Advil, having previously taken Vicodin and Prednisone. Advil seemed to work better than Vicodin. The doctor's assessment was a herniated disc at L4-5 and L5-S1 along with facet arthropathy, SI joint pain, and myofascial pain. An L4-5 ESI was recommended. (PX 8; RX 4)

Petitioner presented to DMH Millennium Pain Center on November 1, 2011 reporting no changes since his last visit of October 31, 2011. Petitioner underwent an L4-5 LESI. (PX 8; RX 4)

Petitioner reported back to Dr. Heim on November 11, 2011 regarding epidural injections. He had undergone one on November 1, 2011 and noticed some changes thereafter. The epidural helped significantly as the right sciatica resolved. His low back pain spasms and arthritic symptoms were still present, however. He was to return to the Pain Clinic next week. Dr. Heim noted, "Did also review that previously in 2008 he had a herniated disc at L4-5 and now he has continued herniation at L4-5 with some bulging discs that are worse at L5-S1." (PX 4, pp. 21-22)

As of November 21, 2011 Dr. Heim noted that Petitioner continued to have low back pain with some left sciatica, minimally occurring at present. The right sciatica had resolved with an injection. Petitioner stated that his pain had been ongoing since July 11, 2011 and he wished to see a surgeon. He was referred to Dr. Pencek and kept off work through January 17, 2012 at which time the doctor wished to re-examine him. (PX 4, p. 19; PX 7)

In anticipation of his upcoming appointment with Dr. Pencek, Petitioner completed a Questionnaire for the doctor on December 13, 2011. In it, he stated he was being seen for lower back pain and left leg pain. He didn't not state whether or not his injury was work-related (leaving the question unanswered) but denied it was related to an auto accident. He also did not address whether he had a lawsuit pending. (PX 5)

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 2910 on December 27, 2011 alleging an accident date of March 4, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX 5[3])

On January 10, 2012 Petitioner was examined by Dr. Pencek at St. Mary's in Decatur in regard to his left sciatic pain. Petitioner reported low back pain and left hip pain. At times, he noted bilateral hip pain. Petitioner also reported numbness and tingling in his left foot and the inability to bend or twist with pain or the ability to ride in a car for long distances. Petitioner reported injuring his back at work in 2008 at which time he was examined by Dr. Chu. Petitioner reported electing not to pursue surgery at that time preferring, instead, to be treated by a chiropractor. Petitioner, a machinist for Respondent, further reported that his pain was tolerable until March of 2011 when his workload at work increased and his symptoms progressively worsened. Petitioner had been off work since July 17, 2011. Petitioner further reported increased pain by leaning forward as it would result in a "shocking feeling" up his spine and out to the sides. Lying down would help as would steroids which Dr. Heim had prescribed to him. He had not done any therapy since 2008. He hadn't seen a chiropractor recently either. Petitioner had undergone an epidural steroid injection in November of 2011 which relieved his left leg pain but resulted in urinary incontinence for two weeks. Dr. Pencek noted some tenderness to palpation at the L5 region. Strength was 5/5 bilaterally with a steady gait and no need for assistance. He toe walked without difficulty. Heel walk reportedly caused pain as did flexion of the knee with resistance. Petitioner had positive straight leg raising at 30 degrees bilaterally with low back pain. Dorsiflexion while performing straight leg testing only increased pain on the right. Petitioner's MRI from 2011 revealed "black discs" at L4-5 and L5-S1. At L4-5 there was disc bulging mildly flattening the anterior aspect of the thecal sac. The neural foramen was patent. At L5-S1 there was moderate foraminal encroachment from a bulging disc on the right mildly impinging upon the right-sided L5 nerve root. Dr. Pencek recommended physical therapy. He noted a discogram might be necessary in the future. (PX 5)

Dr. Heim re-examined Petitioner on January 17, 2012. Petitioner's left sciatica was reportedly no better. Indeed, Petitioner felt they were sores. He had seen a neurosurgeon who ordered physical therapy for thirty days but it was not scheduled to begin until February 1, 2012. If physical therapy did not help a discogram was being recommended. In the meantime Petitioner was to remain off work. A prescription for lidocaine patches was given since they had helped before. On exam, Petitioner walked slowly around the office. He would sometimes sit on the exam table and sometimes not due to back discomfort. Petitioner had muscle spasms and tenderness around the low back. Straight leg lifting was positive. Petitioner was kept off work through March 13, 2012 ("tentatively"). (PX 4, pp. 17-18; PX 7)

Petitioner underwent four sessions of physical therapy beginning in mid-February of 2012. In conjunction with the initial examination he gave a history of onset in March of 2011 when he was pushing a hoist at work and noticed increased pain that evening. (PX 5; RX 4)

Petitioner followed up with Dr. Pencek on February 21, 2012 at which time he reported no improvement from the physical therapy. Dr. Pencek noted Petitioner had a large extruded disc at L4-5 on the right. A lumbar discogram was ordered. Petitioner was reporting low back pain, right hip pain, and right knee pain, worse since the discogram. (PX 5)

Petitioner underwent a brief course of physical therapy in February and March of 2012. (PX 5)

[3] Petitioner's counsel advised at trial that the original accident date alleged in the Application for Adjustment of Claim was March 4, 2011. It was subsequently amended to allege an accident date of March 3, 2011.

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 11599 on March 12, 2012 alleging an accident date of March 30, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX6)

Petitioner returned to see Dr. Heim on March 13, 2012 reporting he was scheduled for a discogram on March 29, 2012 and anticipated undergoing a lumbar laminectomy and spinal fusion. Petitioner remained unable to work with a limited level of activity although the doctor encouraged as much activity as possible. He also recommended trying to lose some weight before surgery. Medications were refilled. He was kept off work through June 14, 2012 and was to return for a visit on June 13, 2012. (PX 4, pp. 15-16)

Petitioner underwent a discogram on March 29, 2012 at St. Mary's Hospital in Decatur. The discogram, performed by Dr. Furry, was performed at three levels: L3-4, L4-5, and L5-S1. Dr. Furry noted the discogram was positive at L4-5. (PX 5)

Petitioner returned to see Dr. Heim on April 27, 2012 regarding his left sciatica which was continuing to be a significant problem. Petitioner had done more research and wished to be seen by Dr. Kovalsky in Mt. Vernon who was performing lumbar surgery with disc replacements rather than fusions. He was referred for a consultation. (PX 4, pp. 11-12)

Petitioner was examined by Dr. Kovalsky on May 16, 2012. According to the doctor's notes, Petitioner was a self-referral for evaluation of chronic low back pain. Petitioner reported being injured in 2008 and then re-injured himself in March of 2011. Petitioner had not been working since July of 2011. Petitioner initially tripped over a large part lying on the floor and grabbed a chain to keep from falling. He then twisted his back in the process and injured his back. Petitioner then re-injured his back lifting in March of 2011. Petitioner's primary complaint was low back pain. His secondary complaint was referred pain into his legs. Petitioner's back pain was reportedly constant and worse with activity. His leg pain was described as intermittent and worse on the left than the right. Dr. Kovalsky concluded that Petitioner was suffering from degenerative lumbar disc disease at L4-5 and L5-S1 along with a central disc herniation at L4-5 and a right central disc herniation at L5-S1. He felt Petitioner was a candidate for a two level total disc arthroplasty at L4-5 and L5-S1. The doctor recommended a twenty pound weight loss prior to surgery. Once surgery was approved by workers' compensation the doctor recommended he be evaluated by Dr. Shores, his "access surgeon." In the interim he recommended continuing with medication per his family doctor. He remained unable to work. (PX 6)

On May 25, 2012 Petitioner signed his Application for Adjustment of Claim in case number 12 WC 19337 (AX 4). Petitioner alleged an accident date of August 1, 2008 when he was "injured at work." (AX 4)

Dr. Heim re-examined Petitioner on June 13, 2012 regarding his medications. Petitioner reported being scheduled for a two level lumbar laminectomy on August 28th, as his surgeon had undergone a hip replacement recently and would be unable to perform any surgeries until the end of August. Petitioner remained uncomfortable. He was kept off work as of July 19, 2011 with an anticipated return to work on October 8, 2012. He was to return to see the doctor sometime after his surgery and before the 8th. (PX 4, p. 10)

Petitioner returned to see Dr. Heim on October 1, 2012 noting his back surgery had been cancelled. Petitioner's surgery "was in arbitration" and he didn't know which surgery he would be undergoing. Petitioner reported decreased sleeping lately due to low back pain. He was having a lot of low back muscle spasms and throbbing at the present along with intermittent bilateral right and left leg sciatica issues. His left leg felt a little weak that day. Petitioner was not working. He was taking some Vicodin at

bedtime. He was told to resume a ten day course of Prednisone. Petitioner was to return the first week of January. He remained off work. (PX 4, p. 8)

Dr. Heim re-examined Petitioner on January 2, 2013 for his back. He was no better and his case was presently in a "review mode" which might take up to 180 days. Petitioner was still in a lot of discomfort and was using his Vicodin as needed. The Prednisone helped but only for a short while. He was to return to see the doctor on April 22, 2013 for an anticipated April 24th return to work. (PX 4, pp. 5-6)

Petitioner returned to see Dr. Heim on April 22, 2013 for a medication check-up. Petitioner reported significant low back pain. His appeal for low back surgery had been denied and his lawyer was working on other possibilities. Petitioner reported a lot of stress in his life for which he was taking some medication. His weight was down six pounds. He moved slowly around the office due to low back pain. He remained off work and his medications were continued. Petitioner was to return in four months for a recheck. (PX 4, pp. 3- 4)

Dr. Heim re-examined Petitioner on November 20, 2013 regarding his medications. Petitioner reported ongoing significant problems with his sciatica. His surgery had been denied. Dr. Heim was scheduled for a deposition. Petitioner had experienced right kidney stones which the doctor felt accounted for some ongoing right flank pain. Petitioner's weight was up a few pounds. He remained off work with a possible resumption date of April 2, 2014. (PX 4)

Deposition of Dr. Dennis Heim

The deposition of Dr. Dennis Heim was taken on December 10, 2013. (PX 1) Dr. Heim is board certified in family medicine. Dr. Heim testified consistently with his office notes discussed above. He testified that when he saw Petitioner on March 4, 2011 he did so due to significant low back pain that had begun on March 3rd and kept Petitioner from being able to work that day. Petitioner denied any prior significant pain in his low back. Dr. Heim testified that Petitioner had related to him that his job required him to move heavy pieces of building equipment with his arms, upper body and trunk muscles when he noticed the back discomfort. Dr. Heim recommended Petitioner not work for a few days and prescribed some Prednisone and Skelaxin to help with inflammation, swelling, and muscle spasms. Dr. Heim further acknowledged seeing Petitioner again on April 6 and April 11, 2011. He did not testify that these visits dealt with Petitioner's back. (PX 1, pp. 1-9)

Dr. Heim also testified that Petitioner returned to see him on July 20, 2011 regarding a flare-up in his left-sided sciatica. Petitioner's physical examination was consistent with left-sided sciatica (or pinching of a nerve) and the doctor again recommended Prednisone and Vicodin along with use of his home lumbar traction machine. He was taken off work. As of August 15, 2011 Petitioner's left sciatica was no better, his exam reflected mild tenderness in the left lower back, positive straight leg raising on the left, and a positive Faber on the left lower region of Petitioner's back. Petitioner told the doctor he had not been working since July 19, 2011 and the doctor kept him off work. He then re-examined Petitioner on September 19, 2011 noting the same complaints with some general improvement. Petitioner didn't feel he could return to work at that time. Dr. Heim examined him and felt he should remain off work. (PX 1, pp. 9- 12)

Dr. Heim further testified that when he examined Petitioner on October 17, 2011 Petitioner's left-sided sciatica had improved but he was now complaining of right-sided symptoms down his right leg. His use of the inversion therapy had not helped. He remained off work and the doctor ordered an MRI. Dr. Heim testified that he again saw Petitioner on November 11, 2011 at which time Petitioner was discussing the epidural steroid injections he was receiving and which had helped on the right side but not the left. Dr.

Heim testified that the MRI report revealed a herniated disc at L4-5 and a worsening bulging disc at L5-S1. Dr. Heim kept him off work. As of November 21, 2011 the right sciatica had resolved. The doctor testified that when he saw Petitioner on January 17, 2012 Petitioner felt his left-sided sciatica was getting worse. Petitioner was examined and felt to be unable to work. Lidoderm patches were prescribed for pain management. As of March 13, 2012 Petitioner was reporting that his activity level remained quite limited and he was scheduled for a discogram. Dr. Heim kept him off work. (PX 1, pp. 12 -18)

Dr. Heim testified that in April of 2012 he and Petitioner discussed a consultation with Dr. Kovalsky and the doctor referred Petitioner to him. Thereafter, Dr. Kovalsky examined him and subsequently recommended a two level fusion. Dr. Heim further testified that he saw Petitioner on October 1, 2012 noting Petitioner was upset that his surgery had been cancelled and he wasn't sleeping well because of his low back pain. Petitioner reported bilateral sciatica issues for which he was taking Vicodin. Petitioner also reported left leg weakness. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 18-20)

Dr. Heim testified that he again examined Petitioner in January and April of 2013 with ongoing back complaints and discomfort being noted. Petitioner was taking Vicodin as needed. In April Petitioner was complaining of stress because of his appeal for low back surgery being denied and he was having some other issues as well. Petitioner was moving very slowly due to his low back pain and remained unable to work. (PX 1, pp. 20-22)

Dr. Heim testified that he last saw Petitioner on November 20, 2013 for a medication check. Petitioner was still complaining of low back pain and issues with sciatica. Petitioner was also passing kidney stones, using his Skelaxin, Norco, and Lidoderm intermittently. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 22-23)

Dr. Heim was of the opinion that Petitioner had ongoing herniated discus and bulging discs which needed surgical repair. When asked if the injury Petitioner described to him could have caused or aggravated Petitioner's condition of ill-being, Dr. Heim testified that based upon the history he was provided on March 4, 2011 Petitioner had been doing well, returned to work, and had an injury at his work station that had resulted in a painful back with sciatica. He recommended the surgery proposed by Dr. Kovalsky noting that Petitioner has multiple level disc disease which would not benefit from being repaired at solely one level as it would be highly probable that adjacent levels would destabilize to the point of requiring a second surgery. (PX 1, pp. 23-25)

On cross-examination Dr. Heim testified that he has treated Petitioner since April 15, 1996. The doctor was unaware that Petitioner sustained a fall at work in 1994 that resulted in back pain. Dr. Heim also did not know if Petitioner had periodically been seen by Dr. Heimbrecht. Dr. Heim acknowledged correspondence from Dr. Heimbrecht dated January 22, 2001 noting a history of Petitioner having low back pain since a fall at work in 1994 which had resulted in sciatica that significantly impacted his ability to be mobile. (PX 1, pp. 25-28)

Dr. Heim also acknowledged seeing Petitioner on August 5, 2008 at which time Petitioner reported an acute worsening of his low back pain after stepping off a ladder and twisting. He also agreed that Petitioner then underwent an MRI in August of 2008 that showed a herniated disc at L4-5 and degenerative discs at L4-5 and L5-S1. (PX 1, pp. 28-30) On further cross-examination Dr. Heim also acknowledged that on August 14, 2008 he signed off on a two page disability form for Respondent at which time he indicated Petitioner's low back condition was not work-related. (PX 1, pp. 30-31)

Based upon the foregoing, Dr. Heim agreed that Petitioner had degeneration of his low back with a herniated disc and sciatica on two occasions prior to March of 2011. He also agreed that Petitioner's complaint on March 4, 2011 was thoracic pain radiating around his right mid chest. The doctor had no recollection of how high or low on Petitioner's thoracic spine or chest those pain complaints were. The doctor further agreed that Petitioner denied any leg or sciatic complaints at that time. Dr. Heim also agreed that when he saw Petitioner on April 6, 2011 he was complaining of left anterior chest discomfort which would have nothing to do with Petitioner's mid-back or low back. He also acknowledged that Petitioner voiced no low back complaints nor did he comment upon back pain at that visit. He also didn't mention anything about sciatica. Dr. Heim further testified that at the April 11, 2011 visit Petitioner told him his earlier back pain had resolved and he mentioned no sciatic complaints. (PX 1, pp. 31-34)

Dr. Heim also testified on cross-examination that Petitioner presented on July 20, 2011 with sciatic complaints that Petitioner associated with back pain for the preceding month and that the sciatica complaints had worsened in the previous five days. Dr. Heim further testified that Petitioner told him, at that time, that he had last experienced sciatica in 2008. Dr. Heim further testified that Dr. Heimbrecht had completed a Respondent disability form in July of 2011 and indicated Petitioner's condition was not related to his work. (PX 1, pp. 34-37) Dr. Heim also agreed that the first recorded complaint in 2011 of sciatica occurred on July 20, 2011. Dr. Heim also testified that when he saw Petitioner on March 4, 2011 Petitioner was not specifically talking about a sciatica issue. He also agreed that Petitioner's MRI in 2011 showed disc degeneration and sciatica issues and that those findings were also present in 2008 but the "wording was different." (PX 1, p. 38) He stated that his causal relationship opinion was based on an assumption that Petitioner had ongoing back pain or sciatica symptoms from March forward, which is not recorded anywhere in any of the records that he has or has been provided. (PX 1, pp. 34-40)

On redirect examination Dr. Heim testified that he has seen Petitioner for approximately 17 years, including occasions prior to March 4, 2011. As of March 4, 2011 he agreed Petitioner's back was "generally stable." He also agreed that prior to that visit they had not discussed a referral to a neurosurgeon. He also agreed that maneuvering heavy pieces of building equipment with one's arms, upper body and trunk muscles could aggravate or cause a disc herniation or degenerative disc disease leading to the necessity of a fusion. He also agreed that left foot tingling could be a sign of sciatica, disc herniation or an aggravation of degenerative disc disease. Dr. Heim also agreed that lumbago could indicate pain in one's lower back. Dr. Heim further agreed that one can have some low back pain and that as time progresses that pain increases in the low back and down one's leg. When asked if that could or might have been what happened to Petitioner, Dr. Heim replied it was possible that a person could have degenerative low back arthritis that could progress to cause sciatica and he believed that the type of injury Petitioner described to him could have aggravated his particular condition. (PX 1, pp. 40-44)

On further cross-examination, Dr. Heim agreed that tingling in one's left food can be caused by a variety of things. (PX 1, p. 45)

At the request of Respondent, Petitioner underwent an examination on February 4, 2014 with Dr. Sergey Neckrysh. In a letter to Respondent's attorney dated February 17, 2014 Dr. Neckrysh summarized his evaluation. (RX 2 – RX 2) In his report Dr. Neckrysh noted Petitioner gave a history of having sustained his first injury around August 1, 2008. At that time Petitioner was sent over by his supervisor to receive training and he fell into a hole in the ground. As he was falling down, he grabbed the chain hanging from the hoist and twisted his body in a "funny way" and he started complaining of left foot pain. Petitioner then presented to Dr. Heim on 8/5/08 who noted a history of back pain for one month

and an acute exacerbation while stepping off a ladder. Petitioner, thereafter, underwent an MRI on August 19, 2008. He followed up with Dr. Chu on September 8, 2008. While surgery for a right-sided disc herniation was discussed Petitioner decided not to undergo surgery, preferring, instead, to try chiropractic treatment. Petitioner did, in fact, undergo chiropractic treatment, from September 25, 2008 through March 11, 2009. He then followed up with Dr. Heim on August 14, 2008 and the doctor signed off on a disability form.

Dr. Neckrysh further noted in his report that Petitioner was subsequently seen by Dr. Bahrainwala, Respondent's company doctor, in February of 2009 who felt Petitioner had non-occupational low back pain. There were some additional visits in May of 2009 and Petitioner was eventually released to return to work with a 25 pound weight restriction. At that time Petitioner denied any numbness, tingling, or weakness.

According to Dr. Neckrysh's report Petitioner's next injury occurred after returning to work and working with a 2000 pound part that had a manual hoist which he had to attach the part to and then push the part along the production line. He would also have to stop the movement of the part by pulling with his body. He felt it was beyond his restrictions but his attempts to bring it to the company's attention were ignored. Then, on "March 3, 2011" Petitioner got his right foot caught and fell backwards experiencing back and right leg pain which the doctor noted was the primary issue of the evaluation that day. Dr. Neckrysh reviewed the Decatur Plant medical site notes along with Dr. Heim's records of that time. Dr. Neckrysh noted that Respondent's medical records reflected that Petitioner caught his left foot on a cable on March 30, 2011 and that Petitioner then fell backwards bruising his right wrist, left shin and right lower back. As of March 31, 2011 Petitioner had no focal abnormalities of his low back and his active range of motion was normal. The doctor further noted Dr. Heim's April 11, 2011 office visit which was silent regarding any lower back complaints and Dr. Heim's July 20, 2011 visit noting a "flare-up" in Petitioner's sciatica. Dr. Neckrysh noted that Petitioner was seen by Dr. Kurt Heimbrecht on July 20, 2011 who signed off that there was a causal relationship between the accident Petitioner had reported and the left sciatica. (RX 2 – RX 2, p. 3) Petitioner also told Dr. Neckrysh he had been referred for epidural injections but due to the side effects of the first one, he only underwent one injection.

Dr. Neckrysh also noted that Petitioner had resolved sciatica in the right leg as of November 21, 2011 but ongoing left sciatica as of January 17, 2012 when he was referred to Dr. Pencek. Dr. Neckrysh noted Petitioner's history to Dr. Pencek of having injured his back in 2008. Dr. Neckrysh also reviewed Petitioner's discogram. Petitioner had then been seen by Dr. Kovalsky who recommended surgery in the form of a two level disc arthroplasty but approval was denied. Since then Petitioner has been in a "holding pattern" as nobody will pay for his surgery.

Included in the doctor's report was a comment that Petitioner told him during the examination that his pain has always been in his left foot; however, the doctor noted various medical records documenting lower right foot pain. (RX 2 – res. ex. 2, p. 3)

On physical examination Petitioner was noted to walk in the room with "significant pain, grimacing on his face, jerking his right foot, claiming that it is still impossible for him to walk without support, and that he is using a walker." Examination of Petitioner's lower extremities was very limited due to Petitioner's subjective complaints of pain. He admitted to tenderness of the lumbar spine in the midline and upon palpation of bilateral sacroiliac joints. He did not display objective weakness on exam but every motor task in the lower extremities bilaterally was very limited due to pain complaints. Right side straight leg raising was positive at 40 degrees and crossed over to his left leg; left leg at 60 degrees. Petitioner could dorsiflex his feet but did so very dramatically. No films were available for the doctor to review.

Dr. Neckrysh was of the opinion that Petitioner had degenerative disease of his lumbar spine with complaints of right leg pain unsupported by any current imaging studies. The doctor further opined that Petitioner's current condition had "nothing to do" with Petitioner's performance of job duties on August 1, 2008, March 4, 2011 or March 30, 2011. He felt the timing of Petitioner's reported symptoms was inconsistent with work-related exacerbations or aggravations but more consistent with flare-ups of degenerative disc disease. He felt the MRI showed no surgical pathology but, rather, age appropriate disc degeneration at L4-5 and L5-S1 which still don't require surgery. Dr. Neckrysh acknowledged that the discograms reportedly showed annular tears at L4-5 and L5-S1 but discography is a highly controversial matter and he wouldn't base his clinical or surgical decisions on the results of a discogram. He further felt that Petitioner had fully recovered from his acute disc herniation in 2008.

Dr. Neckrysh was also of the opinion that Petitioner was at maximum medical improvement as a result of any of the injuries; however, further work-up of his degenerative disc disease and right leg pain would be warranted. If he were the treating doctor he would have Petitioner undergo an EMG to verify any radiculopathy. He would also try a diagnostic block at L4-5 on the right and send him to a neurosurgeon who specializes in spinal cord stimulation. He felt a two level disc arthroplasty was an unnecessary procedure as there is no data to support the benefits of such a procedure. He noted that Petitioner has complaints of right leg pain which such a procedure would not even potentially help. Finally, the doctor felt Petitioner needed no work-related restrictions and he couldn't verify Petitioner's complaints of leg pain. In his report the doctor noted that Petitioner was, on the day of his exam with him, stating that his pain was always in the left foot; however, the doctor noted multiple treating records surround the accident on August 1, 2008 show treatment for right foot pain. (RX 2 – RX 2)

Petitioner returned to see Dr. Heim on March 21, 2014 regarding his medications. Overall, Petitioner was not doing very well. He was still having significant problems with his sciatica and had been unable to walk very much because of it and bad weather. His case was in the legal system with depositions having been taken. He had undergone an examination with an independent physician who, in Petitioner's words, "did not really do anything that was of any objective unbiased examination." He was taking Norco 1 or 2 tablets a day and had had no further kidney stones since his last visit. His weight was up. Dr. Heim noted Petitioner could not do a lot of outdoor exercising because he was being monitored and watched by his work comp people so his exercise was limited. The doctor suggested he walk inside the house. Petitioner's ability to work was not addressed. (PX 4)

Petitioner was re-examined by Dr. Heim on April 25, 2014. No back complaints were noted. His weight was stable. The visit was for medications. (PX 4)

Dr. Heim again examined Petitioner regarding his back pain and medications on June 6, 2014. Petitioner was feeling more relaxed with Librium. He has been doing a little bit more walking and had been up to twenty minutes until his back significantly flared up with the walking. The back pain was so bad and the sciatica so bad (left leg) that he had to resume Prednisone for a short while. The sciatica was improving but not resolved. Petitioner's attorney was working on his case. He was noted to be moving slowly due to back and leg pain. Petitioner was to return in three months for blood pressure. No off work status was noted. (PX 4)

Deposition of Dr. Sergey Neckrysh

The deposition of Dr. Sergey Neckrysh was taken on September 4, 2014. (RX 2) Dr. Neckrysh testified consistent with his earlier written report. He was of the opinion that Petitioner's condition as of the date

of his examination was not causally related in any way to the incidents of August 1, 2008, March 4[4], 2011, or March 30, 2011. (RX 2, p. 11) Dr. Neckrysh acknowledged on cross-examination that he only examined Petitioner on one occasion. Dr. Neckrysh was also asked about some 2001 records he reviewed and he agreed that nothing in them suggested Petitioner needed back surgery or an MRI at that time or showed positive findings for sciatica, positive straight leg raising. (RX 2, pp. 25-27) Dr. Neckrysh agreed that, in general terms, one could herniate a disc or aggravate a pre-existing herniated disc stepping off a ladder and twisting. (RX 2, p. 28) He further agreed that if one fell backwards landing on their buttocks, it could aggravate a herniated disc. (RX 2, p. 29) He also acknowledged that Petitioner's symptoms improved somewhat after using his traction machine. He also testified that Dr. Niehaus' records suggested that Petitioner had a herniated disc and right leg pain for which surgery had been recommended but Petitioner decided not to pursue it. (RX 2, p. 31) He did not have an opinion as to whether or not Petitioner still needed surgery in March of 2009 because he did not undergo another MRI and the doctor didn't know if he still had right leg pain. He did acknowledge that Dr. Bahrainwala saw Petitioner on February 2, 2009 and noted Petitioner had no more pain, numbness, tingling or weakness. (RX 2, pp. 32-33)

Dr. Neckrysh was also asked to assume that on "May 3, 2011" Petitioner reported pushing and pulling on large fixtures all day and experiencing some back pain and then questioned whether such an activity could aggravate degenerative disc disease. Dr. Neckrysh replied "Yes and no. I mean, it could cause a temporary flare-up of the muscle pain, facet pain which usually are a very self-limiting event. (RX 2, p. 34) He was also asked to assume that on March 30, 2011 Petitioner fell and landed on his buttocks and then asked whether that event could aggravate the degenerative disc disease. Dr. Neckrysh replied that any fall or excessive physical load on the spine may produce soft tissue injury or symptoms but it will not effect in any way degeneration. (RX 2, p. 35) He did not believe such an injury could make asymptomatic degenerative disc disease symptomatic. (RX 2, pp. 35-37) He did acknowledge that a fall or trauma could trigger "an investigation" but one would need objective evidence of an injury on imaging studies or clinical exam by a neurosurgeon. Thus, the doctor agreed that a fall such as the one Petitioner had on March 30, 2011 would aggravate degenerative disc disease but it could cause a disc condition such as a herniation but absent objective evidence of a disc change, there would be no connection between the two. Back spasms after such a fall would indicate a soft tissue injury. (RX 2, p. 38) He also agreed that right buttock pain could be indicative of a number of things. (RX 2, p. 40)

Dr. Neckrysh testified that the discogram ordered by Dr. Pencek was positive at L4/5 which meant there was disruption or inflammation or pathology within the L4/5 disc which, for some surgeons, is sufficient to recommend surgery. However, Dr. Neckrysh, personally, would not recommend a fusion since there was no concordant level of pain. (RX 2, pp. 44-45)

On redirect examination Dr. Neckrysh acknowledged that the May 4, 2009 report of Dr. Bahrainwala suggested that Petitioner had fully recovered from his disc herniation noted in 2008. (RX 2, p. 52) He also agreed that the January 22, 2001 report from Family Medical Care noted back pain and sciatica, the latter of which indicated irritation to a nerve root. (RX 2, pp. 53-54) The doctor also agreed that the October 21, 2011 MRI did not indicate any new disc injury or herniation in Petitioner's lumbar spine. (RX 2, p. 54) On further cross-examination the doctor acknowledged that he only read the MRI report and did not actually read the film. (RX 2, p. 55)

Petitioner was re-examined by Dr. Heim on September 15, 2014 but the record is incomplete and any history and treatment plans were not provided. (PX 4)

[4] The date of accident was subsequently amended from March 4th to March 3rd

Deposition of Dr. Don Kovalsky

The deposition of Dr. Don Kovalsky was taken on October 14, 2015. (PX 2) Dr. Kovalsky is an orthopedic spine specialist board certified in orthopedic surgery with a subspecialty in spinal surgery. Dr. Kovalsky testified regarding his first visit with Petitioner in 2012 at which time Petitioner reported having back problems intermittently and then injuring himself in March of 2011. Petitioner told the doctor he was a machinist and had tried to work for a few months but then stopped working in July of 2011. Petitioner told the doctor he tripped over a large object or some sort of metallic part on the floor, tried to grab a chain to keep from falling and twisted his back in the process of doing so. He believed the original date of injury was 2008 followed by a re-injury in March of 2011 when he lifted a heavy object resulting in an increase in back pain as of March. When Dr. Kovalsky saw Petitioner in May of 2012 Petitioner was also reporting bilateral leg pain. Dr. Kovalsky testified that Petitioner's physical examination was consistent with mechanical back pain combined, possibly, with discogenic pain or disc disease. He felt Petitioner might have low grade instability due to the amount of pain he had with extension which would also be consistent with some facet arthritis. Dr. Kovalsky reviewed Petitioner's x-ray and MRI and felt they showed moderate narrowing of the L5-S1 disc space which would typically be a degenerative process as well as mild narrowing with the L4-5 disc space. The spine itself was stable. He also had some facet arthritis on the oblique views of his spine. He felt the MRI showed fairly significant narrowing of the L5-S1 disc space which would not be an acute finding. He also had a diffuse disc herniation at L5-S1 (more right than left sided) and he had mild disc dehydration (central disc herniation) at L4-5 that wasn't causing any significant nerve compression. There was some mild internal derangement of that disc which would be age related. He also had some facet arthritis at L4-5 and L5-S1. In summary Dr. Kovalsky felt Petitioner had pre-existing degenerative disc disease and discogenic pain that was aggravated by the work injury in 2011 when he tripped over a part. (PX 2, pp. 1- 10) Dr. Kovalsky testified that he has recommended an anterior fusion at L5-S1 and a disc replacement at L4-5. However, before doing so, he would need to see a new MRI and updated x-rays. (PX 2, pp. 10-14)

Dr. Kovalsky was asked to assume that on March 3, 2011 Petitioner was loading and unloading fixtures that required him to push and pull on parts on a hoist all day and that there was a "large lifting device" that was "hard on him" when he was putting on and off the parts and that while doing these activities Petitioner noticed back pain. Based upon that assumption Dr. Kovalsky testified that such an event could be the straw that broke the camel's back but not the sole cause of Petitioner's problem. (PX 2, pp. 14-15)

On cross-examination Dr. Kovalsky acknowledged that the only MRI he saw was from October 21, 2011. He further acknowledged being unfamiliar with Dr. Heim's records as he didn't review them. When shown Dr. Heim's March 4, 2011 office note he acknowledged that it did not refer to any lumbar complaints, only thoracic. He also acknowledged that the April 6, 2011 note of Dr. Heim didn't reflect any back complaints. He next acknowledged that Dr. Heim's July 20, 2011 office note records a history of low back pain for one month with a recent flare-up of sciatica. Finally, he acknowledged that Dr. Heim's note of August 15, 2011 suggests that all of Petitioner's complaints (low back and sciatica complaints) began on July 19, 2011 when he stopped working. (PX 2, pp. 16-20)

Dr. Kovalsky also agreed that Petitioner's degenerative disc disease at L4-5 and L5-S1 pre-dated the events of 2011. The doctor was then asked whether the histories as shown in Dr. Heim's records suggested that the condition for which Petitioner presented to him were no longer related to any work-related exacerbation in March of 2011 and the doctor said it was hard to say completely because in the July note there was no reference to actually when Petitioner was injured but Dr. Kovalsky acknowledged

that he didn't treat Petitioner at that time and the records certainly don't document an injury occurring in March. He testified, "It's a much more vague history than – he was having symptoms when that doctor saw him in July, but there was again no mention of a very specific date of onset." (PX 2, pp. 20-21) He further agreed that if one assumed the history in the July 2011 office note of an onset thirty days earlier that would not relate to an event in March. He further agreed that when Petitioner was seen by Dr. Heim in March he wasn't really complaining of lumbar pain; rather he had thoracic pain. (PX 2, p. 21)

Dr. Kovalsky testified that it would be impossible for him to say whether Petitioner's lumbar pain was related to any work incident. He testified, "I can't speak for Dr. Heim but, you know, based upon this [his records] he has no evidence in his records of a specific lumbar injury which occurred in March of 2011." (PX 2, p. 23) Dr. Kovalsky also testified that based upon his training and expertise Petitioner's pre-existing degenerative condition would be the kind of condition subject to exacerbation of back pain with normal activity or any sort of minor event that happens in everyday life. (PX 2, p. 23) He further added that with such disease one will have flare-ups and those flare-ups can become more frequent as the condition progresses resulting in increased pain and length. (PX 2, p. 23) Dr. Kovalsky also agreed that in light of Petitioner's pre-existing condition and Dr. Heim's July 20, 2011 office note, Petitioner had an onset in June of 2011 without any history of an aggravating event and that such an onset could be consistent with the natural progression of his degenerative disc disease. (PX 2, p. 24)

Dr. Kovalsky testified that Petitioner's radicular symptoms as of May 16, 2012 were mild, not severe, and he had no weakness, no sensory deficits, and no reflex changes. His straight leg raising test on the right was equivocal and mildly positive on the left as was the Valsalva test. He testified that nothing in Petitioner's clinical presentation indicated to him that Petitioner's radicular symptoms were traceable to L5-S1 rather than L4-5. He further added that Petitioner has an asymmetrical contained disc herniation on the right at L5-S1 and a small central disc herniation at L4-5 which doesn't appear to be causing any nerve compression whatsoever. He agreed that the positive results on clinical exam were on the left side, not the right side. Based upon the doctor's training and experience he did not feel Petitioner was a surgical candidate due to his radicular pain. (PX 2, pp. 24-29)

Dr. Kovalsky further acknowledged that he initially recommended a possible disc replacement at L5-S1 but he has stopped doing that because so many patients were starting to see problems. He was still recommending surgery at two levels so that L4-5 can act as a buffer zone. He is recommending the disc replacement at L4-5 rather than a fusion because patients are less likely to develop adjacent segment disease with the replacement as one is still allowing for motion. Dr. Kovalsky felt that if he fused Petitioner at L4-5 he had a 35 to 40 % chance of developing a surgical condition at L3-4. Dr. Kovalsky also testified that he would need to do additional imaging on Petitioner to determine if there has been any progression of Petitioner's facet arthritis such that he would need a fusion and not a disc replacement. He felt a disc replacement at L5-S1 for Petitioner was "out of the question" given the doctor's philosophical change and the fact Petitioner is much older and has facet arthritis dating back three years. (PX 2, pp. 29-43)

On redirect examination Dr. Kovalsky testified that Petitioner told him he had been having back pain since the March 2011 and that he had been experiencing episodes of back pain even before that which were usually self-limited. He further testified that if Petitioner had low back pain after the "March 11th" event and was never symptom free thereafter, it would support an aggravation theory. However, if he developed a symptom free interval thereafter, it would only be another exacerbation. "If he had symptoms in March and improved and then had recurrent of symptoms later on and it wasn't a work related episode, then you would chalk that flare up to exacerbation of a preexisting condition. So in

order for me to feel that this is work related those symptoms had to have started and remained persistent indefinitely after that specific period of pain." (PX 2, pp. 43-44)

Dr. Kovalsky was further asked to assume that at the time of the March 3, 2011 event Petitioner had to stop the movement of the 2,000 lb. part by pulling it with his body. Based upon that assumption, Dr. Kovalsky testified that such activities could exacerbate low back pain in someone with pre-existing degenerative disc disease. (XP 2, pp. 45-46)

Deposition of Dr. Kimberly Terry

The deposition of Dr. Kimberly Terry was taken on May 9, 2016. (RX 3) Dr. Kimberly Terry testified that she is a board certified neurosurgeon practicing in San Antonio, Texas. (RX 3) She testified that a two-level disc replacement was not medically necessary based on the records she reviewed and the ODG standards. (RX 3) She testified that disc arthroplasty is indicated for single-level degenerative disc disease and that multiple level disc arthroplasty would be outside of FDA indications. (R's E. 3) She prepared a supplemental report based on the subsequent suggestion of a fusion of L5-S1 and a disc replacement at L4-5. (RX 3) In reviewing this, she cited to another nationally recognized treatment guideline besides ODG; namely, the ACOEM which indicates that this proposed procedure was not medically necessary. (RX 3) She testified further that, again, the FDA indications for artificial disc replacement were inconsistent with this proposal as there is multi-level degenerative disc disease and there is little in the literature to support the efficacy and safety of this sort of procedure. (RX 3) She did concede that a radicular type of pain can be an indication that a fusion is medically necessary. (RX 3) Likewise, a positive straight leg raise would be one indication that a fusion might be medically necessary. (RX 3) She testified that it is "possible" that Petitioner could meet a standard of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies although she noted that he had a normal examination per the note of Dr. Kovalsky. (RX 3) There was no objective evidence of radiculopathy, only the subjective report of pain radiating down the leg. (RX 3) "Spinal segment collapse" under ODG would be significant degeneration of the disc space. (RX 3) When she cites to ACOEM regarding "severe and disabling lower leg symptoms," she is talking about the clinical findings on examination, such as reflexes, strength, and those kinds of things. (RX 3) She bases her opinions on the procedure that is proposed and she was asked if he needs a particular type of surgery. (RX 3) She stated that she would have to re-review everything, but Petitioner might be a candidate for a lumbar fusion. (RX 3)

The 19(b) Arbitration Hearing

Petitioner's three cases against Respondent proceeded to arbitration on August 18, 2016. They were consolidated for purposes of trial with separate decisions to issue. The issues in dispute in case # 12 WC 19337 were accident, causal connection, medical bills, temporary total disability, prospective medical, and the statute of limitations. The disputed issues in case # 12 WC 02910 were accident, causal connection, medical bills, temporary total disability, and prospective medical care. The disputed issues in case # 12 WC 11599 were causal connection, medical bills, temporary total disability benefits, and prospective medical care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was employed by Respondent on August 1, 2008, as a CNC machinist. In this job, he unloaded fixtures, kept machines running, changed tooling, performed quality inspections, and washed and readied parts for shipping. On August 1, 2008 Petitioner went from Section 8334 to Section 8336 to train another employee on the job at that location. He testified that as he was doing so, he was at a computer control panel and he stepped backward, at which time his foot went inside a part that

had been placed on the floor, unbeknownst to Petitioner. Petitioner testified that he started to fall over and he grabbed the chain of a hoist "real hard" to keep from falling. He testified that this jerked him and twisted him and he injured his back.

Petitioner testified that he went to Dr. Heim and was given a twenty-five pound lifting restriction.

Petitioner also testified that he filled out a weekly disability benefits form for Respondent on which he marked that an accidental injury was not involved. (PX 1, Dep. Ex. 4) Petitioner acknowledged that he didn't fill out an incident report. He indicated at arbitration that this was suggested by a supervisor since he was in line for a promotion.

Petitioner testified that he had some history of "muscle problems" in his back in the past, but denied that he had ever had nerve pain or sciatica before August 1, 2008. He denied having ever seen a Dr. Heimbrecht. He denied ever having nerve pain that radiated down his legs to his feet.

Petitioner acknowledged seeing a chiropractor and being released by same in February/March of 2009.

Petitioner acknowledged that he had been seen a few times by the doctors at the Caterpillar medical department after August 1, 2008.

Petitioner further testified that he was employed as a CNC machinist by Respondent at its Decatur facility on March 3, 2011. Petitioner testified that he was assigned to Section 8334 but was reassigned to Section 8336, which he claimed was outside of his lifting restrictions. Petitioner testified that he filed a grievance regarding the reassignment but was ultimately re-assigned to the section as he was told he would not have to work beyond his restriction. Petitioner testified that as of March 3, 2011 he was required to push a part that was well over 1,000 pounds on a manual jib hoist. He also testified that he had to pull 70 to 80 pound parts out of a tub down at floor level, bending at the waist in order to do that; however, he stated that when he injured his back, he was moving the part on the jib hoist. He introduced photographs, including a photograph of a large part on a hoist. (PX 10, p. 1) Petitioner indicated that he would have to slow down the part (acting like a brake) and, that as he was doing so, he noticed discomfort in his low back.

Petitioner testified that he sought medical treatment on March 4, 2011 with Dr. Heim.

Petitioner then testified that on March 30, 2011, he was inside a machine cleaning up chips when he stepped backward and his left foot caught on a wire, causing him to fall backward onto the side of the machine. He testified that he had pain in the lower and mid part of his back after this event. Petitioner testified that, thereafter, he returned to see Dr. Heim on July 20, 2011.

Petitioner testified that he hasn't worked since July 20, 2011 when Dr. Heim took him off work. Petitioner further testified that he has continued to treat with Dr. Heim who has referred him to both Dr. Pencek and Dr. Kovalsky. Petitioner testified that Dr. Kovalsky has recommended surgery and Petitioner would like to proceed with the surgery if the doctor still feels it is necessary.

Petitioner testified that as of the time of arbitration, his back always hurts and he is in pain. He indicated that he could not bend and could not do simple tasks around the house. He needed to lie down afterward if he did work outside. His back would get stiff and he could not function. Petitioner testified that his back was different after March 3, 2011 explaining that as long as he was following his

restrictions he didn't have a lot of issues. He acknowledged some occasional pain prior thereto but nothing like what he currently experiences.

Petitioner was asked if he treated for his back between March of 2009 and 2011 to which he replied that he had a home decompression unit that he used for treatment. Petitioner denied having a lifting restriction before August 1, 2008.

Petitioner also acknowledged that he reported mid-back pain to Respondent on March 8, 2011 and to Dr. Heim on March 4, 2011. When asked if he denied any low back or leg pain at that time he testified he was "sure they talked about it."

Petitioner also acknowledged working his regular job between March 30, 2011 and July 18, 2011 (Section 8334). He could not recall if he had any low back or leg complaints by March 31, 2011. Petitioner also testified that he filled out another disability form when he went off work as of July 20, 2011. Petitioner acknowledged seeing Dr. Kovalsky on one occasion in 2012.

On redirect examination Petitioner testified that he injured his low back on March 3, 2011; however, he didn't know why the records only referred to his mid-back as his lower back "has been an issue since 2008." Petitioner also testified that after the early March incident his back progressively worsened.

Petitioner's medical bills are found in PX 9. Included in PX 9 is a bill from Elite Care, LLC. In the amount of $8,853.65 for treatment rendered to Petitioner between September 25, 2008 and March 11, 2009.[5]

The Arbitrator concludes:

Issue (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 is causally related to his injury.

Petitioner has the burden of proving, by a preponderance of the credible evidence, all of the elements of his claim. *Parro v. Industrial Commission*, 250 Ill.App.3d 551, 553, 630 N.E.2d 860 (1993), *affirmed*, 167 Ill.2d 385 (1995). To obtain compensation under the Act, a Petitioner must prove that some act or phase of his or her employment was a causative factor in the ensuing injuries. *Land and Lakes Company v. Industrial Commission*, 359 Ill.App.3d 582, 592, 834 N.E.2d 583 (2005). The Arbitrator does not find the opinions of Dr. Heim or Dr. Kovalsky persuasive. Given Petitioner's credibility issues and pre-existing problems in his low back, causation cannot be established by a chain of events.

While Petitioner sustained an accident on March 30, 2011 there is very minimal, if any, treatment given to him immediately thereafter. He voiced no ongoing complaints in April of 2011 nor did he seek any treatment in May, June, or a substantial part of July. Indeed, when Petitioner did resume treatment on July 20, 2011 Petitioner did not relate his complaints top the accident of March 30, 2011; rather, he noted a "flare-up" of a month's duration which would be consistent overall with his history of degenerative disc disease and chronic low back pain. Furthermore, Petitioner had a new complaint of sciatica and said it had begun five days earlier. He would later tell Dr. Heim on August 15, 2011 that his lower back pain and sciatica all started on July 19, 2011. Petitioner never testified to a work accident on that date and any suggestion that his lower back pain as of July 20, 2011 was an

[5] No office notes or records for these visits is a part of the record.

ongoing deterioration of his condition that began on March 30, 2011 is simply not credible or persuasive in light of the many inconsistencies in the record.

At the arbitration hearing Petitioner denied having any sciatica before 2008, suggested that any prior back problems were merely muscular in nature and denied ever seeing a doctor named "Heimbrecht." The objective evidence in the record suggests otherwise. The medical evidence reflects that Dr. Heimbrecht had Petitioner as a patient as of January 22, 2001. (PX 1, Dep. Ex. 2) Dr. Heimbrecht noted at that time that Petitioner had a history of back pain ever since a fall at work in 1994. (PX 1, Dep. Ex. 2) He indicated that as of that time, Petitioner had sciatica with radiating pain down the leg and a positive straight leg raise test, and that with the slightest lifting or trauma, there is recurrence of his back pain. (PX 1, Dep. Ex. 2) Dr. Heimbrecht subsequently noted that Petitioner's subsequent off-work period beginning July 19, 2011, was not related to his work at Caterpillar. (PX 1, Dep. Ex. 5) Finally, Petitioner also gave inconsistent histories to his various doctors regarding the onset date for his back pain. In sum, Petitioner's inconsistent histories and testimony which were contradicted by medical evidence undermine his credibility.

As for the expert opinions relied upon by Petitioner, Dr. Heim testified that "the injury that Mr. Johnston described could have aggravated or caused his condition of ill-being." (PX 1) He based this upon a history taken on March 4, 2011, before the alleged accident in this case. (PX 1) He testified that the causal relationship opinion he offered would be based on an assumption that Petitioner had ongoing back pain or sciatica symptoms from March forward, which he acknowledged was not recorded anywhere in any of the records he had or had been provided. (PX 1)

Dr. Don Kovalsky, Petitioner's most recent treating surgeon, testified that, assuming on March 30, 2011, Petitioner had an incident where he caught his foot on a wire table and he fell backward, this is the type of event that could aggravate the condition that he had diagnosed. (PX 2) He felt that Petitioner had pre-existing degenerative disease and discogenic pain aggravated by the work injury "when he tripped over the part." (PX 2) He acknowledged that Petitioner's pre-existing degenerative condition is the kind that is subject to exacerbation of back pain with normal activity or any sort of minor event. (PX 2) He agreed that if the history indicated an onset of back pain and sciatica 30 days before the visit with Dr. Heim in July that the symptoms would not be related to any sort of event in March. (PX 2) He did think that the records were not 100% clear as to when the lumbar pain symptoms started. (PX 2)

Petitioner was examined on Respondent's behalf by Dr. Sergey Neckrysh on October 4, 2014. (RX 2) Dr. Neckrysh was unable to validate Petitioner's leg complaints at the time of the examination given the sum total of the evidence. (RX 2) He testified that Petitioner's diagnosis was of degenerative disease of the lumbar spine which had nothing to do with any work duties or work related accident on March 30, 2011. (RX 2) The complaints he had at the time of the IME of chronic back pain were consistent with degenerative disease of the lumbar spine and had no relationship to the alleged accidents. (RX 2) He thought that a hypothetical event of falling on the buttocks would not necessarily aggravate degenerative disc disease but could cause a different condition in a disc such as a herniation. (RX 2) The MRI taken after March 30, 2011, on October 21, 2011, did not show any disc herniation. (RX 2) At the time of the IME, Petitioner presented with significant pain behaviors including grimacing on his face, jerking of his right foot, and the use of a walker because he claimed he could not walk without support. (PX 2) The Arbitrator notes that Petitioner's presentation at the time of hearing was inconsistent with the presentation at the time of the IME with Dr. Neckrysh. Dr. Neckrysh offered the opinions that Petitioner had degenerative disc disease and that there was no relationship to the March

30, 2011 event. The Arbitrator finds the opinion of Dr. Neckrysh better grounded in fact and the circumstances of this case.

Based upon the sum total of the evidence, the Arbitrator concludes that Petitioner has failed to prove a causal relationship between his condition of ill-being in his low back and his accident on March 30, 2011. Petitioner's claim for compensation is 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?

Based upon the Arbitrator's findings with respect to Issue (F) – Causal Connection, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to the payment of medical expenses as outlined in Petitioner's Exhibit 9. Petitioner has failed to prove that his low back condition was causally related to an accident arising out of and in the course of the employment on March 30, 2011. No medical bills are awarded.

Issue (K): Is Petitioner entitled to any prospective medical care?

Based upon the Arbitrator's findings with respect to Issue (F) – Causal Connection, above, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to the payment of future medical as outlined in the deposition of Dr. Kovalsky, his most recent treating surgeon. (PX 2) Petitioner has failed to prove that any such medical care would be causally related to an accident arising out of and in the course of the employment on or about March 30, 2011.

As a further basis of the Arbitrator's decision in this respect, the Arbitrator finds that Petitioner has failed to prove medical necessity of the surgical procedures proposed by Dr. Kovalsky. Dr. Kovalsky first proposed a two-level disc arthroplasty contingent upon any technical complications at the L5-S1 level. (PX 6, pp. 1-2) At his deposition, he amended this recommendation to a recommendation for a one-level fusion at L5-S1 and a disc arthroplasty at L4-5. (PX 2) He then opined that if Petitioner on repeat radiographs had extensive facet arthritis, he might change the recommendation again to a two-level fusion with a disc arthroplasty at L3-4. (PX 2)

Respondent presented utilization review evidence by Dr. Terry establishing that nationally recognized treatment guidelines indicate that neither the two-level disc replacement originally proposed, nor the hybrid procedure of a fusion at L5-S1 and a disc arthroplasty at L4-5 were medically necessary or indicated. (RX 3) Dr. Terry noted that not only do the nationally recognized treatment guidelines ODG and ACOEM indicate against the procedures alternatively proposed by Dr. Kovalsky, that FDA indications for lumbar disc replacement are for single-level degenerative disc disease which Petitioner did not have. (RX 3) This was true of both of the procedures recommended by Dr. Kovalsky. (RX 3) Beyond this, Dr. Neckrysh, the Chief of Spine Surgery at the University of Illinois at Chicago, indicated that the two-level disc arthroplasty proposed was an unnecessary procedure which had no data to support it and a lumbar arthroplasty does not have a remote potential of helping leg pain assuming that Petitioner had it. (RX 2, Dep. Ex. 2) Only when there is a confirmed diagnosis of discogenic back pain by discography and no other degenerative findings on the images or clinically, would a disc replacement be indicated. (RX 2) It appears that the statement that it was "absolutely necessary" was a typographical. (RX 2) Based upon the sum total of the evidence, given Dr. Kovalsky's admission that his originally planned procedure produced less than optimal results and his vagueness regarding what procedures would actually be performed, and the opinions of Dr. Terry and Dr. Neckrysh

that the procedures proposed by Dr. Kovalsky were not consistent with nationally recognized treatment guidelines, FDA standards, or the circumstances under which such a procedure might be contemplated, the Arbitrator finds that Petitioner has failed to prove medical necessity for such a procedure. Prospective medical is, therefore, denied.

Issue (L): What temporary total disability benefits are in dispute – TTD?

Based upon the Arbitrator's findings with respect to Issue (F) – Causal Connection, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to temporary total disability compensation for the period claimed of July 18, 2011 through August 18, 2016. The Arbitrator finds that the evidence fails to establish that Petitioner's condition of ill-being with respect to his low back was causally related to an accidental injury arising out of and in the course of the employment on or about March 30, 2011. Petitioner's claim for temporary total disability is, therefore, denied.

Furthermore, Dr. Neckrysh credibly testified that he could not recommend any work-related restrictions as of his IME of February 4, 2014, given Petitioner's unverifiable complaints. (RX 2) No doctor has certified him off of work after the IME. (PX. 7) This forms an additional basis for the denial of TTD after February 4, 2014.

****

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

Mary Kezirian,

Petitioner,

vs.

NO: 12WC 12088

IL Dept. of Human Services,

Respondent.

17IWCC0590

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b), having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of medical expenses 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 14, 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.

17IWCC0590

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: SEP 27 2017
MJB/bm
o-9/18/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

KEZIRIAN, MARY
Employee/Petitioner

Case# **12WC012088**

IL DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0590

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:

0810 BECKER PAULSON & HOERNER PC
RODNEY W THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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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

NOV 14 2016

RONALD A. RASCIA, 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
19(b)

Case # 12 WC 12088

Consolidated cases: N/A

17IWCC0590

Mary Kezirian
Employee/Petitioner

v.

Illinois Department of Human 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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 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. ☒ 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 _____

17IWCC0590

FINDINGS

On the date of accident, **April 20, 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 **in the right index finger** *is* causally related to the accident, but Petitioner's condition of ill-being **in the right hand, right elbow and right shoulder** ***is not*** causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$40,509.00**; the average weekly wage was **$798.25**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

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

ORDER

As Petitioner has failed to prove that her current condition of ill-being in the right shoulder and right elbow is causally related to the accident of April 20, 2009, Petitioner's request for prospective medical treatment to the right shoulder and right elbow as recommended by Dr. Lehman is denied.

Respondent shall pay Petitioner temporary total disability benefits of **$532.17/week** for **5** weeks, **for the timeframe of April 21, 2009 through May 25, 2009,** as provided in Section 8(b) of the Act.

Respondent shall pay for medical services **rendered up to and including February 5, 2010** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for treatment rendered up to and including February 5, 2010** directly to the provider. Respondent shall pay any unpaid, related medical expenses **for treatment rendered up to and including February 5, 2010** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

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.

17IWCC0590

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

Signature of Arbitrator

11/10/16

Date

ICArbDec19(b)

NOV 14 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Mary Kezirian
Employee/Petitioner

Case # 12 WC 12088

v.

Consolidated cases: N/A

Illinois Department of Human Services
Employer/Respondent

17IWCC0590

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is 63 years of age and lives in Belleville. She testified that she has worked for the State of Illinois for more than 30 years. She testified that she works in East St. Louis, and has worked at that location for 21 years. She testified that she is a public aid eligibility assistant, and that her job duties include entering information into the computer, writing out envelopes and processing applications for welfare assistance. She testified that she helps people both on the phone and in person, and that she spends all day on the computer. She testified that she works 37½ hours per week, and that she has two daily 15-minute breaks.

Petitioner testified that on the date of accident, she and a co-worker went out for a late break and that it was extremely windy. She testified that her co-worker put her coat in the door. She testified that she opened the door with her hand, had her hand on the door and was walking away from the door when the wind caused the door to shut. She testified that she was walking away with her arm stretched out. She testified that at the time of the accident, she was going into the building and that the door opened outward. She testified that she was walking away from the door, and that the door slammed onto her hand with her arm stretched out. She testified that she did not realize that her hand was in the door. She testified that she had her right hand on the door handle as she was walking in, and that the wind blew the door closed on her right hand.

Petitioner testified that she did not realize she was hurt and that a co-worker went to get someone while she sat on the floor. She testified that she went to Memorial Hospital that day, where they took x-rays. She testified that she went back to the hospital the next day because she was called by a doctor who asked her to come back. She testified that she remembered staying there for several hours, and that her right hand was bandaged.

Petitioner testified that she then saw Dr. Hehmann, and that she started seeing him in April of 2009. She testified that she told him she was having problems with her hand. She testified that he ordered physical therapy as well as additional x-rays. She testified that her physical therapy was at Memorial Hospital, and that that was where the x-rays were done as well. She testified that she continued to follow with Dr. Hehmann and that he eventually released her to return to work on May 26, 2009. She testified that while she was off work, she did not receive any benefits and that she used her sick time because financially she could not afford it.

Petitioner testified that when she returned to work, she continued to see Dr. Hehmann and that she last saw him on February 5, 2010. She testified that as she continued to work, she became concerned about her right hand and arm. She testified that she told him about her shoulder because she works every day and that she uses her right hand to type, that she felt like it was getting worse and that she did not know why. She testified that Dr. Hehmann said that he could not help her for her arm and shoulder, so he referred her to a different doctor.

Petitioner testified that she saw Dr. Anderson on February 23, 2010 and that she was referred to him by Dr. Hehmann. She testified that when she initially saw Dr. Anderson, she provided him with a history of her work injury. She testified that she told him about the symptoms she was having at that time. She testified that she believed that she was given a shoulder injection and that he ordered more physical therapy. She testified that she underwent physical therapy at Memorial Hospital. She testified that she continued to work while she was seeing Dr. Anderson. She denied any change in her shoulder from the injection. She testified that she saw Dr. Anderson again on March 23, 2010, at which time he released her from his care.

Petitioner testified that after she returned to work after her two visits with Dr. Anderson, her symptoms when she worked were that her whole shoulder and arm were getting worse, that it was more painful in her fingers and that her hand was getting harder to bend. She testified that she uses a lot of lotion, which loosens her hand. She also testified that her shoulder started hurting more as she typed and wrote. She testified that she returned to Dr. Anderson in July of 2013.

Petitioner testified that when she next saw Dr. Anderson, she continued to tell him about her symptoms. She testified that he ordered an MRI of her shoulder. She testified that she paid for the MRI out-of-pocket. She testified that she returned to Dr. Anderson after the MRI, and that he went over the results with her. She testified that he then sent her to Dr. Naseer for electrical studies on both arms, and that she returned to him after the testing was done. She testified that Dr. Anderson might have mentioned surgery, but that he did not go into details. She testified that she continued to work, that each day her right side got worse and that she had a bump in the biceps area on her right arm.

Petitioner testified that she followed up with Dr. Anderson in 2014, and that he injected her shoulder again. She testified that she last saw Dr. Anderson in November of 2014 at which time they again discussed surgery, but that she felt that he did not care or want to hear about her pain and what had happened to her. She testified that when they tried to discuss surgery and she asked questions, he said he could not guarantee the outcome.

Petitioner testified that when she saw Dr. Anderson in 2013 and 2014, she showed her group insurance and that she paid the co-pays as well as some of the deductibles. She testified that she took a day off work to have the testing done and that she used sick leave.

Petitioner testified that on January 7, 2016, she saw Dr. Lehman and that her lawyer recommended him. She testified that her brother also sees Dr. Lehman, and that he performed surgery on him. She testified that when she saw Dr. Lehman she told him about how she had been injured at work and that she told him about her complaints. She testified that when she saw him, she was having issues with the shoulder, the bump and her elbow all the way down to her fingers. She testified that they discussed surgery on her shoulder, her bump and her elbow, and that he said something needed to be done with her hand but he did not say what. She testified that after the exam by Dr. Lehman, she decided she wanted to have surgery performed by him.

Petitioner testified that she has not seen any other medical providers, and she denied having had any further injuries to her right shoulder or right arm since the accident. She testified that she does not take any prescription medications related to the accident, but that she took 6 Ibuprofen every day.

Petitioner testified that her index finger tingles and that all of her fingers are hard to bend. She testified that her right hand gets stiff and that she uses lotion to "loosen" it up. She testified that things she can no longer do are things like pumping a hairspray bottle and that she cannot clean very well, as everything she does is right-handed. As to her right shoulder, Petitioner testified that it hurts whenever she moves the right arm such as when washing her hair, performing activities of daily living and working. She testified that her "bump" is in the biceps area, and that it hurts more and more every day.

Petitioner denied having any other workers' compensation claims. She denied having any problems with her right hand, right shoulder, right biceps or having any tingling in her hand before the accident at issue.

On cross examination, Petitioner agreed that her visit with Dr. Lehman in January was her last treatment and that her attorney referred her to Dr. Lehman. She testified that Dr. Lehman recommended surgery and that she wants to undergo it, but that surgery was not yet scheduled.

On cross examination, Petitioner testified that she was hurt on April 20th and that the office administrator called her the night of the accident to see if she was okay, and testified that she said she would not be in to work and that she needed a sick day. She testified that she was told to come in the next day, but she did not fill anything out.

On cross examination, Petitioner agreed that her signature appeared on the first page of Respondent's Exhibit 1. She testified that she did not type the accident description, but that the information had been typed on the document when she signed it. She testified that the date of June 26, 2009 was not the correct date, and that she believed that she signed it on April 21, 2009. She agreed that the document accurately reflects what she said happened.

On cross examination, Petitioner testified that she went to the emergency room immediately after the accident happened and that she told the emergency room personnel what caused her injuries. She agreed that the records stated that she caught her hand in a door, and that that was what she told them. She testified that she had stiches for the laceration on her finger, and that the emergency room record where the left hand was circled was incorrect as it was her right hand.

On cross examination, Petitioner testified that after the emergency room, she started treating with Dr. Hehman and that she treated with him up until February of 2010. She testified that Dr. Hehmann referred her to Dr. Anderson. When asked when she saw Dr. Anderson whether she told him how she was injured, Petitioner responded that she tried and that she told him the body parts where she was complaining of pain.

On cross examination, Petitioner agreed that she returned to Dr. Anderson in March of 2010 after she completed physical therapy. She testified that she did not recall stating that her shoulder pain had resolved. She testified that she was having hand pain in March. She agreed that from March of 2010 until July of 2013, she saw no one else for her shoulder, hand or elbow pain. She testified that she told Dr. Anderson everything that was hurting, but that she was not sure he listened to her. She testified that she did not recall his having dictated one of his notes in front of her in August of 2013. When asked if she was unhappy with him, Petitioner responded that she respected him but that Dr. Anderson would not answer her questions.

On cross examination whether on August 20, 2013 Dr. Anderson offered her surgery, Petitioner responded that he may have spoken about it but that he could never give her answers. She testified that he indicated that the surgery may help but it may not, and that he did not explain anything nor could he guarantee anything.

On cross examination, Petitioner testified that her whole right side gets worse and worse every day. She testified that she spoke to her brother, sought legal counsel and that her attorney was familiar with Dr. Lehman. She testified that Dr. Lehman has performed several surgeries on her younger brother. She testified that when she saw Dr. Lehman, she told him how accident happened. She testified that Dr. Lehman's note that said that the door slammed shut by the wind and closed on her arm was incorrect, and that it closed on her hand.

The medical records of Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1.[1] The records reflect that Petitioner was seen on April 20, 2009 for a chief complaint of injury to the left hand, and it was noted that Petitioner had a crush injury when her hand was caught in the door. The location of the injury was noted to be the left fingers, and the pictorial notation was that of the index finger on the left hand. The nursing records noted that Petitioner stated that a door got closed on her right hand at work that day, and that she was complaining of a laceration to the index finger. Petitioner underwent x-rays of the right hand on that date, which were interpreted as revealing palmar subluxation of the second proximal phalanx, best appreciated in the lateral projection; no associated fracture is identified; mild ulnar subluxation of the first proximal phalanx is also noted, although this is most compatible with degenerative change; the remainder of the visualized bony structures are unremarkable. It was noted that Petitioner had a 4.5 cm wound on the right index finger, and the clinical impression was that of laceration to the right index finger which was repaired. Petitioner was issued a work slip indicating that she should be able to return to work after being released by the doctor and that her work limitations were to be determined. (PX1).

The records of Memorial Hospital reflect that Petitioner was seen on April 21, 2009 for a chief complaint to the right index finger. It was noted that Petitioner stated that she was called back in on that date to have her right index finger looked at. While the handwriting was arguably illegible, it was noted that Petitioner was to keep her laceration dry and clean, that she was to use Bacitracin ointment and a splint, that she was to follow up with Dr. Hehmann and that she was given a work note. Petitioner underwent x-rays of the second finger on the right hand on that date, which were interpreted as revealing soft tissue swelling but no fracture; subluxation of the proximal phalanx; there is no joint space narrowing or arthritis. The clinical impression was that of right index finger laceration and right index finger subluxation of MCP joint. The return to work instructions noted that Petitioner should be able to return to work after released by the doctor, and that she needed no work limitations. (PX1).

The records of Memorial Hospital reflect that Petitioner was seen on April 27, 2009 at the Memorial Hand Therapy Center for a diagnosis of right index finger laceration. It was noted that Petitioner was to be seen two times per week for four weeks. The Initial Evaluation noted that Petitioner was referred by Dr. Hehmann, and that on April 20, 2009 a door slammed on her hand at work. It was noted that Petitioner had sutures, that she was called back to the emergency room the next day, that the plastic surgeon was called but that she did not have surgery, that she followed up with Dr. Hehmann in the office and that therapy was ordered. The records reflect that Petitioner underwent therapy for the timeframe of April 27, 2009 through May 20, 2009. The Discharge Summary noted that Petitioner made good progress with treatment; that the short-term goals were achieved; and that the long-term goals were achieved. It was noted that Petitioner was released to return to work. (PX1).

The records of Memorial Hospital reflect that Petitioner underwent x-rays of the right hand on May 1, 2009, which were interpreted as revealing (1) degenerative change with mild medial subluxation at the first digit metacarpophalangeal joint; (2) little change in previously seen mild palmar subluxation at the second digit metacarpophalangeal joint on the oblique view; (3) mild degenerative change at the third digit proximal interphalangeal joint. The records reflect that Petitioner also underwent x-rays of the right

[1] Highlighting found in the exhibit was not done by the Arbitrator.

wrist on the same date, which were interpreted as revealing no fracture, subluxation or other bony abnormality is identified; the scapholunate distance is within normal limits. (PX1).

The records of Memorial Hospital reflect that Petitioner underwent x-rays of the third digit on the right hand on June 12, 2009, which were interpreted as revealing persistent focal soft tissue bulging about the proximal interphalangeal joint with mild tiny dystrophic calcification, but no acute looking fracture or dislocation; remaining digit looks intact; anterior subluxation of the proximal phalanx of the second digit relative to the second metacarpal head is noted. Petitioner also underwent x-rays of the second digit on the right hand on the same date, which were interpreted as revealing recurrent anterior subluxation of the proximal phalanx of the second digit relative to the second metacarpal; there is more focal soft tissue swelling than on the study in April, but again no fracture. (PX1).

The records of Memorial Hospital reflect that Petitioner underwent x-rays of the right hand on August 21, 2009, which were interpreted as revealing no interval fractures or dislocations identified; previously described volar subluxation of the first MCP joint is again noted; there is mild narrowing of the second MCP joint with again some minimal volar subluxation; paraarticular calcifications are noted involving the third digit proximal interphalangeal joint, stable; no erosions are identified; soft tissues are unremarkable. Petitioner also underwent x-rays of the right thumb on the same date, which were interpreted as revealing persistent mild volar subluxation of the first metacarpophalangeal joint; there are no fractures identified; degenerative changes also present; no periarticular erosions or soft tissue calcifications are appreciated. (PX1).

The records of Memorial Hospital reflect that Petitioner underwent x-rays of the right thumb on September 11, 2009, which were interpreted as revealing mild degenerative arthritic changes of the first metacarpal – carpal joint are noted; there is advanced degenerative arthritic changes of the first metacarpal phalangeal joint with loss of the joint space, deformity of the articular cortical borders and mild subluxation of the proximal phalanx relative to the metacarpal bone; there is no significant change compared to prior study (*i.e.,* August 21, 2009). Petitioner also underwent x-rays of the left hand on that date, which were interpreted as revealing mild to moderate narrowing of the distal interphalangeal joint of the second and third fingers, and proximal interphalangeal joint of the first through fifth fingers; there is prominent degenerative hypertrophic changes of the first metacarpal – phalangeal joint with loss of the joint space and subchondral surface; there is degenerative narrowing of the second metacarpal phalangeal joint, with slight subluxation of the proximal phalanx relative to the metacarpal head; the remainder of the study is unremarkable. Petitioner also underwent x-rays of the left thumb on the same date, which were interpreted as revealing advanced arthritic changes of the first metacarpal phalangeal joint, with loss of the joint space, deformity of the articular margins and subchondral sclerotic change; marginal hypertrophic changes are also seen involving the joint margins; the study is otherwise unremarkable. (PX1).

The records of Memorial Hospital reflect that Petitioner was referred for physical therapy for the right hand, right arm and right shoulder on February 26, 2010. It was noted that the complaints started on April 20, 2009, and that it was a work-related injury. The treatment area was noted to be the right scapula/arm. The Cervical Evaluation form completed on February 26, 2010 noted that Petitioner's hand was caught in a door and that she had radiation to the right scapula/shoulder. It was noted that the therapist questioned whether the hand pain was secondary to problems with either the shoulder or cervical spine. At the time of the March 1, 2010 visit, it was noted that Petitioner stated that she would rate her pain in her right arm at a 6/10, and that she reported that she slept well at night. At the time of the March 8, 2010 visit, it was noted that Petitioner reported that her pain increased after typing all day. At the time of the March 15, 2010 visit, it was noted that Petitioner stated that she was upset that she received a cortisone injection and was then referred to physical therapy, and that she did not think this was the appropriate course of action. It was noted that Petitioner continued to complain of right shoulder and arm

pain, and that she had noted some improvement since the injection. Petitioner last received therapy on March 17, 2010. (PX1).

The medical records of Dr. Richard Hehmann were entered into evidence at the time of arbitration as Petitioner's Exhibit 2.[2] The records reflect that Petitioner was seen on April 24, 2009, at which time it was noted that she was status post right index finger laceration. It was noted that clinically Petitioner had some degenerative changes to the joints, and that the laceration was healing satisfactorily. At the time of the May 1, 2009 visit, it was noted that the wound appeared to be healing satisfactorily and that Petitioner was going to hand therapy. At the time of the May 6, 2009 visit, it was noted that Petitioner was healing satisfactorily and that the suture line was intact. Petitioner was issued a work slip on May 1, 2009, taking her off work until further notice. Petitioner was issued another work slip on May 6, 2009, indicating that she would return to work on May 21, 2009. (PX2).

The records of Dr. Hehmann reflect that Petitioner was seen on May 20, 2009, at which time it was noted that Petitioner had been going to therapy and was doing well. It was noted that Petitioner would be returned back to full-time regular work on May 26, 2009. At the time of the June 12, 2009 visit, it was noted that Petitioner had a scar and laceration to the right index finger. It was noted that Petitioner now related that her other fingers were also "damaged" and that she felt abnormal bone in her index finger. It was noted that Petitioner's range of motion was improved. At the time of the June 26, 2009 visit, it was noted that Petitioner's MCP joint subluxation had no clinical basis, that Petitioner moved the MCP joint fine, and that she had more complaints about her PIP joint. At the time of the August 21, 2009 visit, it was noted that Petitioner's wound was healing satisfactorily and that she related multiple complaints to her thumb. It was noted that Petitioner had slightly decreased range of motion of the index finger. (PX2).

The records of Dr. Hehmann reflect that Petitioner was seen on September 11, 2009, at which time it was noted that she continued to complain about the thumb. It was noted that Dr. Hehmann believed that Petitioner had degenerative changes at the MC joint of both thumbs. At the time of the September 25, 2009 visit, it was noted that Petitioner had both hands x-rayed and that she had some degenerative arthritis of both hands. It was noted that Petitioner had swelling of the index and long finger. At the time of the November 6, 2009 visit, it was noted that Petitioner had not responded well to the Celebrex so she was recommended to take Ibuprofen. At the time of the February 5, 2010 visit, it was noted that Petitioner was now complaining that her whole hand, arm and shoulder were bothering her a great deal. It was noted that the examination revealed some crepitus in the shoulder, and that she was to be seen by Dr. Weimer for her painful shoulder and arm. Petitioner was to return on an as needed basis. (PX2).

The medical records of Dr. Peter Anderson/Illinois Southwest Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 3.[3] The records reflect that Petitioner completed a Questionnaire Information Sheet – Shoulder on February 23, 2010, on which she indicated that her whole right arm and hand hurt since November of 2009. The corresponding office note of Dr. Anderson indicated that Petitioner presented with complaints of primarily shoulder pain but hand pain as well. It was noted that Petitioner complained of injuring herself at work almost a year ago, and that a door slammed on her hand and was blown by the wind. It was noted that Petitioner's x-rays appeared to show some degenerative subluxation to the 2nd MCP joint and some arthritis at the CMC joint of the first finger on the right hand, and that she was now complaining of a lot of shoulder pain which did not start until November. It was noted that the impression was that of rotator cuff tendinitis and degenerative changes in the hand, and that Petitioner was recommended a cortisone shot for her right shoulder. It was noted that Petitioner would try therapy for the shoulder and hand. (PX3).

[2] Highlighting found in the exhibit was not done by the Arbitrator.
[3] Highlighting found in the exhibit was not done by the Arbitrator.

The records of Dr. Anderson reflect that Petitioner was seen on March 23, 2010, at which time she complained of shoulder pain. It was noted that for the large part the pain had resolved, but that she continued to complain of some typical hand pain. It was noted that Dr. Anderson told her that he did not have much else to offer other than therapy and time, and that he thought that Petitioner was probably going to have to live with some of what she had. It was noted that Dr. Anderson was pleased that her hand was so much better. Petitioner was released. At the time of the July 2, 2013 appointment, it was noted that Petitioner presented with complaints of right shoulder and right hand pain, and that it started back in 2009 when she caught her arm in a door and that since that time she had had problems. It was noted that Petitioner's pain had returned. It was noted that examination of Petitioner's hand demonstrated catching of the thumb at the base consistent with a trigger thumb. Petitioner was recommended to undergo an injection of the shoulder and thumb, which she declined. It was noted that Petitioner wanted an MRI scan of the shoulder. It was noted that Petitioner had a ruptured biceps tendon on the right. It was also noted that Petitioner was unhappy that he could not relate everything to the accident that she had, and that Dr. Anderson thought "really none of this is related." (PX3).

Included within the records of Dr. Anderson was the report for an MRI of the right shoulder performed on August 16, 2013 at Gateway Regional Medical Center, which was interpreted as revealing (1) full-thickness tear of the supraspinatus tendon; (2) possible disruption of the long head of the biceps tendon; (3) benign appearing lesion of the humeral head; correlation with plain radiographs is recommended. (PX3).

The records of Dr. Anderson reflect that Petitioner was seen on August 20, 2013, at which time it was noted that Petitioner's MRI showed a small tear of the rotator cuff. It was noted that Dr. Anderson had a long discussion regarding what caused it and that catching her hand in the door was "not a great way to do it, but it is possible." It was noted that Petitioner had some swelling in her right hand and some tingling in her right second finger, and that nerve conduction studies were recommended to rule out carpal tunnel syndrome. It was noted that Petitioner had arthritis in both hands and had particularly prominent MCP joints of her thumb and that she had deviation of the left hand at the DIP joint. It was noted that Petitioner would be "checked" for carpal tunnel syndrome and see if she had "damaged this" when she had the injury, and that for the shoulder, Petitioner was offered surgery. It was noted that Petitioner seemed unhappy that Dr. Anderson "could not relate everything to the injury." Included within the records was the Nerve Conduction & EMG Report dated August 22, 2013 as prepared by Dr. Naseer. The report indicated an impression of (1) complains of right hand pain; (2) no carpal tunnel syndrome; (3) bilateral ulnar neuropathy across the elbow; (4) normal needle exam. (PX3).

The records of Dr. Anderson reflect that Petitioner was seen on September 10, 2013, at which time it was noted that she was "not a whole lot better" and that she remained fairly symptomatic. It was noted that Petitioner had a rotator cuff tear and bicipital tendon tear for which she had been offered surgery several times but had declined. It was noted that Dr. Anderson did not think surgery on her hand and elbow was indicated as she said that her thumb and index finger on the right hand were more problematic than her fourth and fifth fingers. At the time of the September 23, 2014 visit, it was noted that Petitioner returned complaining of shoulder pain, that the possibility of surgical intervention was discussed and that she had consistently declined. It was noted that Petitioner did not have pain in an anatomic distribution, and that it was generalized throughout the forearm and hand. It was noted that a cortisone injection in the shoulder was performed on that date. At the time of the November 4, 2014 visit, it was noted that Petitioner returned complaining of shoulder pain and that she did not think the injection helped. It was noted that Petitioner still had pain with activity, that she had pain in her knuckles, that she had deformity in her hands consistent almost with a rheumatologic picture and that she had pain down her arm and pain in her neck. It was noted that rotator cuff surgery was again offered and declined, and it was noted that Petitioner wanted to "live with it." (PX3).

The transcript of the deposition of Dr. Richard Lehman was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Dr. Lehman testified that he is an orthopedic surgeon whose practice is primarily sports-related and typically involves extremity-type injuries. He testified that he is board-certified in orthopedic surgery and sports medicine. (PX4).

Dr. Lehman testified that he performed an IME on January 7, 2016, at which time Petitioner's main complaints were pain in her right hand, weakness in her right hand and swelling and discomfort in her hands. He testified that Petitioner stated that she was injured in April of 2009, that she got her arm caught in a door and, by her history, it was a heavy door that slammed shut onto her right arm and, by her history, compressed her upper arm. He testified that people with significant underlying rheumatoid arthritis or degenerative arthritis have weakness in their hands and limitations, and that it predisposes them to abnormal stresses because they cannot use their hands in a normal pattern. He testified that on x-ray, Petitioner had degenerative changes noted as well as damage to the biceps tendon or a "Popeye" deformity, which was likely due to an attritional tear of her biceps tendon. (PX4).

Dr. Lehman testified that his diagnoses were that of severe ulnar neuropathy leading to interosseous wasting, a chronic rotator cuff tear and underlying degenerative arthritis of her hands or possible rheumatoid arthritis. He testified that it was his opinion that Petitioner had a pre-existing rotator cuff tear, and that, if her history is correct, she would have had some type of traction injury on her shoulder or some type of a compressive traction injury if her arm really got caught in a heavy door the size that she said it got caught in. He testified that it could have aggravated her condition of ill-being in the shoulder, given that she weighed less than 100 pounds. He testified that as to the right-sided ulnar neuropathy issue, he believed that Petitioner had pre-existing ulnar neuropathy bilaterally and, assuming the history was accurate that she slammed her arm, it would have been a compressive stress to the ulnar nerve. As to the right hand, Dr. Lehman testified that he felt that Petitioner had significant arthritis in her right hand, that repetitively using her right hand could exacerbate her arthritis and that he did not believe that the accident would have materially changed the severity of her underlying arthritis. (PX4).

Dr. Lehman testified based on Petitioner's MRI scan, he recommended that she get her rotator cuff fixed (either by repair or graft) and her ulnar nerve released and transposed. He testified that he felt that the trauma, given her underlying pathology, size and history, would certainly have traumatized her shoulder and believed that it contributed to her progression of pathology and believed it was why her grip strength was so much worse on the right than it was on the left. He testified that he believed that the treatment she received prior to the IME was reasonable and necessary to attempt to cure and/or relieve her from the effects of the accident of April 20, 2009. (PX4).

On cross examination, Dr. Lehman agreed that Petitioner reported to him that she developed shoulder pain shortly after the incident. He agreed that Petitioner's history was that this happened when the wind blew the door shut and it caught her arm in the door. He agreed that the emergency room history that noted that Petitioner's hand was caught in the door was different than catching her arm in the door. He agreed that the history of injury on the accident report that indicated that as she was entering the door, a gust of wind blew the door closed on her right hand was different than it closing on her right arm. He agreed that he stated that if the history that Petitioner gave was correct, that the need for surgery for her shoulder and elbow would be related to the incident. He agreed that if the history was that it closed on her hand, however, it could change his opinion. (PX4).

On cross examination, Dr. Lehman agreed that catching the hand in the door was a different mechanism, so he agreed that just catching the hand was not a mechanism to tear the rotator cuff. He agreed that he was familiar with Dr. Anderson and that he was a competent doctor. When asked about his understanding of the timing of onset of shoulder pain as having developed shortly after the incident, Dr. Lehman testified that his understanding was that it was contiguous with the injury and would have either been the day of the accident or the next day. (PX4).

On redirect examination when asked to assume that instead of the door actually closing on her shoulder or elbow and it closed on her hand but in the process it pulled her and tugged her arm as it was closing on her hand and whether that would be the type of injury consistent with an aggravation of the pre-existing conditions in the rotator cuff and ulnar nerve, Dr. Lehman responded that his assumption was that she had a compressive ulnar nerve issue so he did not believe a traction injury would have exacerbated her ulnar nerve. He testified that it was possible that it could have exacerbated or manifested her shoulder pain, but he agreed with Dr. Anderson that it was not a mechanism by which you tore or damaged the rotator cuff. He testified that he believed that the rotator cuff tear was pre-existing, and that it was subject to being aggravated by stretching, torqueing or direct trauma to the shoulder. He testified that as to the hand, if the door closed on the hand itself, it would have made Petitioner symptomatic related to her pre-existing degenerative arthritis. (PX4).

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

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Workers' Compensation Employee's Notice of Injury noted that Petitioner indicated that as she was entering the door, a gust of wind blew the door closed onto her right hand. The Illinois Form 45: Employer's First Report of Injury noted an accident description of "[w]order was holding the door while walking through the doorway, the wind blew the door shut while the worker's hand was still in the doorway, injuring the worker's right index finger." The Supervisor's Report of Injury or Illness noted that the wind blew the door closed as Petitioner was entering the door, and that her index finger on her right hand got stuck in the door. The Worker's Compensation Witness Report noted that LaDonna Teverbaugh and Petitioner were coming inside the employee entrance, Ms. Teverbaugh put her code in and Petitioner pulled the door open, Ms. Teverbaugh walked in the door first and as she started to walk away, she heard the door slam and a few seconds later heard Petitioner say "my hand." It was noted that Ms. Teverbaugh turned around and noticed Petitioner's right hand was slammed inside the door, that she ran and pushed the door open, sat Petitioner on the floor and called 911. It was also noted that Ms. Teverbaugh elevated Petitioner's hand, then ran to contact other individuals after which she returned to Petitioner to assist. It was noted that the injured finger was on Petitioner's right hand (index finger), that all of the skin was pulled back, and that Petitioner's hand was wrapped in a paper towel and held up with a pencil, after which Petitioner went to the hospital. (RX1).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on April 20, 2009, Petitioner sustained an accident that arose out of and in the course of her employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the right shoulder, right elbow and right hand is causally related to the accident of April 20, 2009, but that Petitioner has proved that her current condition of ill-being in the right index finger is causally related to the accident of April 20, 2009.

In so concluding, the Arbitrator notes that the initial post-accident medical records reference issues only with the right index finger. The Arbitrator notes that the emergency room records at Memorial Hospital on April 2, 2009 make no reference whatsoever to involvement of either the right shoulder or elbow, nor do any of the medical records of Dr. Hehmann up until the office visit of February 5, 2010, at which time it was noted that Petitioner was now complaining that her whole hand, arm and shoulder were bothering her a great deal. (PX1; PX2). The Arbitrator notes that Dr. Anderson's medical records reflect that Petitioner completed a Questionnaire Information Sheet – Shoulder on February 23,

2010, on which she indicated that her whole right arm and hand hurt since November of 2009, which is contrary to the onset of symptomatology as reported to Dr. Lehman at the time of the IME on January 7, 2016. (PX3; PX4). Furthermore, the Arbitrator notes that the Dr. Anderson at the time of the July 2, 2013 appointment noted that Petitioner was unhappy that he could not relate everything to the accident that she had, and further noted that he thought "really none of this is related." (PX3).

Furthermore, the Arbitrator notes that Dr. Lehman on cross examination agreed that Petitioner reported to him that she developed shoulder pain shortly after the incident; that the emergency room history that noted that Petitioner's hand was caught in the door was different than catching her arm in the door; that the history of injury on the accident report that indicated that as she was entering the door, a gust of wind blew the door closed on her right hand was different than it closing on her right arm; that if the history that Petitioner gave was correct, that the need for surgery for her shoulder and elbow would be related to the incident but that if the history was that it closed on her hand, however, it could change his opinion. (PX4). Finding the foundation upon which Dr. Lehman based his causation opinion to be flawed in light of the inconsistent medical evidence and testimony by Petitioner in this case, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the right shoulder, right elbow and right hand is causally related to the accident of April 20, 2009, but that Petitioner has proved that her current condition of ill-being in the right index finger is causally related to the accident of April 20, 2009.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up to and including February 5, 2010 was reasonable, necessary and causally related to the work accident of April 20, 2009. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 5, **for medical services rendered up to and including February 5, 2010,** as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being in the right shoulder and right elbow is causally related to the accident of April 20, 2009, Petitioner's request for prospective medical treatment as recommended by Dr. Lehman is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that the parties stipulated at the time of arbitration that Petitioner was entitled to temporary total disability benefits for the timeframe of April 21, 2009 through May 25, 2009. As such, the Arbitrator awards temporary total disability benefits for this timeframe as agreed to by the parties.

As to Petitioner's request for temporary total disability benefits for the dates of July 2, 2013, August 16, 2013, August 20, 2013, September 10, 2013, September 23, 2014 and November 4, 2014, in light of the Arbitrator's findings as to the issue of causation, Petitioner's request for temporary total disability benefits for these particular dates is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Johnston,

Petitioner,

vs. NO: 12 WC 19337

17IWCC0585

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 18, 2016, is hereby affirmed and adopted.

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

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

17IWCC0585

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

DATED: SEP 26 2017
TJT:yl
o 9/18/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

JOHNSTON, LARRY
Employee/Petitioner

Case# **12WC019337**

12WC002910
12WC011599

CATERPILLAR INC
Employer/Respondent

17IWCC0585

On 10/18/2016, 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 0.47% 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:

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

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

17IWCC0585

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Larry Johnston
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # **12 WC 19337**

Consolidated cases: **12 WC 02910 and 12 WC 11599**

An *Application for Adjustment 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 **August 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 Statute of Limitations

FINDINGS 17IWCC0585

On the date of accident, **August 1, 2008,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,914.00**; the average weekly wage was **$844.50**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$11,859.65** for other benefits, for a total credit of **$11,859.65**.

Respondent is entitled to a credit of **$27,309.45** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on August 1, 2008 that arose out of and in the course of his employment with Respondent or that his current condition of ill-being is causally related to the alleged 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

October 13, 2016
Date

ICArbDec19(b)

OCT 18 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to medical records, in a letter dated January 22, 2001 Dr. Kurt J. Heimbrecht, a doctor affiliated with Family Medical Care of Decatur, stated that Petitioner had been experiencing back pain ever since he fell at work in 1994. Petitioner was noted to have symptoms of sciatica down his leg. He added, "With the slightest lifting or trauma there is recurrence of his back pain." The doctor went on to note a four day exacerbation for which he was recommending medication and physical therapy. (PX 1, dep. ex. 2)

In an August 7, 2001 Post Offer Medical-Factory Exam form from Respondent Petitioner denied any prior back pain, back surgery or numbness/tingling in his legs/feet; however, he acknowledged having consulted with a doctor about a back strain. (RX 1)

Petitioner completed a Post Offer Medical Questionnaire for Respondent on May 20, 2003. He denied any prior back surgery of any kind. He denied any prior back pain or injury. (RX 1)

Petitioner underwent a "Vehicle Operator Exam" for Respondent on December 11, 2003. He denied any chronic low back pain. (RX 1)

In March of 2006 Petitioner was treated at Decatur Memorial Hospital for gallstones. (RX 4)

In October of 2006 Petitioner was seen at Prairie Cardiovascular regarding cardiac issues. (RX 4)

Petitioner presented to Dr. Heim on August 5, 2008 regarding back pain. Petitioner gave a history of low back pain that "worsened acute[ly]" on August 1, 2008 when he stepped off a ladder and twisted, which "unfortunately messed up his back." Petitioner was reportedly unable to walk very well and noted pain radiating into his anterior thighs. Petitioner could not put his shoes on. He was using Skelaxin and Advil with minimal relief and was not sleeping well nor could he work for the last two days. Petitioner was observed walking very slowly with tenderness to his low back. Straight leg lifting pulled significantly into his low back at only 20 degrees. He was unable to perform FABER. Petitioner was taken off work from August 4, 2008 through August 7, 2008 and told to use heat and/or ice and perform exercises. He was to call if no better. (PX 4, pp. 62-63; PX 5)

Petitioner returned to see Dr. Heim on August 13, 2008 in regard to his "right sciatica" which was no better. The right anterior thigh discomfort had moved distally to the right lateral calf as well as to the foot which felt numb. Petitioner denied any left leg weakness but was so uncomfortable that he couldn't walk very well. Petitioner had been using Prednisone for five days which helped with discomfort but the tapering had not done so. He had also been using Tylenol as needed. Petitioner continued to move very slowly and with discomfort. He had mild tenderness to his right low back. Straight leg lifting was positive at 20 degrees of movement on the right side. He did not tolerate much extension of the right leg. Petitioner was instructed in a Prednisone regimen. An MRI of the lumbar spine was ordered and Petitioner was taken off work. FMLA papers were to be completed. (PX 4, pp. 60-61; PX 5)

Petitioner underwent lumbar spine x-rays at Decatur Memorial Hospital, per Dr. Heim, on August 19, 2008. According to the radiologist's report, Petitioner presented with a history of low back and right leg pain along with right leg numbness. The radiologist's impression was a large extruded herniated disc to the right of midline at L4-5, indenting upon the thecal sac at and medial to the origin of the right-sided nerve root sleeve while extending inferiorly to rest behind the posterior aspect of the L5 vertebral body on the right, posterior disc bulging at L5-S1, and L4-5, foraminal encroachment by disc bulge most evident on the right at L5-S1 and greater than at any other lumbar levels, and degenerative changes. (PX 5; RX 4)

After the MRI, Petitioner was advised of an appointment with Dr. Chu on August 25, 2008. (PX 5, notations on MRI report)

On September 8, 2008 Petitioner completed a Patient Profile Form. Petitioner indicated he was being seen for both back and right leg pain, with the back being more bothersome than the leg. Petitioner stated that his back pain had begun three weeks prior to August 1, 2008 but he noticed an increase in his pain on August 1, 2008. Petitioner was noted to have morning pain in his ankle and right buttock and numbness in the top of his right foot and his right big toe. He was taking Advil on a daily basis. Petitioner denied an injury or accident, marking that the back problem began "spontaneously." On the pain drawing, he marked lower back pain which was moderate in nature and staying the same. Petitioner reported that walking, standing, and sitting made his pain worse and that his leg felt weak from the knee down. Petitioner could only sit and stand comfortably for thirty minutes. He slept comfortably for two hours and could not walk comfortably whatsoever. Petitioner reported being unable to work since August 4, 2008 and that the following activities were limited because of his pain: dressing; light household chores; heavy household chores; social life; and travel. He had given up walking, swimming, and bike riding due to his pain. (PX 5)

Petitioner was examined by Dr. Chu on September 8, 2008. Dr. Chu felt Petitioner had a large herniated disc at L4-5. Petitioner told the doctor he had experienced back pain prior to August 1, 2008 but it was "not very significant." Petitioner told Dr. Chu that he started experiencing severe pain radiating down his ankle with numbness in his right foot, big toe and on top of his right foot all of which began on August 1, 2008. Petitioner described his pain as constant and moderate to severe since that time. Petitioner was uncertain as to whether he wished to proceed with surgery and he was instructed to return in two weeks with his MRI film which the doctor wished to review. (RX 2 – res. ex. 2, p. 2)[1]

Petitioner returned to see Dr. Chu two weeks later, advising him he did not wish to proceed with surgery as he wished to treat with a chiropractor instead. (RX 2 – res. ex. 2, p. 2)

Petitioner treated with a chiropractor, Dr. Eric Niehaus from September 25, 2008 through March 11, 2009. (RX 2 – res. ex. 2, p.2)[2]

On January 9, 2009 Dr. Niehaus released Petitioner to return to work with a 25 lb. lifting restriction which was to remain in effect until March 11, 2009 or until Petitioner was re-evaluated. (RX 1) Petitioner was cleared by Respondent to return to work on that date. (RX 1)

According to Respondent's company medical records Petitioner was seen on February 2, 2009 in follow-up for chiropractic care for spinal decompression. Petitioner had been released to return to work with restrictions for lower back pain. He was noted to have a herniated disc at L4-5. Petitioner denied any

[1] The actual records of Dr. Chu are not a part of the record.
[2] The actual records of Dr. Niehaus are not a part of the record.

further low back pain and was not taking any narcotics. He had been off work since August 4, 2008. He denied any numbness, tingling, or weakness in his lower extremity. He had normal range of motion with bilateral lower extremity strength and sensation. Petitioner was advised to return to see the company medical department once cleared for return to work at regular duty. (PX 3; RX 1)

According to Respondent's medical department records, Petitioner was seen in the medical department on February 20, 2009 for a herniated disc. There is a reference to Incident # 81752. He had last worked on August 3, 2008 and had returned to work on February 2, 2009. Petitioner had undergone a spinal decompression. Petitioner denied weakness, numbness, or tingling in his lower extremity. He was not on any medication and was no longer having lower back pain. There is reference to an incident date/procedure date of December 3, 2008. (PX 3)

Petitioner returned to Respondent's medical department on May 4, 2009 reporting he had been in physical therapy at his chiropractor's office and his back was good. He denied any more pain, numbness, tingling, or weakness. The assessment was "much improved lower back pain" and Petitioner was told to continue with his restrictions and return to see the company medical department once he was released to regular duty. (PX 3; RX 1)

Petitioner was examined by Dr. Heim on June 9, 2009 regarding his medications. He had last been seen in November of 2008. Petitioner reported his back was doing "very well." He had a herniated disc that was treated with decompression therapy and he had done well. Petitioner was on a 25 lb. weight lifting restriction at work without any problems and the doctor felt he should continue with that to keep his back healthy. Petitioner was noted to still be under some stresses and he was out of work, at least until August. Petitioner was taking a half tablet of Celexa daily. (PX 4, pp. 56- 57)

Dr. Heim re-examined Petitioner on October 19, 2009 regarding Petitioner's low back pain which had improved with Prednisone. Petitioner had also borrowed a piece of medical equipment called a Lumbar Home Trac that utilized a stretching of his lumbar spine. Petitioner reported that previous lumbar traction had helped and he wished to have his own medical equipment. He denied any leg weakness but was still on his Prednisone that began on October 16, 2009. A script for a Saunders Lumbar Home Trac was given based upon a diagnosis of sciatica. He was off work as of October 15, 2009 but the doctor felt he could return to work as of October 19, 2009. (PX 4, pp. 50-51)

Petitioner was seen at Decatur Memorial Hospital on November 18, 2009 for lower back pain that had begun in August of 2008. Dr. Heim had issued a script for Saunders Lumbar traction and Petitioner was being instructed in its use. (RX 4, pp. 123-132)

Petitioner returned to Dr. Heim on February 1, 2010 for a medication check. Petitioner reported occasional left anterior chest discomfort with more of a pleuritic component. No back complaints were noted or discussed. (PX 4, pp. 46-47)

Dr. Heim re-examined Petitioner on April 23, 2010 regarding his low back pain for which Petitioner reported he was "doing well." Petitioner was doing low back exercises, walking on a daily basis, keeping his weight under control and managing with a 25 pound weight restriction at work for which he needed "reaffirmation." He denied any discomfort down his legs and avoided lifting a lot of heavy objects at home. His back was non-tender and everything looked negative. Straight leg raising was negative. FABER did not pull into his back. He had normal deep tendon reflexes to his legs. Petitioner was advised to continue his medications, home physical therapy and weight loss. A note was given regarding his permanent 25 lb. weight restriction at home and at work. (PX 4, pp. 44-45; RX 1, p. 88)

Petitioner was re-examined in Respondent's medical department on April 26, 2010 regarding a "non-occ back check-up." Petitioner was noted to have 2 years of L5 disc discomfort. He was status post decompression surgery. Petitioner completed a pain drawing showing "pain" in the mid lower back region just above his buttocks. There is a reference to "Dr. Niehaus over 4 mo." And "LWT 6 mo – 2008." Petitioner wasn't taking any pain pills beyond Advil and didn't require a TENS unit. Petitioner reportedly could lift up to 10 lbs. "okay." His condition was described as "non-occ L5 lumbar disc disease" and he was to continue with Dr. Heim's restriction of 25 lbs. Petitioner was to return in a year for a review. (PX 3; RX 1)

According to Respondent's medical records, Petitioner was seen in the Medical Department on July 26, 2010 after undergoing a kidney stone lithotripsy on July 9, 2010 (Incident # 93036)(PX 3; See also RX 4, pp. 70 – 121). Petitioner had last worked on July 6, 2010 and was returning to work on July 26, 2010. He was given no new restrictions but was to continue his 25 lb. lifting restriction per Incident # 81752. (PX 3) Petitioner was cleared by Respondent's medical department to return to work on July 26, 2010. (RX 1, p. 95)

Respondent's Progress Notes from its medical department dated January 3, 2011 show that Petitioner had undergone surgery for an umbilical hernia on November 30, 2010. Petitioner was released to return to work with his previous 25# lifting restriction to remain in effect. (RX 1; RX 4, pp. 46- 69)

Petitioner presented to Dr. Heim on March 4, 2011 for a "workers' Comp" injury. Petitioner gave a history of right back pain radiating to his right flank area that had begun the day before. He also complained of a headache and desired some Avapro samples. Petitioner reported working at a work station for the last four days which he had not been stationed at for the better part of a year or so. The company had reportedly tried to make the work station more feasible for Petitioner with different wenches and tackle but he had to maneuver some heavy pieces of building equipment with his arms, upper body and trunk muscle which resulted in significant worsening after work. Petitioner was unable to go to work on the 4th and didn't feel he could work on the 5th due to muscle spasms to the right thoracic muscles radiating around the right mid chest. He denied any leg pain or sciatica. Advil wasn't helping. Petitioner moved around slowly with tenderness around the lower aspect of the right parascapular area along with tenderness to the right mid thoracic muscles and right mid chest wall. Straight leg raising was negative. FABER pulled into the right thoracic muscles. There was no tenderness across the lower back. Petitioner was taken off work as of March 4th but told he could resume work on March 7th. He was given a Prednisone taper and told to use heat and ice. Range of motion exercise was encouraged. Petitioner advised the doctor that "in the course of rotating work stations he will not be on the same work station for a long time. If he is not able to work on Monday '[he is] to get in touch [with the doctor.]'." (PX 4, pp. 35-36)

On March 8, 2011 Petitioner completed a Caterpillar Employee Incident Report regarding an accident on March 3, 2011 while working in Department 8336 Building B67C. Petitioner stated:

> Work in in dept. 8336 on load stand, load and unloading fixtures. dept. has a manual hoist in this area. I was pushing and pulling on parts on hoist all day, also large lifting device is hard on me whey [sic] putting it on and off the parts. Back was a little sore when I left work. I just thought this was normal because I have not done this job in about

4 yrs. I woke up Thursday night with bad pain in my mid back right

side. (PX 3; RX 1)

Petitioner reported a sharp dull pain in his right mid back. In response to the question "Have you had a prior injury to the affected body part/parts?" Petitioner replied "Yes" and stated "I have had a lower back injury." (PX 3) Petitioner further indicated that he was treating with Dr. Heim. The record notes the incident number as "99750." (PX 3) Petitioner completed a pain drawing showing right mid-back "minimal to mild" pain. Petitioner denied any radiating pain complaints and described his level of pain as "3/10." According to the narrative, "Petitioner injured back while running load stand." (PX 3)

Petitioner was examined by Respondent's nurse on March 8, 2011 in conjunction with incident number 99750. The nurse noted Petitioner had injured his right mid-back while running the load stand. (PX 3)

Petitioner was seen by the Medical Department on March 8, 2011 and a "Progress Note" was entered. Petitioner was complaining of mid-back pain spasms radiating to the "right side" that had awaken him. He had a history of a herniated disc at L5-S1 and permanent 25 # lifting restrictions (since 2008). Petitioner had undergone a spinal decompression in the past. Petitioner's back was reportedly feeling better that day. He had seen a doctor who put him on Prednisone and Skelaxin. Petitioner reported doing okay with getting in and out of a chair and going up steps or stairs and squatting. He could cross his legs. Petitioner's condition was described as lumbago. Petitioner was released to return to work with his 25# restriction and was to return if needed. (PX 3)

Petitioner completed another Caterpillar Employee Incident Report on March 30, 2011 after he fell backwards onto way covers in "4449" when his left foot caught on a wire cable. Petitioner noted right wrist, left shin, and right lower back injuries. He further mentioned "bruised." He denied receiving any medical care outside of Respondent at that time. (PX 3) Petitioner was seen by Respondent's nurse that same day regarding incident #100317. Petitioner's wrist was noted to be beginning to bruise. He was given ice for the wrist and antibiotic ointment and a band-aid for his shin. He was released to return to work. This was recorded as Incident # 100317. (PX 3)

According to Respondent's Medical "Progress Note" dated March 30, 2011 Petitioner was being seen for the first time after a fall that day at work. Petitioner complained of bruises and abrasions to his right wrist, left shin, and right buttocks. On exam, Petitioner's right wrist had some shallow abrasions on the radial side and was tender. There was no deformity, however. Petitioner also had abrasions on his left shin but no deformity. Petitioner buttock's area revealed tenderness with no other abnormalities. Petitioner was advised to use Advil, and ice. He was released to his regular job and told to come back the next day. (PX 3; RX 1) Petitioner completed a pain drawing showing achiness and minimal pain in his right lower back/buttocks region. (PX 3)

Petitioner was examined by Dr. Fabrique at Respondent's Occupational Health and Wellness Center on March 30, 2011. He was complaining of bruises and abrasions of his right wrist, left shin, and right buttock after falling at work earlier that day. His pain drawing was referenced (showing pain at the right wrist, left shin, and right lower back/hip region). Petitioner was noted to have a shallow abrasion on the radial side of his right wrist with tenderness but no deformity, an anterior medial abrasion of the left shin with tenderness but no bony deformity, and tenderness in the right mid-buttock without any other abnormalities. Petitioner was advised to use Advil and apply ice to the sore areas. He was able to return to work but was told to come back the next day. (PX 3; RX 1)

Petitioner returned to Respondent's medical department on March 31, 2011 as instructed. He reported being stiff and sore. His right wrist was sore and bruised and he had iced it the previous evening. Petitioner's right knee was sore also. Petitioner's range of motion for his back was normal. He was kept on his regular job and told to return on April 6, 2011. (PX 3; RX 1)

Petitioner was re-examined by Dr. Fabrique on March 31, 2011 and reported ongoing stiffness and soreness. His right knee was sore. Some swelling of the ulnar side of the right wrist was noted. He had full active range of motion. Dr. Fabrique's assessment was occupation contusion/abrasions of the right wrist, left leg, and right buttock. He was advised to return on April 6, 2011. (PX 3; RX 1)

Petitioner did not return to Respondent's Medical Department or Dr. Fabrique on April 6, 2011 as instructed. (PX 3)

Petitioner did, however, return to see Dr. Heim on April 11, 2011, to discuss medications as the Avapro (for his headaches) was too expensive. No low back or leg complaints were noted. (PX 4, p. 31)

Petitioner presented to Dr. Heim on July 20, 2011 due to a "flare-up" of his sciatica. According to the doctor's note the last time Petitioner had a flare-up was in 2008 and it was right sciatica. Petitioner was now reporting left sciatica explaining that he had been experiencing low back pain for the last month with worsening left sciatica in the preceding last five days. Petitioner had been utilizing his lumbar traction machine at home which helped minimally. He had been taking Advil as needed which helped minimally and, rarely, using Vicodin. Petitioner had not worked the 19th or 20th due to progressing pain. Petitioner moved around slowly. He had no significant tenderness across his low back. Straight leg raising was positive on the left and FABER pulled subtly into his left low back as well. Petitioner was started on Prednisone and told to continue the Vicodin as needed. He could use his lumbar traction. Petitioner was advised he could return to work on July 26, 2011 unless an extension was needed in which case he should call. (PX 4, pp. 29-30)

Petitioner returned to see Dr. Heim on August 15, 2011 regarding persistent back pain. His left sciatica was reportedly no better. The Prednisone was of minimal benefit. Petitioner had not worked since July 19, 2011 "when this all started." Petitioner commented that his right-sided sciatica had resolved after six months and he had seen the back specialist who did not highly suggest any surgical procedures. Petitioner had been using his inversion table with some improvement noted and Skelaxin helped decrease muscle spasms and walk better. Standing and lying down seemed to help his pain a lot. He denied any left leg weakness. Petitioner was able to walk a little more easily that day with some slight tenderness to the left low back being noted. Straight leg raising was positive on the left and FABER pulled slightly into the left low back. His legs were normal neurovascularly. Petitioner was to continue the Prednisone and return to work on September 20, 2011 but the doctor wanted to see him on the 19th. Petitioner was to resume Advil after the Prednisone was finished. They elected to hold off on the MRI for the time. (PX 4, pp. 27-28; RX 1)

As instructed Petitioner return to Dr. Heim on September 19, 2011 reporting about thirty percent improvement but with his work schedule and duties he didn't feel he could return to work at the present time. Petitioner noted he was looking for another job that would be less physically demanding on his body. Dr. Heim suggested Petitioner try the inversion t.i.d. which he had been using at home. The Prednisone had reportedly helped. Dr. Heim also noted that it had previously taken about six months for his sciatica to fully resolve. Petitioner was noted to be moving slowly with some tenderness to his low back. Straight leg lifting pulled significantly into the left back and was positive on the left side for sciatica. Petitioner's exam was essentially unchanged from the 15th of August. Dr. Heim provided

Petitioner with another ten day Prednisone course and kept him off work until October 19th. (PX 4, pp. 25-26; PX 7)

Petitioner returned to see Dr. Heim on October 17, 2011 as previously instructed. Petitioner reported that his left-sided sciatica improved and bout two weeks earlier was noted to be gone but the right-sided sciatica with calf discomfort had begun. He did not feel he could return to work. On exam, he moved very slowly. Standing and walking seemed to help the most. He had some mild tenderness to the lower lumbar muscles. Straight leg lifting was negative bilaterally but pulled into both sides of his low back. He was kept off work as of "July 19, 2011" through November 23, 2011. An MRI was ordered. Petitioner was to return on November 21, 2011. (PX 4, pp. 23-24; PX 7; RX 1)

Petitioner underwent a lumbar spine MRI on October 21, 2011 at Decatur Memorial Hospital. The impression was: (1) Foraminal encroachment on the right side at L5-S1, mildly impinging upon the right-sided nerve root sleeve within the foramen and (2) Degenerative changes of the lumbar spine, mild to moderate in appearance. (PX 4, p. 132; PX 5; RX 1; RX 4)

Petitioner presented to DMH Millennium Pain Center on October 31, 2011 regarding his low back pain. By history, Petitioner reported low back pain since 2008 which had worsened in August. He reported having a herniated disc and denying any accident or injury to his back, stating "just woke up in the morning and was in a lot of pain." Petitioner reported some days he was okay and some days he just couldn't move. He reported some numbness and tingling in his legs, more so on the left than the right. The pain would radiate down the back of his leg and into the thigh area. Petitioner also reported that he has some ankle pain and that it feels like it's broke. Petitioner was on Advil, having previously taken Vicodin and Prednisone. Advil seemed to work better than Vicodin. The doctor's assessment was a herniated disc at L4-5 and L5-S1 along with facet arthropathy, SI joint pain, and myofascial pain. An L4-5 ESI was recommended. (PX 8; RX 4)

Petitioner presented to DMH Millennium Pain Center on November 1, 2011 reporting no changes since his last visit of October 31, 2011. Petitioner underwent an L4-5 LESI. (PX 8; RX 4)

Petitioner reported back to Dr. Heim on November 11, 2011 regarding epidural injections. He had undergone one on November 1, 2011 and noticed some changes thereafter. The epidural helped significantly as the right sciatica resolved. His low back pain spasms and arthritic symptoms were still present, however. He was to return to the Pain Clinic next week. Dr. Heim noted, "Did also review that previously in 2008 he had a herniated disc at L4-5 and now he has continued herniation at L4-5 with some bulging discs that are worse at L5-S1." (PX 4, pp. 21-22)

As of November 21, 2011 Dr. Heim noted that Petitioner continued to have low back pain with some left sciatica, minimally occurring at present. The right sciatica had resolved with an injection. Petitioner stated that his pain had been ongoing since July 11, 2011 and he wished to see a surgeon. He was referred to Dr. Pencek and kept off work through January 17, 2012 at which time the doctor wished to re-examine him. (PX 4, p. 19; PX 7)

In anticipation of his upcoming appointment with Dr. Pencek, Petitioner completed a Questionnaire for the doctor on December 13, 2011. In it, he stated he was being seen for lower back pain and left leg pain. He didn't not state whether or not his injury was work-related (leaving the question unanswered) but denied it was related to an auto accident. He also did not address whether he had a lawsuit pending. (PX 5)

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 2910 on December 27, 2011 alleging an accident date of March 4, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX 5[3])

On January 10, 2012 Petitioner was examined by Dr. Pencek at St. Mary's in Decatur in regard to his left sciatic pain. Petitioner reported low back pain and left hip pain. At times, he noted bilateral hip pain. Petitioner also reported numbness and tingling in his left foot and the inability to bend or twist with pain or the ability to ride in a car for long distances. Petitioner reported injuring his back at work in 2008 at which time he was examined by Dr. Chu. Petitioner reported electing not to pursue surgery at that time preferring, instead, to be treated by a chiropractor. Petitioner, a machinist for Respondent, further reported that his pain was tolerable until March of 2011 when his workload at work increased and his symptoms progressively worsened. Petitioner had been off work since July 17, 2011. Petitioner further reported increased pain by leaning forward as it would result in a "shocking feeling" up his spine and out to the sides. Lying down would help as would steroids which Dr. Heim had prescribed to him. He had not done any therapy since 2008. He hadn't seen a chiropractor recently either. Petitioner had undergone an epidural steroid injection in November of 2011 which relieved his left leg pain but resulted in urinary incontinence for two weeks. Dr. Pencek noted some tenderness to palpation at the L5 region. Strength was 5/5 bilaterally with a steady gait and no need for assistance. He toe walked without difficulty. Heel walk reportedly caused pain as did flexion of the knee with resistance. Petitioner had positive straight leg raising at 30 degrees bilaterally with low back pain. Dorsiflexion while performing straight leg testing only increased pain on the right. Petitioner's MRI from 2011 revealed "black discs" at L4-5 and L5-S1. At L4-5 there was disc bulging mildly flattening the anterior aspect of the thecal sac. The neural foramen was patent. At L5-S1 there was moderate foraminal encroachment from a bulging disc on the right mildly impinging upon the right-sided L5 nerve root. Dr. Pencek recommended physical therapy. He noted a discogram might be necessary in the future. (PX 5)

Dr. Heim re-examined Petitioner on January 17, 2012. Petitioner's left sciatica was reportedly no better. Indeed, Petitioner felt they were sores. He had seen a neurosurgeon who ordered physical therapy for thirty days but it was not scheduled to begin until February 1, 2012. If physical therapy did not help a discogram was being recommended. In the meantime Petitioner was to remain off work. A prescription for lidocaine patches was given since they had helped before. On exam, Petitioner walked slowly around the office. He would sometimes sit on the exam table and sometimes not due to back discomfort. Petitioner had muscle spasms and tenderness around the low back. Straight leg lifting was positive. Petitioner was kept off work through March 13, 2012 ("tentatively"). (PX 4, pp. 17-18; PX 7)

Petitioner underwent four sessions of physical therapy beginning in mid-February of 2012. In conjunction with the initial examination he gave a history of onset in March of 2011 when he was pushing a hoist at work and noticed increased pain that evening. (PX 5; RX 4)

Petitioner followed up with Dr. Pencek on February 21, 2012 at which time he reported no improvement from the physical therapy. Dr. Pencek noted Petitioner had a large extruded disc at L4-5 on the right. A lumbar discogram was ordered. Petitioner was reporting low back pain, right hip pain, and right knee pain, worse since the discogram. (PX 5)

Petitioner underwent a brief course of physical therapy in February and March of 2012. (PX 5)

[3] Petitioner's counsel advised at trial that the original accident date alleged in the Application for Adjustment of Claim was March 4, 2011. It was subsequently amended to allege an accident date of March 3, 2011.

Petitioner signed his Application for Adjustment of Claim in case # 12 WC 11599 on March 12, 2012 alleging an accident date of March 30, 2011. Petitioner claimed he was "injured at work" and injured his "back and other parts of the body." (AX6)

Petitioner returned to see Dr. Heim on March 13, 2012 reporting he was scheduled for a discogram on March 29, 2012 and anticipated undergoing a lumbar laminectomy and spinal fusion. Petitioner remained unable to work with a limited level of activity although the doctor encouraged as much activity as possible. He also recommended trying to lose some weight before surgery. Medications were refilled. He was kept off work through June 14, 2012 and was to return for a visit on June 13, 2012. (PX 4, pp. 15-16)

Petitioner underwent a discogram on March 29, 2012 at St. Mary's Hospital in Decatur. The discogram, performed by Dr. Furry, was performed at three levels: L3-4, L4-5, and L5-S1. Dr. Furry noted the discogram was positive at L4-5. (PX 5)

Petitioner returned to see Dr. Heim on April 27, 2012 regarding his left sciatica which was continuing to be a significant problem. Petitioner had done more research and wished to be seen by Dr. Kovalsky in Mt. Vernon who was performing lumbar surgery with disc replacements rather than fusions. He was referred for a consultation. (PX 4, pp. 11-12)

Petitioner was examined by Dr. Kovalsky on May 16, 2012. According to the doctor's notes, Petitioner was a self-referral for evaluation of chronic low back pain. Petitioner reported being injured in 2008 and then re-injured himself in March of 2011. Petitioner had not been working since July of 2011. Petitioner initially tripped over a large part lying on the floor and grabbed a chain to keep from falling. He then twisted his back in the process and injured his back. Petitioner then re-injured his back lifting in March of 2011. Petitioner's primary complaint was low back pain. His secondary complaint was referred pain into his legs. Petitioner's back pain was reportedly constant and worse with activity. His leg pain was described as intermittent and worse on the left than the right. Dr. Kovalsky concluded that Petitioner was suffering from degenerative lumbar disc disease at L4-5 and L5-S1 along with a central disc herniation at L4-5 and a right central disc herniation at L5-S1. He felt Petitioner was a candidate for a two level total disc arthroplasty at L4-5 and L5-S1. The doctor recommended a twenty pound weight loss prior to surgery. Once surgery was approved by workers' compensation the doctor recommended he be evaluated by Dr. Shores, his "access surgeon." In the interim he recommended continuing with medication per his family doctor. He remained unable to work. (PX 6)

On May 25, 2012 Petitioner signed his Application for Adjustment of Claim in case number 12 WC 19337 (AX 4). Petitioner alleged an accident date of August 1, 2008 when he was "injured at work." (AX 4)

Dr. Heim re-examined Petitioner on June 13, 2012 regarding his medications. Petitioner reported being scheduled for a two level lumbar laminectomy on August 28th, as his surgeon had undergone a hip replacement recently and would be unable to perform any surgeries until the end of August. Petitioner remained uncomfortable. He was kept off work as of July 19, 2011 with an anticipated return to work on October 8, 2012. He was to return to see the doctor sometime after his surgery and before the 8th. (PX 4, p. 10)

Petitioner returned to see Dr. Heim on October 1, 2012 noting his back surgery had been cancelled. Petitioner's surgery "was in arbitration" and he didn't know which surgery he would be undergoing. Petitioner reported decreased sleeping lately due to low back pain. He was having a lot of low back muscle spasms and throbbing at the present along with intermittent bilateral right and left leg sciatica issues. His left leg felt a little weak that day. Petitioner was not working. He was taking some Vicodin at

bedtime. He was told to resume a ten day course of Prednisone. Petitioner was to return the first week of January. He remained off work. (PX 4, p. 8)

Dr. Heim re-examined Petitioner on January 2, 2013 for his back. He was no better and his case was presently in a "review mode" which might take up to 180 days. Petitioner was still in a lot of discomfort and was using his Vicodin as needed. The Prednisone helped but only for a short while. He was to return to see the doctor on April 22, 2013 for an anticipated April 24th return to work. (PX 4, pp. 5-6)

Petitioner returned to see Dr. Heim on April 22, 2013 for a medication check-up. Petitioner reported significant low back pain. His appeal for low back surgery had been denied and his lawyer was working on other possibilities. Petitioner reported a lot of stress in his life for which he was taking some medication. His weight was down six pounds. He moved slowly around the office due to low back pain. He remained off work and his medications were continued. Petitioner was to return in four months for a recheck. (PX 4, pp. 3- 4)

Dr. Heim re-examined Petitioner on November 20, 2013 regarding his medications. Petitioner reported ongoing significant problems with his sciatica. His surgery had been denied. Dr. Heim was scheduled for a deposition. Petitioner had experienced right kidney stones which the doctor felt accounted for some ongoing right flank pain. Petitioner's weight was up a few pounds. He remained off work with a possible resumption date of April 2, 2014. (PX 4)

Deposition of Dr. Dennis Heim

The deposition of Dr. Dennis Heim was taken on December 10, 2013. (PX 1) Dr. Heim is board certified in family medicine. Dr. Heim testified consistently with his office notes discussed above. He testified that when he saw Petitioner on March 4, 2011 he did so due to significant low back pain that had begun on March 3rd and kept Petitioner from being able to work that day. Petitioner denied any prior significant pain in his low back. Dr. Heim testified that Petitioner had related to him that his job required him to move heavy pieces of building equipment with his arms, upper body and trunk muscles when he noticed the back discomfort. Dr. Heim recommended Petitioner not work for a few days and prescribed some Prednisone and Skelaxin to help with inflammation, swelling, and muscle spasms. Dr. Heim further acknowledged seeing Petitioner again on April 6 and April 11, 2011. He did not testify that these visits dealt with Petitioner's back. (PX 1, pp. 1-9)

Dr. Heim also testified that Petitioner returned to see him on July 20, 2011 regarding a flare-up in his left-sided sciatica. Petitioner's physical examination was consistent with left-sided sciatica (or pinching of a nerve) and the doctor again recommended Prednisone and Vicodin along with use of his home lumbar traction machine. He was taken off work. As of August 15, 2011 Petitioner's left sciatica was no better, his exam reflected mild tenderness in the left lower back, positive straight leg raising on the left, and a positive Faber on the left lower region of Petitioner's back. Petitioner told the doctor he had not been working since July 19, 2011 and the doctor kept him off work. He then re-examined Petitioner on September 19, 2011 noting the same complaints with some general improvement. Petitioner didn't feel he could return to work at that time. Dr. Heim examined him and felt he should remain off work. (PX 1, pp. 9- 12)

Dr. Heim further testified that when he examined Petitioner on October 17, 2011 Petitioner's left-sided sciatica had improved but he was now complaining of right-sided symptoms down his right leg. His use of the inversion therapy had not helped. He remained off work and the doctor ordered an MRI. Dr. Heim testified that he again saw Petitioner on November 11, 2011 at which time Petitioner was discussing the epidural steroid injections he was receiving and which had helped on the right side but not the left. Dr.

Heim testified that the MRI report revealed a herniated disc at L4-5 and a worsening bulging disc at L5-S1. Dr. Heim kept him off work. As of November 21, 2011 the right sciatica had resolved. The doctor testified that when he saw Petitioner on January 17, 2012 Petitioner felt his left-sided sciatica was getting worse. Petitioner was examined and felt to be unable to work. Lidoderm patches were prescribed for pain management. As of March 13, 2012 Petitioner was reporting that his activity level remained quite limited and he was scheduled for a discogram. Dr. Heim kept him off work. (PX 1, pp. 12 -18)

Dr. Heim testified that in April of 2012 he and Petitioner discussed a consultation with Dr. Kovalsky and the doctor referred Petitioner to him. Thereafter, Dr. Kovalsky examined him and subsequently recommended a two level fusion. Dr. Heim further testified that he saw Petitioner on October 1, 2012 noting Petitioner was upset that his surgery had been cancelled and he wasn't sleeping well because of his low back pain. Petitioner reported bilateral sciatica issues for which he was taking Vicodin. Petitioner also reported left leg weakness. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 18-20)

Dr. Heim testified that he again examined Petitioner in January and April of 2013 with ongoing back complaints and discomfort being noted. Petitioner was taking Vicodin as needed. In April Petitioner was complaining of stress because of his appeal for low back surgery being denied and he was having some other issues as well. Petitioner was moving very slowly due to his low back pain and remained unable to work. (PX 1, pp. 20-22)

Dr. Heim testified that he last saw Petitioner on November 20, 2013 for a medication check. Petitioner was still complaining of low back pain and issues with sciatica. Petitioner was also passing kidney stones, using his Skelaxin, Norco, and Lidoderm intermittently. Dr. Heim felt Petitioner remained unable to work. (PX 1, pp. 22-23)

Dr. Heim was of the opinion that Petitioner had ongoing herniated discus and bulging discs which needed surgical repair. When asked if the injury Petitioner described to him could have caused or aggravated Petitioner's condition of ill-being, Dr. Heim testified that based upon the history he was provided on March 4, 2011 Petitioner had been doing well, returned to work, and had an injury at his work station that had resulted in a painful back with sciatica. He recommended the surgery proposed by Dr. Kovalsky noting that Petitioner has multiple level disc disease which would not benefit from being repaired at solely one level as it would be highly probable that adjacent levels would destabilize to the point of requiring a second surgery. (PX 1, pp. 23-25)

On cross-examination Dr. Heim testified that he has treated Petitioner since April 15, 1996. The doctor was unaware that Petitioner sustained a fall at work in 1994 that resulted in back pain. Dr. Heim also did not know if Petitioner had periodically been seen by Dr. Heimbrecht. Dr. Heim acknowledged correspondence from Dr. Heimbrecht dated January 22, 2001 noting a history of Petitioner having low back pain since a fall at work in 1994 which had resulted in sciatica that significantly impacted his ability to be mobile. (PX 1, pp. 25-28)

Dr. Heim also acknowledged seeing Petitioner on August 5, 2008 at which time Petitioner reported an acute worsening of his low back pain after stepping off a ladder and twisting. He also agreed that Petitioner then underwent an MRI in August of 2008 that showed a herniated disc at L4-5 and degenerative discs at L4-5 and L5-S1. (PX 1, pp. 28-30) On further cross-examination Dr. Heim also acknowledged that on August 14, 2008 he signed off on a two page disability form for Respondent at which time he indicated Petitioner's low back condition was not work-related. (PX 1, pp. 30-31)

Based upon the foregoing, Dr. Heim agreed that Petitioner had degeneration of his low back with a herniated disc and sciatica on two occasions prior to March of 2011. He also agreed that Petitioner's complaint on March 4, 2011 was thoracic pain radiating around his right mid chest. The doctor had no recollection of how high or low on Petitioner's thoracic spine or chest those pain complaints were. The doctor further agreed that Petitioner denied any leg or sciatic complaints at that time. Dr. Heim also agreed that when he saw Petitioner on April 6, 2011 he was complaining of left anterior chest discomfort which would have nothing to do with Petitioner's mid-back or low back. He also acknowledged that Petitioner voiced no low back complaints nor did he comment upon back pain at that visit. He also didn't mention anything about sciatica. Dr. Heim further testified that at the April 11, 2011 visit Petitioner told him his earlier back pain had resolved and he mentioned no sciatic complaints. (PX 1, pp. 31-34)

Dr. Heim also testified on cross-examination that Petitioner presented on July 20, 2011 with sciatic complaints that Petitioner associated with back pain for the preceding month and that the sciatica complaints had worsened in the previous five days. Dr. Heim further testified that Petitioner told him, at that time, that he had last experienced sciatica in 2008. Dr. Heim further testified that Dr. Heimbrecht had completed a Respondent disability form in July of 2011 and indicated Petitioner's condition was not related to his work. (PX 1, pp. 34-37) Dr. Heim also agreed that the first recorded complaint in 2011 of sciatica occurred on July 20, 2011. Dr. Heim also testified that when he saw Petitioner on March 4, 2011 Petitioner was not specifically talking about a sciatica issue. He also agreed that Petitioner's MRI in 2011 showed disc degeneration and sciatica issues and that those findings were also present in 2008 but the "wording was different." (PX 1, p. 38) He stated that his causal relationship opinion was based on an assumption that Petitioner had ongoing back pain or sciatica symptoms from March forward, which is not recorded anywhere in any of the records that he has or has been provided. (PX 1, pp. 34-40)

On redirect examination Dr. Heim testified that he has seen Petitioner for approximately 17 years, including occasions prior to March 4, 2011. As of March 4, 2011 he agreed Petitioner's back was "generally stable." He also agreed that prior to that visit they had not discussed a referral to a neurosurgeon. He also agreed that maneuvering heavy pieces of building equipment with one's arms, upper body and trunk muscles could aggravate or cause a disc herniation or degenerative disc disease leading to the necessity of a fusion. He also agreed that left foot tingling could be a sign of sciatica, disc herniation or an aggravation of degenerative disc disease. Dr. Heim also agreed that lumbago could indicate pain in one's lower back. Dr. Heim further agreed that one can have some low back pain and that as time progresses that pain increases in the low back and down one's leg. When asked if that could or might have been what happened to Petitioner, Dr. Heim replied it was possible that a person could have degenerative low back arthritis that could progress to cause sciatica and he believed that the type of injury Petitioner described to him could have aggravated his particular condition. (PX 1, pp. 40-44)

On further cross-examination, Dr. Heim agreed that tingling in one's left food can be caused by a variety of things. (PX 1, p. 45)

At the request of Respondent, Petitioner underwent an examination on February 4, 2014 with Dr. Sergey Neckrysh. In a letter to Respondent's attorney dated February 17, 2014 Dr. Neckrysh summarized his evaluation. (RX 2 – RX 2) In his report Dr. Neckrysh noted Petitioner gave a history of having sustained his first injury around August 1, 2008. At that time Petitioner was sent over by his supervisor to receive training and he fell into a hole in the ground. As he was falling down, he grabbed the chain hanging from the hoist and twisted his body in a "funny way" and he started complaining of left foot pain. Petitioner then presented to Dr. Heim on 8/5/08 who noted a history of back pain for one month

and an acute exacerbation while stepping off a ladder. Petitioner, thereafter, underwent an MRI on August 19, 2008. He followed up with Dr. Chu on September 8, 2008. While surgery for a right-sided disc herniation was discussed Petitioner decided not to undergo surgery, preferring, instead, to try chiropractic treatment. Petitioner did, in fact, undergo chiropractic treatment, from September 25, 2008 through March 11, 2009. He then followed up with Dr. Heim on August 14, 2008 and the doctor signed off on a disability form.

Dr. Neckrysh further noted in his report that Petitioner was subsequently seen by Dr. Bahrainwala, Respondent's company doctor, in February of 2009 who felt Petitioner had non-occupational low back pain. There were some additional visits in May of 2009 and Petitioner was eventually released to return to work with a 25 pound weight restriction. At that time Petitioner denied any numbness, tingling, or weakness.

According to Dr. Neckrysh's report Petitioner's next injury occurred after returning to work and working with a 2000 pound part that had a manual hoist which he had to attach the part to and then push the part along the production line. He would also have to stop the movement of the part by pulling with his body. He felt it was beyond his restrictions but his attempts to bring it to the company's attention were ignored. Then, on "March 3, 2011" Petitioner got his right foot caught and fell backwards experiencing back and right leg pain which the doctor noted was the primary issue of the evaluation that day. Dr. Neckrysh reviewed the Decatur Plant medical site notes along with Dr. Heim's records of that time. Dr. Neckrysh noted that Respondent's medical records reflected that Petitioner caught his left foot on a cable on March 30, 2011 and that Petitioner then fell backwards bruising his right wrist, left shin and right lower back. As of March 31, 2011 Petitioner had no focal abnormalities of his low back and his active range of motion was normal. The doctor further noted Dr. Heim's April 11, 2011 office visit which was silent regarding any lower back complaints and Dr. Heim's July 20, 2011 visit noting a "flare-up" in Petitioner's sciatica. Dr. Neckrysh noted that Petitioner was seen by Dr. Kurt Heimbrecht on July 20, 2011 who signed off that there was a causal relationship between the accident Petitioner had reported and the left sciatica. (RX 2 – RX 2, p. 3) Petitioner also told Dr. Neckrysh he had been referred for epidural injections but due to the side effects of the first one, he only underwent one injection.

Dr. Neckrysh also noted that Petitioner had resolved sciatica in the right leg as of November 21, 2011 but ongoing left sciatica as of January 17, 2012 when he was referred to Dr. Pencek. Dr. Neckrysh noted Petitioner's history to Dr. Pencek of having injured his back in 2008. Dr. Neckrysh also reviewed Petitioner's discogram. Petitioner had then been seen by Dr. Kovalsky who recommended surgery in the form of a two level disc arthroplasty but approval was denied. Since then Petitioner has been in a "holding pattern" as nobody will pay for his surgery.

Included in the doctor's report was a comment that Petitioner told him during the examination that his pain has always been in his left foot; however, the doctor noted various medical records documenting lower right foot pain. (RX 2 – res. ex. 2, p. 3)

On physical examination Petitioner was noted to walk in the room with "significant pain, grimacing on his face, jerking his right foot, claiming that it is still impossible for him to walk without support, and that he is using a walker." Examination of Petitioner's lower extremities was very limited due to Petitioner's subjective complaints of pain. He admitted to tenderness of the lumbar spine in the midline and upon palpation of bilateral sacroiliac joints. He did not display objective weakness on exam but every motor task in the lower extremities bilaterally was very limited due to pain complaints. Right side straight leg raising was positive at 40 degrees and crossed over to his left leg; left leg at 60 degrees. Petitioner could dorsiflex his feet but did so very dramatically. No films were available for the doctor to review.

Dr. Neckrysh was of the opinion that Petitioner had degenerative disease of his lumbar spine with complaints of right leg pain unsupported by any current imaging studies. The doctor further opined that Petitioner's current condition had "nothing to do" with Petitioner's performance of job duties on August 1, 2008, March 4, 2011 or March 30, 2011. He felt the timing of Petitioner's reported symptoms was inconsistent with work-related exacerbations or aggravations but more consistent with flare-ups of degenerative disc disease. He felt the MRI showed no surgical pathology but, rather, age appropriate disc degeneration at L4-5 and L5-S1 which still don't require surgery. Dr. Neckrysh acknowledged that the discograms reportedly showed annular tears at L4-5 and L5-S1 but discography is a highly controversial matter and he wouldn't base his clinical or surgical decisions on the results of a discogram. He further felt that Petitioner had fully recovered from his acute disc herniation in 2008.

Dr. Neckrysh was also of the opinion that Petitioner was at maximum medical improvement as a result of any of the injuries; however, further work-up of his degenerative disc disease and right leg pain would be warranted. If he were the treating doctor he would have Petitioner undergo an EMG to verify any radiculopathy. He would also try a diagnostic block at L4-5 on the right and send him to a neurosurgeon who specializes in spinal cord stimulation. He felt a two level disc arthroplasty was an unnecessary procedure as there is no data to support the benefits of such a procedure. He noted that Petitioner has complaints of right leg pain which such a procedure would not even potentially help. Finally, the doctor felt Petitioner needed no work-related restrictions and he couldn't verify Petitioner's complaints of leg pain. In his report the doctor noted that Petitioner was, on the day of his exam with him, stating that his pain was always in the left foot; however, the doctor noted multiple treating records surround the accident on August 1, 2008 show treatment for right foot pain. (RX 2 – RX 2)

Petitioner returned to see Dr. Heim on March 21, 2014 regarding his medications. Overall, Petitioner was not doing very well. He was still having significant problems with his sciatica and had been unable to walk very much because of it and bad weather. His case was in the legal system with depositions having been taken. He had undergone an examination with an independent physician who, in Petitioner's words, "did not really do anything that was of any objective unbiased examination." He was taking Norco 1 or 2 tablets a day and had had no further kidney stones since his last visit. His weight was up. Dr. Heim noted Petitioner could not do a lot of outdoor exercising because he was being monitored and watched by his work comp people so his exercise was limited. The doctor suggested he walk inside the house. Petitioner's ability to work was not addressed. (PX 4)

Petitioner was re-examined by Dr. Heim on April 25, 2014. No back complaints were noted. His weight was stable. The visit was for medications. (PX 4)

Dr. Heim again examined Petitioner regarding his back pain and medications on June 6, 2014. Petitioner was feeling more relaxed with Librium. He has been doing a little bit more walking and had been up to twenty minutes until his back significantly flared up with the walking. The back pain was so bad and the sciatica so bad (left leg) that he had to resume Prednisone for a short while. The sciatica was improving but not resolved. Petitioner's attorney was working on his case. He was noted to be moving slowly due to back and leg pain. Petitioner was to return in three months for blood pressure. No off work status was noted. (PX 4)

Deposition of Dr. Sergey Neckrysh

The deposition of Dr. Sergey Neckrysh was taken on September 4, 2014. (RX 2) Dr. Neckrysh testified consistent with his earlier written report. He was of the opinion that Petitioner's condition as of the date

of his examination was not causally related in any way to the incidents of August 1, 2008, March 4[4], 2011, or March 30, 2011. (RX 2, p. 11) Dr. Neckrysh acknowledged on cross-examination that he only examined Petitioner on one occasion. Dr. Neckrysh was also asked about some 2001 records he reviewed and he agreed that nothing in them suggested Petitioner needed back surgery or an MRI at that time or showed positive findings for sciatica, positive straight leg raising. (RX 2, pp. 25-27) Dr. Neckrysh agreed that, in general terms, one could herniate a disc or aggravate a pre-existing herniated disc stepping off a ladder and twisting. (RX 2, p. 28) He further agreed that if one fell backwards landing on their buttocks, it could aggravate a herniated disc. (RX 2, p. 29) He also acknowledged that Petitioner's symptoms improved somewhat after using his traction machine. He also testified that Dr. Niehaus' records suggested that Petitioner had a herniated disc and right leg pain for which surgery had been recommended but Petitioner decided not to pursue it. (RX 2, p. 31) He did not have an opinion as to whether or not Petitioner still needed surgery in March of 2009 because he did not undergo another MRI and the doctor didn't know if he still had right leg pain. He did acknowledge that Dr. Bahrainwala saw Petitioner on February 2, 2009 and noted Petitioner had no more pain, numbness, tingling or weakness. (RX 2, pp. 32-33)

Dr. Neckrysh was also asked to assume that on "May 3, 2011" Petitioner reported pushing and pulling on large fixtures all day and experiencing some back pain and then questioned whether such an activity could aggravate degenerative disc disease. Dr. Neckrysh replied "Yes and no. I mean, it could cause a temporary flare-up of the muscle pain, facet pain which usually are a very self-limiting event. (RX 2, p. 34) He was also asked to assume that on March 30, 2011 Petitioner fell and landed on his buttocks and then asked whether that event could aggravate the degenerative disc disease. Dr. Neckrysh replied that any fall or excessive physical load on the spine may produce soft tissue injury or symptoms but it will not effect in any way degeneration. (RX 2, p. 35) He did not believe such an injury could make asymptomatic degenerative disc disease symptomatic. (RX 2, pp. 35-37) He did acknowledge that a fall or trauma could trigger "an investigation" but one would need objective evidence of an injury on imaging studies or clinical exam by a neurosurgeon. Thus, the doctor agreed that a fall such as the one Petitioner had on March 30, 2011 would aggravate degenerative disc disease but it could cause a disc condition such as a herniation but absent objective evidence of a disc change, there would be no connection between the two. Back spasms after such a fall would indicate a soft tissue injury. (RX 2, p. 38) He also agreed that right buttock pain could be indicative of a number of things. (RX 2, p. 40)

Dr. Neckrysh testified that the discogram ordered by Dr. Pencek was positive at L4/5 which meant there was disruption or inflammation or pathology within the L4/5 disc which, for some surgeons, is sufficient to recommend surgery. However, Dr. Neckrysh, personally, would not recommend a fusion since there was no concordant level of pain. (RX 2, pp. 44-45)

On redirect examination Dr. Neckrysh acknowledged that the May 4, 2009 report of Dr. Bahrainwala suggested that Petitioner had fully recovered from his disc herniation noted in 2008. (RX 2, p. 52) He also agreed that the January 22, 2001 report from Family Medical Care noted back pain and sciatica, the latter of which indicated irritation to a nerve root. (RX 2, pp. 53-54) The doctor also agreed that the October 21, 2011 MRI did not indicate any new disc injury or herniation in Petitioner's lumbar spine. (RX 2, p. 54) On further cross-examination the doctor acknowledged that he only read the MRI report and did not actually read the film. (RX 2, p. 55)

Petitioner was re-examined by Dr. Heim on September 15, 2014 but the record is incomplete and any history and treatment plans were not provided. (PX 4)

[4] The date of accident was subsequently amended from March 4th to March 3rd

Deposition of Dr. Don Kovalsky

The deposition of Dr. Don Kovalsky was taken on October 14, 2015. (PX 2) Dr. Kovalsky is an orthopedic spine specialist board certified in orthopedic surgery with a subspecialty in spinal surgery. Dr. Kovalsky testified regarding his first visit with Petitioner in 2012 at which time Petitioner reported having back problems intermittently and then injuring himself in March of 2011. Petitioner told the doctor he was a machinist and had tried to work for a few months but then stopped working in July of 2011. Petitioner told the doctor he tripped over a large object or some sort of metallic part on the floor, tried to grab a chain to keep from falling and twisted his back in the process of doing so. He believed the original date of injury was 2008 followed by a re-injury in March of 2011 when he lifted a heavy object resulting in an increase in back pain as of March. When Dr. Kovalsky saw Petitioner in May of 2012 Petitioner was also reporting bilateral leg pain. Dr. Kovalsky testified that Petitioner's physical examination was consistent with mechanical back pain combined, possibly, with discogenic pain or disc disease. He felt Petitioner might have low grade instability due to the amount of pain he had with extension which would also be consistent with some facet arthritis. Dr. Kovalsky reviewed Petitioner's x-ray and MRI and felt they showed moderate narrowing of the L5-S1 disc space which would typically be a degenerative process as well as mild narrowing with the L4-5 disc space. The spine itself was stable. He also had some facet arthritis on the oblique views of his spine. He felt the MRI showed fairly significant narrowing of the L5-S1 disc space which would not be an acute finding. He also had a diffuse disc herniation at L5-S1 (more right than left sided) and he had mild disc dehydration (central disc herniation) at L4-5 that wasn't causing any significant nerve compression. There was some mild internal derangement of that disc which would be age related. He also had some facet arthritis at L4-5 and L5-S1. In summary Dr. Kovalsky felt Petitioner had pre-existing degenerative disc disease and discogenic pain that was aggravated by the work injury in 2011 when he tripped over a part. (PX 2, pp. 1- 10) Dr. Kovalsky testified that he has recommended an anterior fusion at L5-S1 and a disc replacement at L4-5. However, before doing so, he would need to see a new MRI and updated x-rays. (PX 2, pp. 10-14)

Dr. Kovalsky was asked to assume that on March 3, 2011 Petitioner was loading and unloading fixtures that required him to push and pull on parts on a hoist all day and that there was a "large lifting device" that was "hard on him" when he was putting on and off the parts and that while doing these activities Petitioner noticed back pain. Based upon that assumption Dr. Kovalsky testified that such an event could be the straw that broke the camel's back but not the sole cause of Petitioner's problem. (PX 2, pp. 14-15)

On cross-examination Dr. Kovalsky acknowledged that the only MRI he saw was from October 21, 2011. He further acknowledged being unfamiliar with Dr. Heim's records as he didn't review them. When shown Dr. Heim's March 4, 2011 office note he acknowledged that it did not refer to any lumbar complaints, only thoracic. He also acknowledged that the April 6, 2011 note of Dr. Heim didn't reflect any back complaints. He next acknowledged that Dr. Heim's July 20, 2011 office note records a history of low back pain for one month with a recent flare-up of sciatica. Finally, he acknowledged that Dr. Heim's note of August 15, 2011 suggests that all of Petitioner's complaints (low back and sciatica complaints) began on July 19, 2011 when he stopped working. (PX 2, pp. 16-20)

Dr. Kovalsky also agreed that Petitioner's degenerative disc disease at L4-5 and L5-S1 pre-dated the events of 2011. The doctor was then asked whether the histories as shown in Dr. Heim's records suggested that the condition for which Petitioner presented to him were no longer related to any work-related exacerbation in March of 2011 and the doctor said it was hard to say completely because in the July note there was no reference to actually when Petitioner was injured but Dr. Kovalsky acknowledged

that he didn't treat Petitioner at that time and the records certainly don't document an injury occurring in March. He testified, "It's a much more vague history than – he was having symptoms when that doctor saw him in July, but there was again no mention of a very specific date of onset." (PX 2, pp. 20-21) He further agreed that if one assumed the history in the July 2011 office note of an onset thirty days earlier that would not relate to an event in March. He further agreed that when Petitioner was seen by Dr. Heim in March he wasn't really complaining of lumbar pain; rather he had thoracic pain. (PX 2, p. 21)

Dr. Kovalsky testified that it would be impossible for him to say whether Petitioner's lumbar pain was related to any work incident. He testified, "I can't speak for Dr. Heim but, you know, based upon this [his records] he has no evidence in his records of a specific lumbar injury which occurred in March of 2011." (PX 2, p. 23) Dr. Kovalsky also testified that based upon his training and expertise Petitioner's pre-existing degenerative condition would be the kind of condition subject to exacerbation of back pain with normal activity or any sort of minor event that happens in everyday life. (PX 2, p. 23) He further added that with such disease one will have flare-ups and those flare-ups can become more frequent as the condition progresses resulting in increased pain and length. (PX 2, p. 23) Dr. Kovalsky also agreed that in light of Petitioner's pre-existing condition and Dr. Heim's July 20, 2011 office note, Petitioner had an onset in June of 2011 without any history of an aggravating event and that such an onset could be consistent with the natural progression of his degenerative disc disease. (PX 2, p. 24)

Dr. Kovalsky testified that Petitioner's radicular symptoms as of May 16, 2012 were mild, not severe, and he had no weakness, no sensory deficits, and no reflex changes. His straight leg raising test on the right was equivocal and mildly positive on the left as was the Valsalva test. He testified that nothing in Petitioner's clinical presentation indicated to him that Petitioner's radicular symptoms were traceable to L5-S1 rather than L4-5. He further added that Petitioner has an asymmetrical contained disc herniation on the right at L5-S1 and a small central disc herniation at L4-5 which doesn't appear to be causing any nerve compression whatsoever. He agreed that the positive results on clinical exam were on the left side, not the right side. Based upon the doctor's training and experience he did not feel Petitioner was a surgical candidate due to his radicular pain. (PX 2, pp. 24-29)

Dr. Kovalsky further acknowledged that he initially recommended a possible disc replacement at L5-S1 but he has stopped doing that because so many patients were starting to see problems. He was still recommending surgery at two levels so that L4-5 can act as a buffer zone. He is recommending the disc replacement at L4-5 rather than a fusion because patients are less likely to develop adjacent segment disease with the replacement as one is still allowing for motion. Dr. Kovalsky felt that if he fused Petitioner at L4-5 he had a 35 to 40 % chance of developing a surgical condition at L3-4. Dr. Kovalsky also testified that he would need to do additional imaging on Petitioner to determine if there has been any progression of Petitioner's facet arthritis such that he would need a fusion and not a disc replacement. He felt a disc replacement at L5-S1 for Petitioner was "out of the question" given the doctor's philosophical change and the fact Petitioner is much older and has facet arthritis dating back three years. (PX 2, pp. 29-43)

On redirect examination Dr. Kovalsky testified that Petitioner told him he had been having back pain since the March 2011 and that he had been experiencing episodes of back pain even before that which were usually self-limited. He further testified that if Petitioner had low back pain after the "March 11th" event and was never symptom free thereafter, it would support an aggravation theory. However, if he developed a symptom free interval thereafter, it would only be another exacerbation. "If he had symptoms in March and improved and then had recurrent of symptoms later on and it wasn't a work related episode, then you would chalk that flare up to exacerbation of a preexisting condition. So in

order for me to feel that this is work related those symptoms had to have started and remained persistent indefinitely after that specific period of pain." (PX 2, pp. 43-44)

Dr. Kovalsky was further asked to assume that at the time of the March 3, 2011 event Petitioner had to stop the movement of the 2,000 lb. part by pulling it with his body. Based upon that assumption, Dr. Kovalsky testified that such activities could exacerbate low back pain in someone with pre-existing degenerative disc disease. (XP 2, pp. 45-46)

Deposition of Dr. Kimberly Terry

The deposition of Dr. Kimberly Terry was taken on May 9, 2016. (RX 3) Dr. Kimberly Terry testified that she is a board certified neurosurgeon practicing in San Antonio, Texas. (RX 3) She testified that a two-level disc replacement was not medically necessary based on the records she reviewed and the ODG standards. (RX 3) She testified that disc arthroplasty is indicated for single-level degenerative disc disease and that multiple level disc arthroplasty would be outside of FDA indications. (R's E. 3) She prepared a supplemental report based on the subsequent suggestion of a fusion of L5-S1 and a disc replacement at L4-5. (RX 3) In reviewing this, she cited to another nationally recognized treatment guideline besides ODG; namely, the ACOEM which indicates that this proposed procedure was not medically necessary. (RX 3) She testified further that, again, the FDA indications for artificial disc replacement were inconsistent with this proposal as there is multi-level degenerative disc disease and there is little in the literature to support the efficacy and safety of this sort of procedure. (RX 3) She did concede that a radicular type of pain can be an indication that a fusion is medically necessary. (RX 3) Likewise, a positive straight leg raise would be one indication that a fusion might be medically necessary. (RX 3) She testified that it is "possible" that Petitioner could meet a standard of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies although she noted that he had a normal examination per the note of Dr. Kovalsky. (RX 3) There was no objective evidence of radiculopathy, only the subjective report of pain radiating down the leg. (RX 3) "Spinal segment collapse" under ODG would be significant degeneration of the disc space. (RX 3) When she cites to ACOEM regarding "severe and disabling lower leg symptoms," she is talking about the clinical findings on examination, such as reflexes, strength, and those kinds of things. (RX 3) She bases her opinions on the procedure that is proposed and she was asked if he needs a particular type of surgery. (RX 3) She stated that she would have to re-review everything, but Petitioner might be a candidate for a lumbar fusion. (RX 3)

The 19(b) Arbitration Hearing

Petitioner's three cases against Respondent proceeded to arbitration on August 18, 2016. They were consolidated for purposes of trial with separate decisions to issue. The issues in dispute in case # 12 WC 19337 were accident, causal connection, medical bills, temporary total disability, prospective medical, and the statute of limitations. The disputed issues in case # 12 WC 02910 were accident, causal connection, medical bills, temporary total disability, and prospective medical care. The disputed issues in case # 12 WC 11599 were causal connection, medical bills, temporary total disability benefits, and prospective medical care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was employed by Respondent on August 1, 2008, as a CNC machinist. In this job, he unloaded fixtures, kept machines running, changed tooling, performed quality inspections, and washed and readied parts for shipping. On August 1, 2008 Petitioner went from Section 8334 to Section 8336 to train another employee on the job at that location. He testified that as he was doing so, he was at a computer control panel and he stepped backward, at which time his foot went inside a part that

had been placed on the floor, unbeknownst to Petitioner. Petitioner testified that he started to fall over and he grabbed the chain of a hoist "real hard" to keep from falling. He testified that this jerked him and twisted him and he injured his back.

Petitioner testified that he went to Dr. Heim and was given a twenty-five pound lifting restriction.

Petitioner also testified that he filled out a weekly disability benefits form for Respondent on which he marked that an accidental injury was not involved. (PX 1, Dep. Ex. 4) Petitioner acknowledged that he didn't fill out an incident report. He indicated at arbitration that this was suggested by a supervisor since he was in line for a promotion.

Petitioner testified that he had some history of "muscle problems" in his back in the past, but denied that he had ever had nerve pain or sciatica before August 1, 2008. He denied having ever seen a Dr. Heimbrecht. He denied ever having nerve pain that radiated down his legs to his feet.

Petitioner acknowledged seeing a chiropractor and being released by same in February/March of 2009.

Petitioner acknowledged that he had been seen a few times by the doctors at the Caterpillar medical department after August 1, 2008.

Petitioner further testified that he was employed as a CNC machinist by Respondent at its Decatur facility on March 3, 2011. Petitioner testified that he was assigned to Section 8334 but was reassigned to Section 8336, which he claimed was outside of his lifting restrictions. Petitioner testified that he filed a grievance regarding the reassignment but was ultimately re-assigned to the section as he was told he would not have to work beyond his restriction. Petitioner testified that as of March 3, 2011 he was required to push a part that was well over 1,000 pounds on a manual jib hoist. He also testified that he had to pull 70 to 80 pound parts out of a tub down at floor level, bending at the waist in order to do that; however, he stated that when he injured his back, he was moving the part on the jib hoist. He introduced photographs, including a photograph of a large part on a hoist. (PX 10, p. 1) Petitioner indicated that he would have to slow down the part (acting like a brake) and, that as he was doing so, he noticed discomfort in his low back.

Petitioner testified that he sought medical treatment on March 4, 2011 with Dr. Heim.

Petitioner then testified that on March 30, 2011, he was inside a machine cleaning up chips when he stepped backward and his left foot caught on a wire, causing him to fall backward onto the side of the machine. He testified that he had pain in the lower and mid part of his back after this event. Petitioner testified that, thereafter, he returned to see Dr. Heim on July 20, 2011.

Petitioner testified that he hasn't worked since July 20, 2011 when Dr. Heim took him off work. Petitioner further testified that he has continued to treat with Dr. Heim who has referred him to both Dr. Pencek and Dr. Kovalsky. Petitioner testified that Dr. Kovalsky has recommended surgery and Petitioner would like to proceed with the surgery if the doctor still feels it is necessary.

Petitioner testified that as of the time of arbitration, his back always hurts and he is in pain. He indicated that he could not bend and could not do simple tasks around the house. He needed to lie down afterward if he did work outside. His back would get stiff and he could not function. Petitioner testified that his back was different after March 3, 2011 explaining that as long as he was following his

restrictions he didn't have a lot of issues. He acknowledged some occasional pain prior thereto but nothing like what he currently experiences.

Petitioner was asked if he treated for his back between March of 2009 and 2011 to which he replied that he had a home decompression unit that he used for treatment. Petitioner denied having a lifting restriction before August 1, 2008.

Petitioner also acknowledged that he reported mid-back pain to Respondent on March 8, 2011 and to Dr. Heim on March 4, 2011. When asked if he denied any low back or leg pain at that time he testified he was "sure they talked about it."

Petitioner also acknowledged working his regular job between March 30, 2011 and July 18, 2011 (Section 8334). He could not recall if he had any low back or leg complaints by March 31, 2011. Petitioner also testified that he filled out another disability form when he went off work as of July 20, 2011. Petitioner acknowledged seeing Dr. Kovalsky on one occasion in 2012.

On redirect examination Petitioner testified that he injured his low back on March 3, 2011; however, he didn't know why the records only referred to his mid-back as his lower back "has been an issue since 2008." Petitioner also testified that after the early March incident his back progressively worsened.

Petitioner's medical bills are found in PX 9. Included in PX 9 is a bill from Elite Care, LLC. In the amount of $8,853.65 for treatment rendered to Petitioner between September 25, 2008 and March 11, 2009.[5]

The Arbitrator concludes:

Issue (C): Did an accident occur on August 1, 2008 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner failed to prove that he sustained an accident on August 1, 2008 that arose out of and in the course of his employment by Respondent. In so concluding the Arbitrator relies upon the lack of corroboration for Petitioner's testimony as to an alleged accident occurring on that date together with Petitioner's general lack of credibility and the substantial delay in the filing of this claim.

Petitioner has the burden of proving, by a preponderance of the credible evidence, all of the elements of his claim. *Parro v. Industrial Commission*, 250 Ill.App.3d 551, 553, 630 N.E.2d 860 (1993), *affirmed*, 167 Ill.2d 385 (1995). Specifically, to obtain compensation under the Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b). In this case, Petitioner claims that he was at work at Respondent's Decatur plant on August 1, 2008, when he was asked to go to Section 8336 to train another employee. He indicated that he was at a computer control panel and his foot went inside a part on the floor when he stepped backward. He claimed that he grabbed a chain to keep from hitting the floor and this jerked and twisted him, injuring his back. Petitioner's testimony as to an accident occurring that day was not corroborated by, or consistent with, any of the medical records. Petitioner's treatment records subsequent to the alleged work accident (up until May of 2012 when he was seen by the doctor of his choosing, Dr. Kovalsky) fail to mention any work accident as described by Petitioner at arbitration.

[5] No office notes or records for these visits is a part of the record.

Petitioner did not seek medical treatment at Respondent's facility immediately after the alleged accident. Rather, he presented to his family doctor the next day giving a history of low back pain that had "worsened acute[ly]" on August 1, 2008 when he stepped off a ladder and twisted, "messing up" his back. There is no reference to work. There is no reference to grabbing a chain, jerking, and twisting. Furthermore, at that same visit Petitioner reported he had been unable to work for the preceding two days, thus implying that he wasn't even at work for Respondent on the date of the alleged accident. Thereafter, Petitioner treated with Dr. Heim on August 13, 2008. Again, there is no mention of a work accident. Petitioner then underwent chiropractic treatment between September of 2008 and March of 2009. While the bill was submitted into evidence, no treatment records were. Petitioner's "Patient Profile," filled out at Neurosurgical and Orthopedic Specialists at St. Mary's on September 8, 2008, reflects that Petitioner had been experiencing pain for three weeks prior to August 1, 2008 but then felt an "increase in pain" on August 1, 2008; furthermore, the pain was noted to have occurred not by injury or accident, but "spontaneously." (PX 5, p. 12)

Petitioner also filled out a disability benefits form in which he indicated that an accidental injury was not involved and while he claimed at trial that a supervisor suggested that he not file a work accident claim because he was in line for a promotion, such testimony was not credible given Petitioner's failure to identify the supervisor and, more importantly, the other inconsistencies between his testimony regarding an accident on August 1st and the medical records.

Petitioner did not file the instant claim until May 25, 2012 after having been examined by Dr. Kovalsky who noted a history of Petitioner having tripped at work and twisting in August of 2008. This was the first mention of such an alleged accident in any medical records and occurred approximately 3 ½ years after the alleged event itself. Its timing and delay is very troubling and undermines whether an accident actually occurred as and when claimed.

Petitioner testified that prior to August 1, 2008, he had had occasional episodes of "muscle soreness" in his back but he denied any sciatic pain or pain down the legs. He also denied having ever having seen Dr. Kurt Heimbrecht. However, Petitioner's family doctor, Dr. Heim, testified that Dr. Heimbrecht was one of his colleagues in his practice. Dr. Heimbrecht also authored a note dated January 22, 2001, in which he indicated that Petitioner was a patient; that Petitioner had had back pain ever since he fell at work in 1994; that he did have symptoms of sciatica with straight leg raising tests being positive and radiation of pain down the leg; and that with the slightest lifting or trauma, there was recurrence of his back pain. (PX 1, Dep. Ex. 2) Furthermore, Dr. Heimbrecht filled out a subsequent disability form for Petitioner on July 26, 2011. (PX1, Dep. Ex. 5) There is also the discrepancy between Petitioner's Post-Offer medical exam of August 7, 2001 and Dr. Heimbrecht's letter of January 22, 2001. One can reasonably infer that Petitioner may not have wanted Respondent to know about any prior back problems at the time of his Post-Offer medical exam (presumably with Respondent) and, therefore, denied same as those problems pre-dated his employment with Respondent. In the end, Petitioner was not a forthright and credible witness.

In sum, Petitioner's credibility has been impeached not with one minor inconsistency, but with a number of different particulars. Given his lack of credibility, combined with inconsistencies between his testimony and the medical records, the Arbitrator is unable to find in Petitioner's favor. Petitioner failed to meet his burden of proof on the issue of accident and his claim is denied.

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

Even assuming, arguendo, that Petitioner sustained an accident on August 1, 2008 that arose out of and in the course of his employment with Respondent, Petitioner failed to prove his current condition of ill-being is causally related to that injury.

To obtain compensation under the Act, a petitioner must prove that some act or phase of his or her employment was a causative factor in the ensuing injuries. *Land and Lakes Company v. Industrial Commission*, 359 Ill.App.3d 582, 592, 834 N.E.2d 583 (2005). 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. *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478, 510 N.E.2d 502 (4th Dist. 1987). In this case, Dr. Kovalsky, Petitioner's most recent treating spine surgeon, noted that Petitioner had pre-existent degenerative discs. (PX 2) Dr. Heim, Petitioner's treating primary care physician, did not causally relate Petitioner's condition of his low back to an incident occurring on August 1, 2008. (PX. 1) Dr. Heim indicated on a disability form for Petitioner's off-work period after August 1, 2008, that Petitioner's condition was not work-related. (PX 1, Dep. Ex. 3) Dr. Kovalsky did not draw a causal relationship to any incident occurring on August 1, 2008. (PX 2) Dr. Pencek, who saw Petitioner from January 10, 2012 through April of 2012, did not offer a causation opinion.

Dr. Neckrysh, Respondent's IME physician, testified that Petitioner's condition of degenerative disease in his low back had no causal relationship to any accident occurring on August 1, 2008. (RX 2) He felt that the pattern and timing of reported symptoms as detailed in the history was not consistent with work-related exacerbations or aggravations, and more consistent with flare-ups of degenerative disc disease unrelated to work activities. (RX 2, Dep. Ex. 2) Petitioner's medical treatment as of February of 2014 had, in Dr. Neckrysh's opinion, no causal relationship to an incident in August 2008. (RX 2) Given the nature of Petitioner's condition, and the questions regarding history as noted in Issue (C) above, the Arbitrator finds Dr. Neckrysh's opinion to be credible and reliable.

The Arbitrator further notes that Petitioner was seen by his family physician, Dr. Heim, on April 23, 2010, and his low back examination was normal, and he had no discomfort down his legs. (PX 4, pp.11-12) Petitioner was followed in Respondent's plant medical department on his return to work on February 2, 2009, and after and as of May 4, 2009, Dr. Bahrainwala noted that Petitioner had no pain, numbness, tingling, weakness, or other symptoms, returning Petitioner to regular duty. (RX 1, p. 82) Both Dr. Bahrainwala and Dr. Braco of Respondent's plant medical department indicated that Petitioner's low back condition at that time was non-occupational. (RX 1, pp. 82-83) Petitioner gave Dr. Heim a history that his episode of sciatica in 2008 had resolved six months later. (PX 4, pp. 17, 19)

It must also be noted that medical records subsequent to the August 1, 2008 alleged accident suggest other accidents (for example, Petitioner's two other claims against Respondent) and histories provided to doctors in which Petitioner provides differing onset dates.

The sum total of the evidence not only supports a finding of lack of causal relationship generally, it supports a finding that Petitioner's current condition of ill-being at the time of arbitration is not causally related in any way to an event or occurrence on or about August 1, 2008. Petitioner has failed to prove that his condition of ill-being with respect to his low back was causally related in any way to an accident occurring on August 1, 2008. Petitioner's claim for compensation is 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?

Based upon the Arbitrator's determinations with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, the Arbitrator concludes that Petitioner has failed to prove entitlement to the payment of the medical expenses found in Petitioner's Exhibit 9. No medical bills are awarded.

Issue (K): Is Petitioner entitled to any prospective medical care?

Based upon the Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, above, the Arbitrator concludes that Petitioner has failed to prove entitlement by a preponderance of the evidence to the payment of future medical as outlined in the deposition of Dr. Kovalsky, his most recent treating surgeon. (PX 2) Petitioner has failed to prove that any such medical care would be causally related to an accident arising out of and in the course of the employment on or about August 1, 2008.

As a further basis of the Arbitrator's decision in this respect, the Arbitrator finds that Petitioner has failed to prove medical necessity of the surgical procedures proposed by Dr. Kovalsky. Dr. Kovalsky first proposed a two-level disc arthroplasty contingent upon any technical complications at the L5-S1 level. (PX 6, pp. 1-2) At his deposition, he amended this recommendation to a recommendation for a one-level fusion at L5-S1 and a disc arthroplasty at L4-5. (PX. 2) He then opined that if Petitioner on repeat radiographs had extensive facet arthritis, he might change the recommendation again to a two-level fusion with a disc arthroplasty at L3-4. (PX 2)

Respondent presented utilization review evidence by Dr. Terry establishing that nationally recognized treatment guidelines indicate that neither the two-level disc replacement originally proposed, nor the hybrid procedure of a fusion at L5-S1 and a disc arthroplasty at L4-5 were medically necessary or indicated. (RX 3) Dr. Terry noted that not only do the nationally recognized treatment guidelines ODG and ACOEM indicate against the procedures alternatively proposed by Dr. Kovalsky, that FDA indications for lumbar disc replacement are for single-level degenerative disc disease which Petitioner did not have. (RX 3) This was true of both of the procedures recommended by Dr. Kovalsky. (RX 3) Beyond this, Dr. Neckrysh, the Chief of Spine Surgery at the University of Illinois at Chicago, indicated that the two-level disc arthroplasty proposed was an unnecessary procedure which had no data to support it and a lumbar arthroplasty does not have a remote potential of helping leg pain assuming that Petitioner had it. (RX 2, Dep. Ex. 2) Only when there is a confirmed diagnosis of discogenic back pain by discography and no other degenerative findings on the images or clinically, would a disc replacement be indicated. (RX 2) It appears that the statement that it was "absolutely necessary" was a typographical. (RX 2) Based upon the sum total of the evidence, given Dr. Kovalsky's admission that his originally planned procedure produced less than optimal results and his vagueness regarding what procedures would actually be performed, and the opinions of Dr. Terry and Dr. Neckrysh that the procedures proposed by Dr. Kovalsky were not consistent with nationally recognized treatment guidelines, FDA standards, or the circumstances under which such a procedure might be contemplated, the Arbitrator finds that Petitioner has failed to prove medical necessity for such a procedure. Prospective medical is, therefore, denied.

Issue (L): What temporary benefits are in dispute – TTD?

Based upon the Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, the Arbitrator finds that Petitioner has failed to prove entitlement by a preponderance of the evidence to temporary total disability compensation for the period claimed of August 4, 2008 through February 1, 2009. The Arbitrator finds that the evidence fails to establish that Petitioner's condition of ill-being with respect to his low back was causally related to an accidental injury arising out of and in the course of the employment on or about August 1, 2008. Compensation for temporary total disability is, therefore, denied.

Issue (O): Other – Statute of Limitations.

Based upon the Arbitrator's findings with respect to Issue (C) – Accident, and Issue (F) – Causal Connection, the Arbitrator finds that the issue of statute of limitations is moot.

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STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA JEFFERS,

Petitioner,

vs. NO: 12 WC 19827

STATE OF ILLINOIS/TAMMS CORRECTIONAL CENTER,

17IWCC0547

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that the Petitioner established that she sustained a work-related accident arising out of and in the course of her employment on July 20, 2011.

The Commission further finds that Petitioner's current condition of ill-being was causally related to the July 20, 2011 accident, and as a result, Petitioner is entitled to reasonable, necessary, and related medical expenses through August 22, 2011, and 12.65 weeks of PPD benefits as Petitioner sustained disability to the extent of five percent (5%) loss of use of the right arm pursuant to Section 8(e) of the Act.

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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The Commission makes the following findings:

1) On July 20, 2011, Petitioner was a teacher working at Respondent's facility; she was in a classroom teaching when she felt a bite, or sharp pinch, on her right arm. (T.13-14). Petitioner testified she was wearing sleeves, but noticed "little legs or something." She knew that an insect had bit her. (T.14). Petitioner noted that the inside, upper area of her right arm was itchy. (T.15-17).

2) Petitioner had previously seen spiders in the classroom and Respondent had provided her with glue traps to trap them. (T.23-24; T.27). Petitioner did not know how often she would see a spider in the classroom, but it was not a daily occurrence – perhaps, once a month. (T.23). Petitioner was also aware that Respondent had someone for pest control, but "At that particular time, I wouldn't necessarily say they had been spraying." (T.28). She did not see them spraying on a regular basis. (T.35). Petitioner also confirmed that classrooms at Respondent's facility were not open to the public. (T.16).

3) Following the incident, Supervisor Geneva Bonifield completed a Report of Injury, which stated, "This teacher reported the incident to me on the afternoon of July 20, 2011. She brought in an accident report telling me she had been spider bitten." Both the supervisor's report (dated August 5, 2011) and Petitioner's own accident report (dated July 26, 2011) were consistent with Petitioner's testimony. (RX2; RX3).

4) Petitioner was treated at the Southeast Missouri Hospital emergency room on July 20, 2011. (T.17; PX1). The physician noted that the affected area was approximately six centimeters; it was warm, swollen, and tender; and, there was a center puncture mark. The history taken at the emergency room was consistent with Petitioner's testimony. Antibiotics were administered at the hospital. Upon discharge, the physician prescribed medication, and recommended that Petitioner ice the area and return to the emergency room if the site became more swollen or painful. (T.17; PX1).

5) Petitioner followed-up with Dr. Cheree Wheeler-Duke, M.D., at Southeast Primary Care on July 22, 2011. She reported the same injury to her right arm and her subsequent complaints. Dr. Wheeler-Duke noted that the prescribed medication was not helping; the erythema was spreading beyond its borders. Dr. Wheeler-Duke suggested that Petitioner continue with ice/warm compressions and medication. There was no need for incision and drainage at that time, "but given her history will not hesitate to refer to surgery if indicated." Petitioner had had a previous spider bite to her right thigh while at a neighbor's house in 2005 that required incision and drainage. (T.27; PX2).

6) Petitioner's pain in her arm persisted and, at the direction of Dr. Wheeler-Duke, she presented to Southeast Wound Care & Hyperbaric Medicine on July 25, 2011. (T.18; PX2). The medical record for that date noted that Petitioner had been bitten by a spider; and, she

was experiencing an eight of 10 pain level, more color change in the affected area, and there was also a spot in the center. She had also been having symptoms of fever and chills. (T.18). Dr. Laura Holmes, M.D., noted a minimum amount of serous exudate draining from the wound. She also indicated that the skin around the wound was hyperpigmented, indurated, and erythematous. She prescribed hyperbaric treatment as she had failed conservative care with steroids and antibiotics. (PX4).

7) Petitioner returned to the emergency room on July 30, 2011 with severe pain to her entire right arm. (T.19; PX1). Examination revealed a 2.7 cm x 2.3 cm oval shaped erythematous deflated bullae with a very thin layer of loose, but intact skin over the entire area. There was a pinpoint black pit at the center with no drainage; there was also redness and swelling. Petitioner was diagnosed with a brown recluse spider bite. She was prescribed antibiotic medication and discharged. (PX1).

8) Petitioner followed-up with Dr. Holmes throughout August 2011 for continued complaints of right arm pain and tingling in her hand. By August 22, 2011, Dr. Holmes stated that the wound had healed, but Petitioner was having some persistent burning, tingling, and numbness. She ordered Petitioner to follow-up with Dr. Wheeler-Duke and return as needed. (PX4).

9) The next medical record in evidence is dated May 22, 2012, when Petitioner returned to Dr. Wheeler-Duke's office with right upper arm discomfort, numbness and tenderness. Petitioner reported that ever since her spider bite, her right arm was tender and numb down to her forearm. Marie Wright, APRN, suspected possible nerve damage or chronic inflammation from the spider bite/infection. She prescribed Mobic and Petitioner was to follow-up with Dr. Wheeler-Duke in one month. (PX2).

10) On June 19, 2012, Petitioner reported to Dr. Wheeler-Duke that the trial of Mobic did not help. Her right arm pain was now radiating to her right hand. Petitioner also had numbness and tingling. The medical record stated, "Patient notes symptoms have occurred since the spider bite she had last summer Now to the point of not being able to use the arm due to discomfort." Dr. Wheeler-Duke ordered labs and an EMG; she also prescribed Neurontin. She also indicated, "Uncertain whether her spider bite last year has caused symptoms." (PX3).

11) The next time Petitioner treated with Dr. Wheeler-Duke was December 12, 2012. Her complaints as to her right arm were unchanged. The medical record noted Petitioner had undergone an EMG/NCS study and diagnostic imaging of her cervical spine "to see if there were other contributory factors but she does not feel that her symptoms originate from anything other than the original injury." Dr. Wheeler-Duke renewed Petitioner's prescription for Neurontin and Ibuprofen and referred her to Dr. Randall Stahly, D.O. (PX3).

12) Petitioner also saw Dr. Holmes the next day, December 13, 2012. Dr. Holmes noted that Petitioner underwent the EMG, which was apparently negative. The EMG was not offered into evidence by the parties. Dr. Holmes still considered the wound healed. Other than Petitioner's complaints of right arm pain, Dr. Holmes indicated that Petitioner had been well otherwise; she has no residual ulcer or induration; and the tissue appeared healthy and without infection. Dr. Holmes stated that Petitioner suffered from chronic pain, "but it is not possible to determine whether other treatment of bite would have made any difference to her outcome." Dr. Holmes also referred Petitioner to a pain specialist. (PX4).

13) On February 5, 2013, Petitioner consulted with pain specialist, Dr. Randall Stahly, at Southeast Medical Group. (T.19). He noted that since the spider bite, Petitioner continued to have pain in the area of the bite, "followed by increasing symptoms of lancinating pain and hyperalgesia associated with paresthesias and hypoesthesia to temperature and pinprick in the distribution of the right medial cutaneous nerve of the arm. Head or neck motion may mildly exacerbate the arm discomfort but there is no cervical radicular component." Dr. Stahly's sensory examination indicated hypoesthesia to temperature and pinprick in the distribution of the right medial cutaneous nerve of the arm. He believed Petitioner had right medial cutaneous nerve palsy. (PX5). Petitioner testified that Dr. Stahly "just told me to continue to take the pain medication because there was nothing else, you know, that he could at this particular time prescribe to me." (T.20). Petitioner saw Dr. Stahly one more time on July 18, 2013, with no changes to her condition or further treatment recommendations. (PX5).

14) Petitioner testified that she worked during the period of time following the injury. (T.20). As of the date of arbitration, she was no longer employed by Respondent as the facility had shut down. She was instead working at Vienna Correctional Center and she also worked part-time at Wal-Mart as a cashier. (T.13-14). Petitioner testified that the area where she was bitten was sensitive and painful. She also experienced a burning sensation. Petitioner stated that her right arm did not bother her every day, but it did bother her. (T.20-21). Wearing long sleeves also bothered her. (T.21). Petitioner would take Aleve, as needed, for pain. (T.22).

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony, and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Indus. Comm'n*, 216 Ill. App. 3d 1048, 1054 (3rd Dist. 1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Dep't v. Indus. Comm'n*, 83 Ill. 2d 528, 533-34 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator denied Petitioner's claim on the basis that she failed to prove that she sustained an accident that arose out of and in the course of her employment on July 20, 2011. The

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Arbitrator found Petitioner was exposed to a neutral risk – not incidental to or associated with Petitioner's employment with Respondent.

For an injury to be compensable under the Act, "a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). "'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Id.* "It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also 'arise out of' the employment." *Id.* This element may be found if 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." *Steak 'n Shake v. Ill. Workers' Comp. Comm'n*, 2016 IL App (3d) 150500WC, ¶ 34; citing *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203-04 (2003).

In analyzing whether Petitioner's injury arose out of her employment, there are three categories of risk to consider: "(1) [R]isks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics." *First Cash Fin. Servs. v. Indus. Comm'n*, 367 Ill. App. 3d 102, 105 (1st Dist. 2006).

In this case, Petitioner's injury was not an employment related risk, or a risk that "is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Steak 'n Shake v. Ill. Workers' Comp. Comm'n*, 2016 IL App (3d) 150500WC, ¶ 35; citing *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 58 (1989). Petitioner was bit by a spider while teaching in a classroom at Respondent's facility; the risk of a spider bite has no relation to Petitioner's job duties as a classroom teacher, or what she was required to do to fulfill those duties. This is also not a claim involving a personal risk (such as a physical disability) that led to Petitioner's injury.

Here, the Arbitrator considered the claim under a neutral risk analysis. "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metro. Water Reclamation Dist. of Greater Chi. v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 1014 (1st Dist. 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.*

The Commission finds that the evidence supports a finding of accident under a neutral risk, quantitative analysis. Petitioner was exposed to a greater risk than the general public in that she would be exposed to a greater risk of encountering insects and spiders at Respondent's facility, a prison, than that of the general public – especially considering that although visitors were likely to be present at Respondent's facility under limited circumstances, the area where Petitioner was injured was not open to the public. Respondent was further on notice and aware of its pest problem

as it had previously sprayed for pests and had provided Petitioner with glue traps to trap said pests or insects; this further supports Petitioner's claim on a qualitative basis. The Commission therefore finds that Petitioner sustained a work-related accident arising out of and in the course of her employment on July 20, 2011.

As to causal connection, the Commission finds that Petitioner's current condition of ill-being was causally related to the July 20, 2011 accident. Causal connection between an accident and an employee's condition may be found in instances where a chain of events demonstrate "a previous condition of good health, an accident, and a subsequent injury resulting in disability." *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

There is no evidence of a prior spider bite to Petitioner's right arm. Following her injury on July 20, 2011, the medical records provided a consistent history of injury and complaints. Petitioner was diagnosed with a brown recluse spider bite, and prescribed antibiotics, pain medication, steroids, and ice/warm compressions. (PX1; PX2). A referral for surgery was entertained and oxygen treatment was ordered; however, Petitioner did not undergo these recommendations. (PX2; PX4). By August 22, 2011, Dr. Laura Holmes, M.D., with whom Petitioner had been treating at Southeast Wound Care & Hyperbaric Medicine, stated that the wound had healed. Although Petitioner was having some persistent burning, tingling, and numbness, she ordered Petitioner to follow-up with her primary doctor and return as needed. (PX4).

The Commission finds that Petitioner established causal connection for her work-related spider bite through August 22, 2011. In determining whether a claimant has reached maximum medical improvement (MMI), a court may consider factors such as a release to return to work, medical testimony or evidence concerning the claimant's injury, the extent thereof, and, most importantly, whether the injury has stabilized. *Mech. Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). The record is void of any formal MMI opinion; however, Dr. Holmes released Petitioner on an as needed basis. She also stated that although Petitioner had persistent burning, tingling, and numbness, her wound had healed. Dr. Holmes made no further treatment recommendations as of August 22, 2011; thus, the Commission finds that Petitioner's condition had stabilized on this date. Petitioner had been also been working throughout the pendency of this claim.

Following Petitioner's release from treatment by Dr. Holmes on August 22, 2011, the record demonstrates that she received no further treatment for her spider bite until May 22, 2012, when Petitioner returned to her primary care physician, Dr. Cheree Wheeler-Duke, M.D., at Southeast Primary Care. (PX2). Petitioner presented with right upper arm discomfort, numbness, and tenderness; Marie Wright, APRN, suspected possible nerve damage or chronic inflammation from the spider bite/infection. She prescribed Mobic and Petitioner was to follow-up with Dr. Wheeler-Duke in one month. (PX2).

17IWCC0547

When Petitioner followed-up with Dr. Wheeler-Duke on June 19, 2012, she had the same complaints, except now the pain was radiating to her right hand. Although Petitioner reported that her symptoms stemmed from the July 2011 spider bite, Dr. Wheeler-Duke indicated, "Uncertain whether her spider bite last year has caused symptoms." (PX3). Medication was prescribed and an EMG was ordered together with lab work. By December 12, 2012, nearly six months later, Dr. Wheeler-Duke noted that Petitioner's complaints to her right arm were unchanged and renewed Petitioner's prescription medication. (T.19; PX3).

Petitioner also saw Dr. Holmes on December 13, 2012. Dr. Holmes noted that Petitioner underwent the EMG, which was apparently negative. The EMG was not offered into evidence by the parties. Dr. Holmes still considered the wound healed, and the tissue appeared healthy and without infection. She opined that Petitioner suffered from chronic pain, "but it is not possible to determine whether other treatment of bite would have made any difference to her outcome." Dr. Holmes referred Petitioner to pain specialist, Dr. Randall Stahly, at Southeast Medical Group. (PX4).

Dr. Stahly examined Petitioner on February 5, 2013. He noted Petitioner's spider bite injury from July 2011 and persistent complaints. His examination of Petitioner suggested that she may have right medial cutaneous nerve palsy, but offered no further explanation or causal connection opinion in this regard. In fact, Petitioner testified that Dr. Stahly "just told me to continue to take the pain medication because there was nothing else, you know, that he could at this particular time prescribe to me." (T.20). Petitioner saw Dr. Stahly one more time on July 18, 2013, with no changes to her condition or further treatment recommendations. (PX5).

In light of the foregoing, the Commission finds that Petitioner established causal connection through August 22, 2011. Consequently, Petitioner is entitled to reasonable, necessary, and related medical expenses incurred from July 20, 2011 through August 22, 2011.

The Commission also finds Petitioner sustained disability to the extent of five percent (5%) loss of use of the right arm pursuant to Section 8(e) of the Act. Petitioner was diagnosed with a brown recluse spider bite, and underwent treatment in the form of prescription medication and ice/warm compressions. (PX1; PX2). Petitioner was released from treatment on an as-needed basis on August 22, 2011 despite persistent burning, tingling, and numbness. (PX4). She returned with the same complaints on May 22, 2012. However, her treating physicians simply prescribed more prescription medication, and a referral to a pain specialist yielded no further treatment recommendations. Dr. Holmes indicated on December 13, 2012, Petitioner did suffer from chronic pain but her bite wound was considered healed and the tissue appeared healthy and without infection. (PX4).

Based on the totality of the evidence, the Commission finds Petitioner to be permanently partially disabled to the extent of 5% loss of use of the right arm pursuant to Section 8(e) of the Act.

17IWCC0547

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on July 21, 2016, is hereby reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 12.65 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the 5% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable, necessary, and related medical expenses incurred from July 20, 2011 through August 22, 2011 pursuant to Sections 8(a) and 8.2 of the Act.

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

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

DATED: SEP 7 - 2017
MJB/pm
O: 7-25-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFERS, LISA
Employee/Petitioner

Case# **12WC019827**

ST OF IL/TAMMS CORRECTIONAL CENTER
Employer/Respondent

17IWCC0547

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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
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

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

LISA JEFFERS
Employee/Petitioner

v.

STATE OF ILLINOIS/TAMMS CORRECTIONAL CENTER
Employer/Respondent

Case # 12 WC 19827

Consolidated cases: _____

17IWCC0547

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 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 _____

17IWCC0547

FINDINGS

On **July 20, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this 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 **$73,048.00**; the average weekly wage was **$1,404.77**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment on July 20, 2011.

All benefits are denied.

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

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

Signature of Arbitrator

July 20, 2016
Date

JUL 21 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LISA JEFFERS
Employee/Petitioner

v.

Case #: 12 WC 19827

STATE OF ILLINOIS/TAMMS CORRECTIONAL CENTER
Employer/Respondent

17IWCC0547

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was 50 years old, single, with no dependent children. She was employed by the State of Illinois, Tamms Correctional Center as an Educator. She testified that on July 20, 2011, she was in her classroom teaching when she felt something along the upper inside part of her right arm. She then felt a sharp pinch, like a bite. She swiped her hand along her arm and noticed what appeared to be insect legs fall out of her shirt sleeve. Shortly thereafter her arm started itching and she asked the teacher in the next room to look at the area. She told Petitioner she had a mark on her arm. Petitioner went to the health care unit and reported the incident to her lieutenant.

Petitioner testified that her classroom is located in the gym area, on the top level, and that this is not an area that is open to the public. She testified she had seen spiders in the area before, maybe once a month, and that she had put glue bug traps down one time prior to being bitten. After being bitten she put the glue traps down constantly and testified that spiders did collect in the traps. She testified she noticed more spiders at work than at home.

On cross-examination, Petitioner conceded she had had a previous spider bite that became infected and had to be incised and drained. The previous bite had been on her right thigh, and occurred when she was helping a neighbor cut weeds and grass. She admitted she had seen spiders in her home as well. Petitioner acknowledged that the facility had someone who would come out to spray for pests, but stated she had not noticed anyone spraying around the time she was bitten or seen anyone spraying on a regular basis. She conceded that someone could have sprayed for bugs before or after her work hours.

Due to increased pain and swelling, Petitioner presented to the Emergency Department at Southeast Missouri Hospital later that day. She complained of right upper arm redness and pain that had started around noon that day. On examination, her right upper inner arm had a 6 cm

area of warmth, swelling, itching, and tenderness, with a center puncture mark. Petitioner reported a history of being stung by an unknown insect while at work at Tamms. She was diagnosed with a brown recluse spider bite and was discharged with instructions to apply ice pack, increase clear liquid intake, keep affected arm elevated. She was instructed to return to the ED if she had a fever or if the site became more swollen or painful or looked worse. PX1.

On July 22, 2011, Petitioner presented to Dr. Cheree Wheeler-Duke at Southeast Primary Care. She complained of pain and rash on her arm that was aggravated by touch. She believed she had been bitten by an insect and reported she had not seen anything inflict the bite, but felt pain in the affected area and swatted something away. She reported she had been icing her arm and marked the wound herself, and that the erythema was spreading beyond the borders of the mark. She reported a history of an infected insect bite six years prior that required incision and drainage by Dr. Silliman. On examination, there was noted a large 8 cm round area of erythema to the upper right arm, consistent with cellulitis. There was a central area that appeared consistent with an insect bite but no underlying necrosis. Dr. Wheeler-Duke diagnosed an insect bite, discontinued the Cefadroxil and changed Petitioner's regimen to include Bactrin and Rifampin. She instructed Petitioner to continue to apply ice several times a day. PX2.

On July 25, 2011, Petitioner followed up with Dr. Wheeler-Duke and reported worsening of the problem in the past three days. Dr. Wheeler-Duke indicated her assessment had changed, based upon the evolving appearance of the wound, to that of a brown recluse spider bite. Petitioner was referred to Dr. Laura Holmes for evaluation for irrigation and debridement. PX2.

On July 25, 2011, Petitioner presented to Dr. Laura Holmes at Southeast Wound Care and Hyperbaric Medicine with history of a spider bite. She reported that the area around the bite was painful and that she had experienced fever and chills on the day it occurred. She also noted that the area was getting more painful with more color change and a spot in the center of the area. On examination, Dr. Holmes noted a large area of erythema on the upper inner arm with a central area of induration and, in that, an irregular area of necrotic purple color. Dr. Holmes noted Petitioner had prior history of a spider bite which required surgical resection. She noted Petitioner's wound had the typical appearance of a brown recluse spider bite and further noted that despite treatment it continued to get worse. She recommended hyperbaric treatment, as there were ischemic changes in the periwound that typically respond to oxygen, and Petitioner had failed good conservative care with steroids and antibiotics. PX4.

On July 30, 2011, Petitioner again presented to the Emergency Department at Southeast Missouri Hospital with complaints of severe pain in her entire arm from suspected spider bite. She reported she had had a spider bite about four years prior that had to be debrided. Her treating doctor was attempting to obtain approval for hyperbaric treatment and was treating with antibiotics in the meantime. She reported the area was not any redder or bigger but that it hurt. She was advised that she was on the usual course of treatment for a brown recluse bite, but the attending doctor did add a medication to help with the pain. PX1.

Petitioner followed up with Dr. Holmes on August 1, 2011. There was visible redness and discoloration of the periwound. The area had opened and there was still some induration. She was started on silvadene dressings and a taper of prednisone. Dr. Holmes noted Petitioner's

condition was generally improved and she was to return in one week. She returned to Dr. Holmes on August 8, 2011. She was still having some symptoms that were persisting, but the bite was resolving well. Dr. Holmes advised Petitioner that the neck and shoulder pain on her left side were unlikely related and that she should follow up with her doctor for that. PX4.

On August 22, 2011, Petitioner followed up with Dr. Holmes and reported burning in the area of the bite and tingling and numbness in her fingers. She was advised to follow up with her doctor for that. Dr. Holmes noted the wound was healed and she was released from care. PX4.

Petitioner next presented for treatment on May 22, 2012, when she saw Nurse Practitioner Marie Wright at Southeast Primary Care. She complained of continued right arm discomfort and reported that since her spider bite her right arm would get tender and numb down to her forearm. Assessment was possible nerve damage or chronic inflammation from soft tissue injury secondary to spider bite and infection. Petitioner was given a prescription of Mobic and instructed to follow up in one month if symptoms persisted or worsened. PX2.

On June 19, 2012, Petitioner returned to Dr. Wheeler-Duke with continued complaint of moderate to severe right arm pain, aggravated by movement and rubbing against something. She also reported numbness, tingling, and tenderness in the arm. The Mobic did not relieve the symptoms. Dr. Wheeler-Duke noted it was uncertain whether the spider bite caused the current symptoms and she ordered an EMG and a trial of Neurontin. PX3.

On December 13, 2012, Petitioner followed up with Dr. Holmes for persistent right upper arm pain, which was like a poker and sensitive to touch. It was noted she had an EMG but no diagnosis and no change in treatment. The Neurontin had not helped. Examination showed the wound to be healed with no drainage or infection, and the tissue appeared healthy. Dr. Holmes noted Petitioner had chronic pain but it was not possible to determine whether other treatment of the bite would have made any difference. She advised Petitioner that a pain specialist may have something to offer, and a referral was made. PX4.

On February 5, 2013, Petitioner presented to Dr. Randall Stahly. He noted Petitioner's history of a brown recluse spider bide in July 2011 which required debridement. Since that time, Petitioner reported she had pain in the area and had increasing problems with hyperalgesia. She had no weakness, loss of dexterity, reflex change, or other neurologic deficit other than sensory loss. On examination, there was noted hypesthesia to temperature and pinprick in the distribution of the right medial cutaneous nerve of the arm. Dr. Stahyly's impression was right medial cutaneous nerve palsy. He increased her dosage of Gabapentin and Petitioner was to return in six weeks. PX5.

Petitioner testified she still experiences pain and tenderness in and around the area of the bite. She noted she is reluctant to wear sleeves because the pain increases when clothes rub against the area.

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.

In support of the Arbitrator's decision relating to issue (C), whether Petitioner sustained an accidental injury that arose out of and in the course of her employment, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 802 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011).

The "arising out of" component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989). Courts have recognized 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 (1st Dist. 2007).

Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill.App.3d 149, 163 (1st Dist. 2000). 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. *Potenzo*, 378 Ill.App.3d at 117.

In this case, the risk faced by Petitioner was a neutral risk. There was no evidence that being around spiders was incidental to or associated with Petitioner's employment. Petitioner attempted to show that her work place had a higher than normal amount of spiders on the premises, thereby exposing her to the risk of a spider bite to a greater degree than the general public. The Arbitrator is not persuaded by this argument. Petitioner's workplace was a classroom, inside a brick building. Though it is reasonable to believe that there were spiders within the building, and within her classroom, the same is true of virtually every building, every workplace, and every home. The Arbitrator finds significant the fact that Petitioner had previously been bitten by a spider while helping a neighbor cut weeks and grass, an area one would expect to have a higher than average number of spiders. The same cannot be said of Petitioner's classroom.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an injury on July 20, 2011, that arose out of and in the course of her employment with Respondent. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

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

Luciano Acevedo,
Petitioner,
vs.
OAC Management,
Respondent.

NO: 12WC 24506

17IWCC0564

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 20, 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: SEP 18 2017
MJB/bm
o-9/12/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ACEVEDO, LUCIANO
Employee/Petitioner

Case# **12WC024506**

OAC MANAGEMENT
Employer/Respondent

17IWCC0564

On 9/20/2016, 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 0.50% 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
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2965 KEEFE CAMPBELL BIERY & ASSOC
PANKHURI K PARTI
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

Luciano Acevedo
Employee/Petitioner

v.

OAC Management
Employer/Respondent

Case # 12 WC 24506

Consolidated cases:

17IWCC0564

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Lynette Thompson-Smith,** Arbitrator of the Commission, in the city of Chicago on **June 24, 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

17IWCC0564

FINDINGS

On 05/14/12, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 this accident.

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

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

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

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

Respondent shall be given a credit for all payments made towards the treatment of Petitioner.

ORDER

The Petitioner has not proven by a preponderance of the evidence that he sustained an accident on May 14, 2012 that arose out of and in the course of his employment with Respondent therefore, no benefits are awarded, pursuant to the Act.

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

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

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability; and 6) the nature and extent of Petitioner's injury. *See,* AX1.

Petitioner's testimony

Petitioner started working for Respondent on July 7, 2001, as chief of management and remodeling. As part of his duties, he was required to paint, install cabinets, install appliances and install doors and windows in company buildings. He was sent to different locations where they needed work done. Petitioner testified he was working for Respondent on May 14, 2012 and suffered a work accident. *Tr. pp. 13-14.*

On May 14, 2012, Petitioner was working in Lansing in condominium buildings. He brought in ceramic tiles and paint and had finished installing the ceramic tile and starting to paint the unit. He was painting the trim when the injury occurred. Petitioner testified that as he was going up and down the ladder and moving it to do the trim, he suffered pain in his back and afterwards, could not lean down to finish the baseboards. Petitioner was also moving boxes of ceramic tiles which weighed between 20-30 pounds. *Tr. pp. 14-20.*

Petitioner finished his job that day the best he could, then notified the company that he would be going to the doctor the next day. Petitioner testified he informed three people that he had developed pain in his back and was going to the doctor. According to Petitioner, he informed both Misters Chappelle and Basic on May 15, 2012; of the strong pain in his back and that he was going to the doctor. Petitioner stated that he also informed Pat Harris, the vice-president of the company, on May 14, 2012 and *Tr. pp. 15-19.*

As a result of his injury on May 14, 2012, he saw Dr. Giokaris the next day complaining of pain in his lower back, on the right. Petitioner testified that he only remembered receiving a sheet from Dr. Giokaris and did not remember whether it said he needed to remain off work. Petitioner testified he turned in the note from Dr. Giokaris to the secretary in Wheeling because that was the location closest to him at the time. *Tr. p. 20-24.*

Petitioner agreed with the medical records that he followed-up with Dr. Giokaris a few times in May of 2012 and during this time, he managed his low back pain with pills. *Tr. p. 24.*

Dr. Giokaris recommended an MRI, which he had on June 14, 2012. Petitioner testified by the time he had the MRI he had been laid off by Respondent and that June 8, 2012 was his layoff date. *Tr. p. 25.*

After undergoing the MRI, he started treating with a chiropractor, Dr. Dabbah, who worked in the same office as Dr. Giokaris. Petitioner was going to Dr. Dabbah approximately three times a week and from time to time would also see Dr. Giokaris.

Petitioner testified that during this time, the right-sided lower back pain, never went away and remained at seven on a scale of one to ten. *Tr. p. 26-27.*

On June 15, 2012, Dr. Giokaris put him on a ten (10) pound lifting restriction and removed him from work. Petitioner stopped seeing his doctors because he was unsure of what was happening with the insurance and was concerned that they were not going to pay. He then testified that during the summer of 2012, he only continued to see Dr. Giokaris.

Petitioner testified he would not agree with the medical records if they showed that Dr. Giokaris released him to return to full duty work on October 11, 2012. Petitioner also testified he did not remember going to his doctor in November 2012 even if the medical records show that he did.

Petitioner was given a shot in his back by Dr. Giokaris, due to the pain and he felt good after the shot, but the pain never completely went away. *Tr. p. 28-29.*

Petitioner did not remember returning to Dr. Dabbah in December 2012 because of the insurance issues but testified if the medical records showed he saw Dr. Dabbah from December 2012 through March 4, 2013, he would not doubt it because he did not remember when he stopped going, due to the insurance problem. *Tr. p. 29-30.*

Petitioner has not seen a doctor for his lower back condition since March 4, 2013 and has been taking over-the-counter medicine for the pain. He has not injured his lower back since May 14, 2012 and his original pain has not gone away. Petitioner then testified because of his back injury, he has lost feeling in the soles of his feet.

Petitioner testified he had received treatment for a lower back injury from 2010 to May 2011 however, between May 2011 and May 2012, he did not have any need to return to his doctor for lower back pain. *Tr. p. 32.*

Presently, his pain is continuous and he has lost feelings in the bottoms of his feet. He testified nothing has changed in his daily activities and he was taking Tramadol for the pain. Once that ran out, he took over-the-counter medicine. He is not presently working and has not had any regular work since his layoff. *Tr. p. 33.*

Upon cross-examination, Petitioner testified he hurt himself while carrying boxes of ceramic tile but then also agreed he told his doctors, back in 2012, that he was carrying bags of cement. Upon further questioning, Petitioner testified he was carrying both boxes of tile and bags of cement. *Tr. p. 34.*

Petitioner then testified he did not go to work the day after he was injured stating that he went to the doctor instead. He then changed his testimony to state that he informed Misters Chappelle and Basic of his injury the next morning before going to the doctor.

Petitioner changed his testimony again and testified that he did not go to work the day after he was injured and informed Misters Basic and Chappelle by phone, to let them know he was going to the doctor. *Tr. p. 35.*

Petitioner testified his injury back in 2010 was work-related and that he had provided notice, at that time, to the same three people. *Tr. p. 36.*

Petitioner agreed with that if the medical records showed that Dr. Giokaris allowed him to return to work on May 21, 2012, then he returned to work on that date. Petitioner testified he did not return to work in a full capacity because he still had pain.

Petitioner testified that Dr. Giokaris put him on ten (10) pound lifting restrictions but noted he would not doubt the medical records if they showed he had been released to full duty work. *Tr. p. 37-38.*

Petitioner testified that he was laid off on June 8, 2012 and Pat Harris was the person who told him about his employment being terminated. Petitioner then testified he did not inform Mr. Harris about his work injury at that time, because he was already aware of it. *Tr. p. 38-39.*

Petitioner agreed that the first time he was put on restrictions was June 15, 2012 and this was a week after he had been laid off. Petitioner did not believe he was released from care by Dr. Giokaris on October 11, 2012 because he had been told that the doctor was awaiting one more test. Petitioner testified he would doubt the medical records if they said that he was released from care. *Tr. pp. 39-40.*

Petitioner did not agree that Dr. Dabbah had released him to full duty work on December 28, 2012 because he never received any note from the doctor saying he had been released. After being shown the certificate to return to school or work note dated December 28, 2012 from Dr. Dabbah, Petitioner testified that it did say he was being released to full duty work. *Tr. p. 41-42.*

Petitioner testified he did not return to work despite being released to full duty work because he had been laid off. He then testified he had not tried to look for another job because he was waiting for the resolution of this claim. Petitioner has not received any treatment after he received the shot from his doctor in March 2013 and that he has not worked anywhere after being terminated by Respondent; however he had been doing side jobs that did not require any lifting. Petitioner testified he had attempted two times to look for other work and that he was paid for the side jobs he worked for about three months. *Tr. pp. 42-44.*

Testimony from Respondent's first witness

Mr. Pat Harris testified that he has been employed by Respondent as vice president of operations, for the last twelve (12) years. He is responsible for property management,

maintenance and construction activities for all the properties. He is also responsible for making sure the forms for workers' compensation claims are filled out but that he did not handle the claim personally. He is the contact person for employees to report their work injuries and that the normal procedure is to meet with the worker, then send them to a medical facility for treatment, if necessary. He would also fill out an accident report with the employee during the meeting and is the person employees are supposed to provide the "off-work" notes or the notes with the work restrictions from their doctors. *Tr. pp. 50-52.*

Mr. Harris knows Petitioner because Petitioner worked for Respondent for a number of years and had filed a workers' compensation claim back in 2010. At that time, Petitioner had reported the injury to him and also provided notes regarding work restrictions. *Tr. p. 53.*

Mr. Harris testified that Petitioner never reported being involved in a work accident on or around May 14, 2012 and that Petitioner never informed him about having injured himself at work. Mr. Harris testified he interacted with Petitioner quite often during the subject week and in none of these interactions, did Petitioner ever mention having hurt his back on May 14, 2012. *Tr. p. 54.*

Mr. Harris testified Petitioner did not ever mention treating for back pain when he saw or met Petitioner around May 14, 2012 and that he was not provided with off work notes by Petitioner relating to an injury. Mr. Harris became aware of Petitioner's claim for injuries approximately a month later after they received notice of a claim being filed at the main office. *Tr. p. 55.*

Petitioner's employment was terminated on the week of June 14, 2012 and the separation agreement was filled out on June 8, 2012. He informed Petitioner he was being laid off and that at no time during this meeting did Petitioner mention that he had been injured on May 14, 2012, or that he actively treating for his injury. *Tr. p. 55-56. 57.*

Mr. Harris was not aware that Petitioner was off work or on restricted duty between May 14, 2012 and June 7, 2012 and to his knowledge; the petitioner was working full duty when he was laid off on June 8, 2012. Petitioner was paid by the hour and was paid for whatever work he performed between May 14, 2012 and June 7, 2012. *Tr. p. 58.*

Mr. Harris testified that in all his interactions with Petitioner between May 14, 2012 and June 7, 2012, the petitioner never appeared to be in pain and never asked for any accommodations in work due to pain in his back or anywhere else. Mr. Harris testified Petitioner did not ever mention even in passing that his back was hurting. *Tr. p. 59.*

Mr. Harris is not aware of any employee named Tom Chapelle and believed the name was Chatel as Tom Chatel was the construction manager. *Tr. p. 60.*

Upon cross-examination, Mr. Harris testified he could not be sure of the specific location Petitioner would have been working in May 2012 because they worked at various locations every day but he did confirm that they have properties in Lansing. He agreed that Petitioner's duties included painting and finishing ceramic tile and that his work would involve going up and down ladders for painting, but that the ceramic tile work was usually at the arm's level. *Tr. p. 60-61.*

Finally, Mr. Harris testified he had received notice of Petitioner's injury about a month after he claimed to have been hurt. Upon re-direct Mr. Harris stated when he said he received notice of the injury after a month, it was an approximation and the time could have been more. *Tr. p. 62.*

Testimony from Respondent's second witness

Mr. Tom Chatel testified he was employed with Respondent as one of the supervisors for maintenance and had been working for Respondent for ten or eleven years. He knew Petitioner but he was not Petitioner's direct supervisor and that Petitioner worked in different locations. He would interact with Petitioner about once a month. *Tr. p. 64-65.*

Petitioner never reported an injury to him. Mr. Chatel was aware Petitioner was hurt because he had mentioned his back was bothering him but never mentioned why it was hurting. He testified he was not aware Petitioner had ever filed a workers' compensation claim in 2010 and did not know if Petitioner was ever off work between May 14, 2012 and June 7, 2012. *Tr. p. 66-67.*

Upon cross-examination, Mr. Chatel testified he did not have any reason to doubt that Petitioner was working at the Lansing location on May 14, 2012 and that his duties involved climbing up and down ladders, carrying boxes of ceramic tiles and bags of cement. *Tr. p. 68-69.*

Mr. Chatel testified on one day, Petitioner that he was having problems with his back and as Mr. Chatel did not see Petitioner on a regular basis, he did not know whether it happened before or after the subject date of accident.

Conclusions of Law

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

It is the burden of every Petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207 at 214, 254 N.E.2d 522 (1969); *Edward Don v. Industrial Commission,* 344 Ill.App.3d 643, 801 N.E.2d 18 (2003).

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For an employee's workplace injury to be compensable under workers' compensation, Petitioner must establish the injury is due to a cause connected with the employment such that it arose out of the employment. *Hansel & Gretel Day Care Center v. Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244. It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

Specifically, Petitioner bears the burden of establishing; by a preponderance of credible evidence, all of the elements of his claim. Petitioner must establish that he sustained accidental injuries that arose out of and in the course of his employment. *Illinois Institute of Technology vs. Industrial Commission, 68* III. 2d 236 (1977).

The requirement that Petitioner prove by a preponderance of the evidence all elements of his claim, means that he must present evidence which is more credible and convincing to the mind and when viewed as a whole, establishes the fact sought to be proved as more probable than not. *In Re: K.O.,* 336 III. App. 3d. 98 (2002). It is the duty of the Arbitrator to view the evidence in its entirety and determine, objectively and reasonably, whether witness testimony is credible, that is, "worthy of belief," based on the totality of the evidence. *Thorson v. Carlson Roofing Company,* 01 I.I.C. 0251.

After hearing the trial testimony, reviewing the evidence in the record and the histories contained in the petitioner's medical records, the Arbitrator concludes Petitioner has failed to prove that on May 14, 2012, an accident occurred that arose out of and in the course of his employment with Respondent.

The Arbitrator finds Petitioner's testimony, while not intentionally misleading, was inconsistent with and contradictory to the medical history included in the records and Petitioner's actions following the alleged date of loss.

Petitioner testified he was injured on May 14, 2014, while he was working with both paint and ceramic tiles and that his job included installing ceramic and painting the unit. Per his testimony, Petitioner had finished installing the ceramic, had moved on to painting the walls and was painting the trim when he allegedly experienced pain in the right side of his lower back.

Upon being questioned further, Petitioner then changed his testimony to claim that while moving the ladder for painting, he was also moving boxes of ceramic tile, each weighing between 20-30 pounds.

It should also be noted that according to Petitioner, he did not feel pain in his back while he was allegedly moving these boxes. Rather he testified that he first felt the symptoms while he was going up and down the ladder while carrying nothing at the time.

Analysis of the medical records entered into evidence by Petitioner shows that he has never provided a consistent mechanism of injury to any of his doctors. As seen in Petitioner's exhibit 3, Petitioner informed Dr. Giokaris that he was carrying heavy sacks of cement, about 80 pounds each and painting when he felt severe pain of the lower back going into the right leg. On June 22, 2012, Petitioner informed Dr. Dabbah he was lifting bags of cement from one area to another, up and down the stairs when he felt like he could not move.
At no point during his testimony at hearing, did Petitioner state that he was carrying 80 pound bags of cement up and down the ladder. The Arbitrator also notes that if Petitioner's testimony is to be believed, then he was painting when he first felt symptoms.

It should also be noted that when Petitioner was confronted with the history he had provided to his doctors in 2012, he changed his testimony to assert he was carrying bags of cement when he was allegedly injured. Upon being pushed to clarify whether he was carrying ceramic tile or cement at the time of the alleged injury, Petitioner, yet again, changed his testimony to claim he was carrying both items.

The Arbitrator notes that these different mechanisms of injury raises concern about the credibility of Petitioner in that it demonstrates a willingness to alter his version of events to incorporate facts placed before him.

While it is generally true that the testimony of a claimant is supported or contradicted by the contemporaneous medical records, the handwritten and largely illegible records maintained by Dr. Giokaris, makes it impossible to determine whether or not Petitioner reported the same mechanism of injury to this doctor.

Petitioner's exhibit 3 does contain a certificate to return to school or work dated May 17, 2012, in which Dr. Giokaris states Petitioner had been under his care from May 15, 2012 and was able to return to work on May 21, 2012. The only diagnosis mentioned is that of

L-spine radiculopathy. More importantly, nowhere does it state that Petitioner's symptoms arose while he was working.

The burden is upon the party seeking an award to "prove by a preponderance of credible evidence the elements of his claim, particularly the prerequisite that the injury complained of arose out of and in the course of his employment." *Hannibal, Inc. v. Industrial Com.*, 38 Ill.2d 473, 475, 231 N.E.2d 409, 410 (1967). As such it is Petitioner's responsibility to provide legible evidence supporting his claims and the Arbitrator notes most of the medical records of Dr. Giokaris documenting Petitioner's complaints at the initial stages of his alleged claim, are handwritten and largely illegible.

It is also the function of the Industrial Commission to judge the credibility of witnesses, to determine the weight to be given to their testimony, and to draw reasonable inferences therefrom. *City of Streator v. Industrial Com.*, 92 Ill.2d 353, 363, 66 Ill.Dec. 71, 442 N.E.2d 497 (1982); *Seiber v. Industrial *24 Com.*, 82 Ill.2d 87, 97, 44 Ill.Dec. 280, 411 N.E.2d 249 (1980); *Phelps v. Industrial Com.*, 77 Ill.2d 72, 74, 31 Ill.Dec. 814, 394 N.E.2d 1191 (1979). Under this established case law, the Arbitrator finds the medical records of Dr. Giokaris unpersuasive and thus cannot be given much weight while trying to make a determination the validity of Petitioner's claims.

As no weight can be given to the early medical records of Dr. Giokaris, due to them being illegible and virtually impossible to read, the Arbitrator's decision can only be based on the testimony provided by Petitioner, which not only changed multiple times during the course of the Arbitration proceedings, it is also contradictory to the medical records of Petitioner's doctors.

The Arbitrator finds that Petitioner has not met his burden of proving, by a preponderance of the evidence that an accident occurred, which arose out of and in the course of his employment by Respondent. In that an accident has not been proven, all other disputed issues are moot and will not be addressed.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC24506
SIGNATURE PAGE

Signature of Arbitrator

September 20, 2016
Date of Decision

SEP 20 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES BAKER,

Petitioner,

17IWCC0571

vs.

NO: 12 WC 26808

THE AMERICAN COAL COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of exposure, disease, arising out of employment, occurring in the course of employment, the last date of exposure, causal connection and nature and extent of permanent disability under the Occupational Disease Act, 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 affirms and adopts the Arbitrator's findings of fact. The Commission also finds that although Petitioner had exposure to coal dust, silica dust, bolting glue fumes and diesel fumes for more than ten years working as an underground coal miner, Petitioner failed to prove he suffers from an Occupational Disease, disablement, or that he was disabled, as defined under the Illinois Workers' Occupational Diseases Act.

The pertinent sections of the Illinois Workers' Occupational Diseases Act state, in part, the following:

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(d) In this Act the term "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public.

A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence.

An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists…

The employer liable for the compensation in this Act provided shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease claimed upon regardless of the length of time of such last exposure, except, in cases of silicosis or asbestosis, the only employer liable shall be the last employer in whose employment the employee was last exposed during a period of 60 days or more after the effective date of this Act, to the hazard of such occupational disease, and, in such cases, an exposure during a period of less than 60 days, after the effective date of this Act, shall not be deemed a last exposure. If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment…

(e) "Disablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment; and "disability" means the state of being so incapacitated.

(f) No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease, except in cases of occupational disease caused by berylliosis or by the inhalation of silica dust or asbestos dust and, in such cases, within 3 years after the last day of the last exposure to the hazards of such disease and except in the case of occupational disease caused by exposure to radiological materials or equipment, and in such case, within 25 years after the last day of last exposure to the hazards of such disease. *820 ILCS 310/1(d), (e), (f)*

The Commission further finds Petitioner was last exposed on February 8, 2012, the date of his retirement, and as of the date of the arbitration hearing on April 12, 2016, had not established he suffers from an Occupational Disease or disablement, or that he is disabled or suffering from

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any respiratory condition either from coal workers' pneumoconiosis (CWP) or any reduced pulmonary capacity that arose out of and in the course of exposures in the coal mine.

The Commission further finds the Arbitrator's reliance on the findings of the National Institute for Occupational Safety and Health (NIOSH) testing results improper, although harmless error. Petitioner underwent an X-ray on February 21, 2012 at his attorney's request. (T, p. 36) The February 21, 2012 X-ray was taken approximately two weeks after Petitioner retired. The May 4, 2007 X-ray, although taken to fulfill NIOSH requirements during the time of the Petitioner's employment, was also used by Dr. Alexander, Dr. Meyer and Dr. Selby for the purpose of comparing the findings with the February 21, 2012 X-ray.

Dr. Henry Smith and Dr. Michael Alexander, both board certified radiologists and B-readers reviewed the February 21, 2012 chest X-ray at Petitioner's request. Dr. Smith and Dr. Alexander interpreted the February 21, 2012 chest X-ray as positive for simple CWP and CWP respectively with profusion 1/0 and P/P opacities. Their opinions differ in the location of the opacities. Dr. Smith opined the opacities were in the middle and lower lung zones bilaterally. Dr. Alexander opined the opacities were in all lung zones. Dr. Alexander held the only opinion that the May 4, 2007 X-ray was positive for CWP. Neither Dr. Smith nor Dr. Alexander examined Petitioner and neither Dr. Smith nor Dr. Alexander testified.

Dr. Christopher Meyer and Dr. Jeffrey Selby, both board certified radiologists and B-readers, reviewed the February 21, 2012 chest X-ray at Respondent's request. Dr. Meyer testified there can be disagreement amongst B-readers as to whether they think they are seeing small opacities or not. Making the distinction between 0/1 and 1/0 opacities is one of the most difficult processes of the entire B-Reader form. (8/30/13DepT, p. 10)

Dr. Meyer testified B-Reading is an epidemiologic evaluation of chest X-rays. There is a very specific form that's been developed to go through and evaluate the chest X-ray for the presence or absence of occupational lung disease. CWP is typically an upper zone predominant process; others like idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. He explained it is very important to show the small opacities and distribution of the small opacities and that is the purpose of the form. The last component is the extent of the lung involvement, the so-called profusion. (8/30/13DepT, pp. 22-23)

Dr. Meyer then testified that (w)e expect CWP and silicosis early in the disease process to be an upper zone predominant disease. You have to grade the film for profusion as well, basically trying to define the density of the small opacities in the lung. So if we were to imagine a film that was completely normal that would be a profusion of zero. (8/30/13DepT, pp. 28-30)

The most abnormal film with small opacities everywhere would be in a general profusion category of 3 and in-between we have threshold values. So one (1) threshold, or a profusion value of one (1), implies a mild amount of disease. Two (2) would be medium involvement of the lung and a profusion value of three (3) would be severe involvement of the lung. Profusion is described in fractionated terms as well in that the numerator of a profusion value implies what we think the value is and the denominator implies the other closest possible value. A 0/1 would mean the X-ray is normal but it might be just a little bit mildly abnormal. 2/1 would mean X-ray has mid-level

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of profusion of abnormality but might actually be a little milder than that. A 1/0 is right on the borderline between abnormal & normal. (8/30/13DepT, pp. 30-31)

Dr. Meyer compared the Petitioner's May 4, 2007 to the February 21, 2012 X-ray and found both negative for CWP. (8/30/13 DepT, pp. 40-41)

Dr. Selby, a certified B-reader since 1985 and re-certified about seven times, examined Petitioner and also compared the 2007 and 2012 X-rays finding both were negative for CWP. (2/2/16 DepT. p. 23)

The Commission concurs with the Arbitrator's finding the testimony of Dr. Selby and Dr. Meyer to be more persuasive than the B-Reader opinions of Dr. Smith and Dr. Alexander and more persuasive than the testimony of Dr. Glannon Paul. The Commission notes specifically Dr. Paul did not review any medical records. (1/11/16 DepT, pp. 18-20) Dr. Paul testified he is neither an A or B reader or board certified in pulmonary medicine. (1/11/16 DepT, pp. 25-26) The Commission finds Dr. Paul's concession that he did not review Petitioner's medical records or know the inhalation time for the tracer gas or the hold time for the tracer gas, tarnishes his opinion and the results of the diffusing capacity he performed.

The Commission notes Dr. Meyer and Dr. Selby agree regarding the impact of film quality and expertise on B-reading results and the fact that comparable experts can disagree. Dr. Meyer, Dr. Selby and Dr. Paul opined similarly without tissue sample, via biopsy or autopsy, presence or absence of coal workers' pneumoconiosis (CWP) cannot be confirmed. In this case, Dr. Smith and Dr. Alexander, hired by Petitioner to perform B-Readings, both found the profusion 1/0, the borderline area between abnormal and normal in the 2012 X-ray.

The Commission is swayed, therefore, by Dr. Selby's testimony regarding the sensitivity of CT scans for the evaluation of lung parenchyma. Dr. Selby testified a high-resolution CT of the chest was completed 7/31/13 and read by Anthony Perkins, M.D., a board-certified radiologist, showing no evidence of black lung disease/coal worker's pneumoconiosis…Dr. Selby reviewed the CT of the chest and agreed with Dr. Perkins' interpretation. (2/2/16 DepT, p. 13)

Dr. Selby opined that Petitioner does not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment…. Mr. Baker is deconditioned and obese. Both can be causative of shortness of breath or exercise limitation. (2/2/16 DepT, p. 22)

Although there are no protocols for standardizing equipment for CT scans, the cuts used for CT, according to Dr. Selby, are based on protocol that is used for any interstitial lung disease and acceptable by the American College of Radiology for all interstitial lung disease. (2/2/16 DepT, p. 40)

Dr. Meyer testified sometimes CT scans are referred for CWP…You don't need contrast for evaluating interstitial lung disease like CWP. (8/30/13 DepT, pp. 40-45)

Dr. Selby also testified CTs of the chest are more sensitive detecting emphysema. There

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was no emphysema seen on the 7/31/13 CT of Petitioner's chest. That was opinion of the radiologist as well. The testing performed on Petitioner 1/29/03 compared to 7/31/13 showed no significant change. Petitioner does not have progressive massive fibrosis or cor pulmonale. (2/2/16 DeptT, pp. 51-52)

The Commission finds that the 7/31/13 CT scan is the best evidence in this case and corroborates the B-Reader findings of Dr. Meyer and Dr. Selby.

The Petitioner's treating medical records through the date of the arbitration hearing confirm the same findings on physical examination as Dr. Selby's comprehensive evaluation found. The Veterans Administration records confirm Petitioner had no shortness of breath or cough, dyspnea on exertion and physical examination of the chest when last seen on 7/29/13 revealed the lungs to be clear to auscultation bilaterally.

Dr. Selby testified Petitioner's chief complaint was his knee hurts. Petitioner told Dr. Selby "he has no respiratory problems he can think of." (2/2/16 DepT, p.10) The Commission finds Petitioner does not have evidence of an occupational disease, disablement, pulmonary or respiratory condition.

The Commission strikes those parts of the Arbitrator's Decision referencing reliance on the NIOSH results. Accordingly, the Commission strikes the second, fourth and fifth sentences in the second paragraph under the Arbitrator's Conclusions of Law. The Commission further strikes the second and third sentences in the third paragraph under the Arbitrator's Conclusions of Law. Finally, the Commission strikes the first sentence of the last paragraph on page 10.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 29, 2016, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove by a preponderance of the evidence that he has an Occupational Disease, disablement, or that he was disabled, as defined in the Illinois Workers' Occupational Diseases Act and all benefits are hereby 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.

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Based upon the denial of compensation herein, no bond is set by the Commission. *820 ILCS 305/19(f)(2)*. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 22 2017
KWL/bsd
O-7/25/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I believe that the record amply supports Petitioner's claim that he was not only exposed to an occupational disease by way of his having worked underground in coal mines for 27 years, but that he also proved by a preponderance of the credible evidence that he suffers from an occupational disease and that he has suffered disablement as a result thereof. More to the point, the testimony and opinions of Drs. Paul and Alexander, as well as the radiographic testing, clearly evidence the fact that Petitioner suffers from coal workers' pneumoconiosis as well as reduced diffusing capacity, which by its very nature restricts his ability to return to the mines and thus has resulted in disablement.

For the above reasons, I would reverse the Arbitrator's decision and find that Petitioner proved that he was exposed to an occupational disease by reason of his employment with Respondent and that said exposure has resulted in disablement and impairment, warranting compensation pursuant to the Act. Therefore, I respectively dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0571

BAKER, CHARLES
Employee/Petitioner

Case# **12WC026808**

THE AMERICAN COAL COMPANY
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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF **WILLIAMSON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0571

CHARLES BAKER
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **12** WC **26808**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **February 8, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$64,955.80**; the average weekly wage was **$1,249.15**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he suffered from coal workers' pneumoconiosis and/or reduced pulmonary capacity that arose out of and in the course of his exposures in the coal mine, and that his current condition of ill-being is causally related to his 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.

Signature of Arbitrator

June 23, 2016
Date

JUN 29 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHARLES BAKER
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

17IWCC0571

Case #: **12 WC 26808**

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was 62 years old, married, with no dependent children. He was employed by The American Coal Company as an underground mechanic, and had been so employed since 2003. Petitioner completed his junior year in high school and later received his GED in 1972. He also received a maintenance mining technology certificate through Rend Lake College. Petitioner served in the armed forced from November 1969 to November 1978. He served in the Marine Corps in Vietnam and later served in the Navy.

Petitioner worked in the coal mines for 27 years, all of which were underground. He was regularly exposed to coal dust, silica dust, bolting glue fumes, and diesel fumes. His last day of employment with Respondent was February 8, 2012. He was exposed to coal dust that day in his classification as underground mechanic. He testified he decided to retire and "get out while the getting was good". He was also having a little bit of trouble breathing, and had some other unrelated medical issues, and he wanted to get out of the atmosphere in the mine. He has not worked for any other coal mine since he retired, nor has he worked elsewhere.

Petitioner began working in the mines in 1980 for Inland Steel. He was a roof bolter, which involved drilling holes into the roof and adding roof bolts for additional support after the coal was mined out. This process created a lot of rock dust, which Petitioner was exposed to. He also used roof bolting glue pins, which had an odor which could take your breath. Petitioner was a roof bolter for about a year, and then got his job as an underground mechanic. That job involved troubleshooting and repair of mechanical, electrical, and hydraulic equipment underground. He repaired the equipment underground in the mine, where the coal miners were working, and where there was a lot of dust. Petitioner worked for Inland Steel until around 1988, when the mine closed.

Following work at Inland Steel, Petitioner worked as a mechanic on assembly lines and machines for a company that made interior car parts. He did that for about three years. Following that, he returned to the coal mines. He worked for Consolidation Coal from the early 1990's to 2003, when the mine closed. He then went to work form Respondent as an underground mechanic, where he remained until his retirement in 2012. He testified the work also exposed him to diesel fumes, as the haulage equipment was diesel powered and he ran into the fumes before he actually got into the unit.

Petitioner testified he first noticed breathing problems about two years before he retired. He noticed as he walked across the unit he would get low on air, which he first attributed to "getting old". He testified that from that time until the day he retired, his breathing problems got worse. He is currently able to walk on level ground at a normal pace for about a mile or climb one flight of stairs before he becomes short of breath. He is not currently on any breathing medications. The breathing difficulties interfere with his ability to mow his grass, which his wife primarily does now, and his ability to take out more than one trash can at a time. They also prevent him from restoring cars, which was previously a hobby. He is still able to ride motorcycles, as it does not involving lifting much weight.

Petitioner testified he gets most of his medical treatment at the VA hospital, for any ailment he may have. He has not really discussed his breathing problem with the doctors at the VA, as he did not believe there was anything they would do. Petitioner testified he was a smoker from ages 13 to 33, but that he had not smoked in 33 years. At the highest point, he was smoking close to three packs a day.

In addition to his breathing problems, Petitioner testified he had Type II diabetes, kidney disease, high blood pressure, and anxiety attacks, all of which require medication.

On cross-examination, Petitioner acknowledged that when he was employed at the mine he had chest x-rays from time to time, which were provided by NIOSH for black lung screening. When he underwent the screening they would write to him and let him know the results of the x-rays. He did not bring any of those letters with him to trial. He testified that when he retired he signed up for Social Security. When he retired he was having other medical problems, including kidney disease and anxiety attacks. He acknowledged he had had knee problems while working in the mine, for which he had surgery, and from which he had recovered.

Petitioner testified he began treating at the VA in 2009, and prior to that he treated with Dr. Julie Atkins at Ultimed Plus/SIMCA. In conjunction with his claim, he had a chest x-ray done by Dr. James Alexander and was examined by Dr. Glennon Paul, both at his attorney's request. He testified he had seen no other physicians in regard to his claim, except for an examination done at his employer's request.

Petitioner testified his hobbies include target shooting and taking long motorcycle trips with his wife. The longest trip they have taken was about 4,500 miles over a 10-day period.

Petitioner was examined by Dr. Glennon Paul at his attorney's request on December 7, 2012. PX1, Dep. PX2. He testified by way of deposition on January 11, 2016. Dr. Paul is board

certified in asthma, allergy & immunology. He is the medical director of St. John's respiratory therapy, clinical assistant professor of medicine at SIU Medical School, and senior physician at the Central Illinois Allergy and Respiratory Clinic. Dr. Paul testified that when he did his fellowship from 1970 to 1972, there were not pulmonary fellowships developed, but that during his fellowship he was responsible for pulmonary diseases. He testified he reads about 100 chest x-rays per week and interprets the same number of pulmonary function tests. He has treated coal miners for coal mining induced lung disease since the 1970's. Dr. Paul is not an A or B reader and is not board certified in pulmonary medicine. PX1

Dr. Paul testified that Petitioner gave a history of working underground in the coal mines for 28 years. He reported some shortness of breath when lifting or going up one flight of stairs. He did not have cough or sputum production. Dr. Paul testified there are causes for shortness of breath with exertion other than lung disease, including heart disease, and that exertional dyspnea is possibly associated with deconditioning. Examination of Petitioner's chest was normal, except that he had rales throughout his lung areas on deep inspiration. Dr. Paul testified this is caused by fibrosis, which is a permanent condition. He testified that Petitioner did not have restrictive lung diseased, based on his pulmonary function studies. Petitioner did have reduced diffusing capacity, which Dr. Paul testified was compatible with black lung disease. PX1.

Dr. Paul testified that Petitioner had coal workers' pneumoconiosis and a decreased diffusing capacity, both of which were caused by inhalation of coal mine dust. He testified that in light of these diagnoses, Petitioner could have no further exposure to the environment of a coal mine without endangering his health. Dr. Paul testified that Petitioner had clinically significant pulmonary impairment caused by the coal dust environment. He further testified that a person could have coal workers' pneumoconiosis despite having a negative chest x-ray. PX1.

On cross-examination, Dr. Paul acknowledged that he had seen Petitioner only one time, at the request of his attorney, and that he has examined hundreds of patients at the request of Petitioner's counsel. Petitioner was not taking any medication at the time he was examined, and Dr. Paul did not ask him if he had ever taken breathing medication in the past. Dr. Paul did not review medical records regarding Petitioner. He testified that Petitioner did not relate to him why he retired when he did, and did not relate to him that he left mining at the time he did due to an occupational disease. PX1.

Dr. Paul testified that simple pneumoconiosis does not have any symptoms and that it will likely progress once the exposure ceases. He acknowledged, however, that when he gave depositions in May 2015 he testified at that time that simple coal workers' pneumoconiosis was unlikely to progress once the exposure ceases. PX1, Dep. RXA, RXB. Dr. Paul testified that when he answered (in May 2015) that it could not progress, he was referring to the chest x-rays. He testified it is more likely not to progress regarding the chest x-rays, but he testified he was currently talking about the disease itself in the lung, and it is likely to progress. He could not say that it was progressing in Petitioner, as he did not have a biopsy. PX1.

With regard to the diffusing capacity he performed, Dr. Paul did not know the inhalation time for the tracer gas, or the hold time for the tracer gas. He did not know the inspiratory volume for the tracer gas. Dr. Paul attributed the decrease in diffusing capacity to scarring of the

lungs by pneumoconiosis, which he testified is permanent. Dr. Paul conceded that he did not know the date of the chest x-ray that he reviewed. He testified that all opacities in the lungs of patients who have coal workers' pneumoconiosis are the same and that it does not matter what the shape is, that they are all due to coal dust. Dr. Paul did not note the profusion of the film. He felt there was a greater involvement in the lower lung zones. PX1.

At Petitioner's request, Dr. Henry Smith reviewed chest x-ray dated February 21, 2012. Dr. Smith is a Board Certified Radiologist and a B-reader. He interpreted the chest x-ray as positive for pneumoconiosis, with profusion 1/0 and P/P opacities in the middle and lower lung zones bilaterally. Dr. Smith's impression was simple coal worker's pneumoconiosis. PX2.

At Petitioner's request, Dr. Michael Alexander reviewed chest x-ray dated February 21, 2012. Dr. Alexander is a Board Certified Radiologist and a B-reader. He interpreted chest x-ray as positive for pneumoconiosis, with profusion 1/0 and P/P opacities in all lung zones. His impression was coal workers' pneumoconiosis. PX3.

Records of NIOSH were admitted into evidence. Chest x-ray of January 19, 2000, was interpreted by B-reader McGraw and B-reader Shipley as being completely negative. Chest x-ray of January 29, 2003, was interpreted by B-reader Parker and A-reader Youssef as being completely negative. Chest x-ray of May 4, 2007, was interpreted by B-reader Meseroll and B-reader Parker as being completely negative. RX5.

At Respondent's request, Dr. Cristopher A. Meyer reviewed Petitioner's chest x-rays dated May 4, 2007, and February 21, 2012. He found the 2007 x-ray to be quality 2 due to poor contrast, and the 2012 x-ray to be quality 2 due to overexposure. Dr. Meyer found no evidence of coal workers' pneumoconiosis on either of the films, and found the 2012 film to be unchanged when compared to the 2007 film. RX1, Dep. RXB.

Dr. Meyer testified by way of deposition on August 30, 2013. He is a Board Certified Radiologist and has been since 1992. He has been a B-reader since 1999. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. He opined that is because radiologists have a better sense of what the variation of normal is. He testified he reads 200 to 250 chest x-rays and 20 to 40 CT scans in an average week. RX1.

Dr. Meyer testified that B-reading is an epidemiologic evaluation of chest x-rays. There is a very specific form that has been developed that the B-reader goes through to evaluate the chest x-ray for the presence or absence of occupational lung disease. The B-reader first evaluates the quality of the film, describes any limitations of the x-ray, and then goes on to classify any parenchymal abnormalities. The B-reader next decides whether there are any small nodular opacities or any linear opacities, and based on the size and appearance of the small opacities, they are given a letter score. The B-reader next describes the distribution of the opacities. Dr. Meyer testified that different pneumoconioses are seen in different regions of the lung, so it is important to describe where the findings are in the lungs. He testified that coal workers' pneumoconiosis is typically an upper zone predominant process. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types, and that coal workers' pneumoconiosis is characteristically described by small round opacities. Finally, the

last component of interpretation for the B-reader is the extent of the lung involvement, or the so-called profusion. Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. RX1.

Dr. Meyer testified that to become a B-reader, one takes a weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. At the end of the weekend there is a certifying exam which is six hours long, with 120 chest x-rays to be categorized. Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. RX1.

At Respondent's request, Dr. Jeffrey W. Selby examined Petitioner on July 31, 2013, and authored a report dated the same day. RX2, Dep. RX3. Dr. Selby testified by way of deposition on February 2, 2016. He is board certified in internal medicine and pulmonology and has been a B-reader since 1985. RX1, Dep. RX1, RX2. Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient care. He consults on chest, lungs, and breathing disorders. His practice also includes occupational lung disease, including individuals with coal workers' pneumoconiosis. RX2.

When Petitioner saw Dr. Selby, his chief complaint was that his knee hurt. He had no respiratory problems that he could think of. He reported he had never been diagnosed with asthma, and he denied cough or wheezing. He did have some shortness of breath with exertion. Petitioner reported to Dr. Selby that he had started smoking at age 12 and smoked two packs per day until age 33. He stopped smoking because of coughing every morning. After he stopped he noticed a significant improvement in his breathing, he had more energy and less coughing, and his food tasted better. Dr. Selby noted that Petitioner was 68 inches tall and weight 270 pounds, giving him a BMI of 41.1, which placed him in the morbidly obese category. Petitioner's chest exam revealed clear breath sounds with good air movement. RX2.

Dr. Selby testified he performed several tests on Petitioner. His oxygen saturation on room air was 97%. A chest x-ray was done, with a B-reading showing a grade 1 quality film. There were no parenchymal or pleural abnormalities consistent with pneumoconiosis, and Dr. Selby testified the film was negative for pneumoconiosis, including coal workers' pneumoconiosis. A CT scan was conducted in conjunction with the examination, and was read by Dr. Anthony Perkins, a board-certified radiologist, as showing no evidence of black lung disease or coal workers' pneumoconiosis. Dr. Selby testified he reviewed the CT himself and agreed with Dr. Perkins' interpretation. A complete pulmonary function study was also done. Dr. Selby testified that the interpretation was a normal spirometry, without improvement post-bronchodilator, normal lung volumes, and normal diffusion capacity. Exercise testing was also performed. Petitioner was only able to complete five minutes and 28 seconds on the treadmill test. He stopped because he complained of shortness of breath and then became a little lightheaded after the treadmill was stopped. Dr. Selby testified there was no objective data to go along with Petitioner's complaints. He had no oxygen desaturation during exercise. Dr. Selby testified that there was no objective evidence of a limitation from a pulmonary standpoint, based on the exercise testing. RX2.

Dr. Selby testified that, in general, if one has scarring that results in a reduction in diffusion capacity, that reduction will not go away. When Dr. Selby measured Petitioner's diffusion capacity, it was normal. Based on that testing there was no evidence of an impairment in gas exchange. Dr. Selby testified that Petitioner was significantly overweight and deconditioned which was the most likely reason for him to be short of breath with exertion. He testified that applying the AMA Guides, Sixth Edition to Petitioner, he would fall under Class 0. Dr. Selby testified that Petitioner was capable of heavy manual labor from a respiratory standpoint. He noted that Petitioner had hypertension, diabetes mellitus and probable sleep apnea, all of which are significant risk factors for heart disease. If Petitioner is ever discovered to have shortness of breath, the most likely etiology would be heart disease if an obvious cause is not found. Petitioner also smoked heavily for over 20 years potentially leading to heart disease and occult lung disease. RX2.

Dr. Selby also reviewed medical records regarding Petitioner which dated from January 2000 through September 2012. He reviewed Dr. Paul's report from his examination and testing performed on December 5, 2012. He also reviewed chest x-rays dated May 4, 2007, and February 21, 2012, and testified there was no evidence of pneumoconiosis on these films. RX2.

Dr. Selby testified that for a proper reading of a chest x-ray for pneumoconiosis, one must have appropriate demographic information on the film identifying the individual and the date the film was taken. On the B-reading form one is asked to indicate what type of opacity is present. The opacities are classified by shape and size. The two shapes are round and irregular. One must indicate the profusion present. Dr. Selby testified there is no such thing as radiographically significant pulmonary impairment, and that he cannot determine pulmonary impairment from chest x-rays. Dr. Selby testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. He did not see any pathologic evidence of pneumoconiosis in Petitioner. RX2.

On cross-examination, Dr. Selby testified that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required. That tissue reaction is called scarring or fibrosis. The scarring of coal workers' pneumoconiosis cannot perform the function of normal, healthy lung tissue. By definition, if a person has pneumoconiosis, he would necessarily have impairment in the function of his lung at the very site of scarring whether that impairment can be measured by spirometry or not. RX2.

Dr. Selby testified that removal from any further exposure to coal dust is the only treatment for coal workers' pneumoconiosis. If a person continues his exposure after he has pneumoconiosis, it is a chronic, slowly progressive disease. If a miner leaves the coal mine with category I pneumoconiosis and does not have any more exposure, in the vast majority of cases the pneumoconiosis does not progress. Dr. Selby testified that if an individual had category I coal workers' pneumoconiosis, he probably would not be having abnormal pulmonary function tests or blood gases or physical examination of the chest or symptoms. Dr. Selby testified that if one wanted to know if a specific miner's pulmonary function was impaired from what it used to be, the way to measure that would be to compare his current pulmonary function to what it was before the insult or injury. Dr. Selby testified that when the testing that was performed on

Petitioner on January 29, 2003, was compared to what he performed on July 31, 2013, there was no significant change. RX2.

Medical records from SIMCA were admitted into evidence. Petitioner was first seen at that facility on April 8, 2002. His health history was negative for asthma. The assessment on that date was elevated blood pressure and moderate obesity. Petitioner was seen on June 24, 2002, and reported he had increased his exercise to walking one mile daily. He had no shortness of breath with same. Petitioner was seen on January 24, 2005, with complaints of pain and swelling in both knees. He had been tripped by a rope and twisted his knees in the process. Review of systems on that date revealed no cough, wheezing or shortness of breath. Petitioner underwent an EKG on February 2, 2005, which revealed a sinus tachycardia. Petitioner was seen on February 21, 2005, at which time he complained that it hurt to take a deep breath. Review of systems respiratory was negative for cough, wheeze or shortness of breath. His EKG was repeated and again revealed an arrhythmia. Petitioner was seen on March 11, 2005, with complaint of wheezing and some sinus congestion. It was noted that he had been hospitalized from February 21 through February 23 for pneumonia, and was being seen at that time in follow up. Petitioner still had a dry cough. Petitioner was seen on March 15, 2005, for follow up. His review of systems respiratory revealed no abnormality. He was next seen on September 30, 2005, with complaint of pain and swelling in the right knee. It was noted that he had undergone left knee surgery following a fall on January 17, 2005. His review of systems respiratory that date was negative. Petitioner was seen in the office for medication refill on July 25, 2006. His review of systems respiratory was negative. Petitioner was seen on January 26, 2009, with complaint of right ear pain after a piece of hot metal entered same while he was welding at work. Review of systems respiratory was negative. He was seen on September 28, 2009. At that time review of systems respiratory was negative. Petitioner was seen on January 4, 2010, for his arthritis. His review of systems respiratory was negative. RX3.

Medical records from Alexander Family Practice were admitted into evidence. Petitioner was seen on January 29, 2003, for a pre-employment physical with Respondent. Petitioner denied ever having had asthma, emphysema or frequent lung infections. In review of systems respiratory Petitioner denied frequent chest colds, constant or bothersome cough, sputum between colds, difficulty breathing, shortness of breath or wheezing. Physical examination of the chest revealed no abnormality. Simple spirometry was performed and was interpreted as normal. Petitioner was seen on January 11, 2010, for evaluation of a laceration of his right index finger. He was placed on limited duty through February 8, 2010. When he was seen on that date, physical examination of the chest revealed the lungs to be clear. He was seen for final evaluation on his finger laceration on October 19, 2010. He was fully recovered from the incident and was released from the doctor's care at that time. RX8.

A chest x-ray was taken at Harrisburg Medical Center on January 29, 2003. Dr. Hisham Youssef interpreted the chest x-ray as negative with classification 0/0. RX7.

Medical records of Crossroads Urology were admitted into evidence. Petitioner was seen on October 5, 2011, for kidney stone. He underwent a CT scan and was found to have a 16mg proximal right ureteral calculus with obstructive uropathy and a 1cm calculus in the left kidney without obstructive uropathy. Petitioner had previous history of nephrolithiasis one year prior.

He had a history of passing stones dating back two years. On October 17, 2011, Petitioner underwent attempted stent placement on the left which was unsuccessful followed by lithotripsy that appeared to adequately pulverize the stone. On the right, lithotripsy was applied to the stone which did not appear to adequately fragment the stone. On October 20, 2011, Petitioner was seen at Crossroads Community Hospital Emergency Room where a CT scan revealed a left small steinstrasse and obstruction on the right. He was admitted for bilateral uretroscopic stone manipulation. Physical examination of the chest at that time revealed his lungs to be clear. Petitioner was seen on November 2, 2011. It was noted he had bilateral indwelling stents and some residual stone fragments. When he returned for follow up on November 16, 2011, the doctor determined that because his stones were high in the ureter it was better to repeat lithotripsy rather than cystoscopy. Petitioner was seen in the hospital again on November 28, 2011, for secondary lithotripsy on the right. Physical examination of the chest that date revealed the lungs to be clear. Petitioner underwent lithotripsy and his stones appeared to be adequately pulverized on that date. Cystoscopy followed and Petitioner's indwelling stents were removed. Petitioner was seen on December 28, 2011, at which time it was charted that Petitioner had passed multiple sandy fragments and was totally asymptomatic. RX6.

Medical records from the Veterans Administration were admitted into evidence. Petitioner was first seen on March 26, 2009, for Agent Orange evaluation. It was recorded that he was an ex-smoker, having had said habit for 25 years. Review of systems respiratory was negative. His pulse ox on room air was 96%. Physical examination of the chest revealed the lungs to be clear to auscultation bilaterally. Chest x-ray performed on that date was interpreted as normal. When Petitioner was seen on September 6, 2011, his review of systems respiratory revealed no shortness of breath or cough. Physical examination of the chest revealed the lungs to be clear to auscultation. He was seen on September 29, 2011. Physical examination of the chest revealed no rales or rhonchi. It was felt that Petitioner was suffering from chronic kidney disease as a result of his creatinine trending higher. Petitioner was seen on March 9, 2012, at which time he related his energy level was good, but he did have some shortness of breath with overexertion. It was noted on that date that Petitioner had worked as a mechanic in a coal mine for 28 years and retired in February, 2012. Petitioner was told by urology that his lab work was deteriorating. On examination his lungs were clear to auscultation. On March 30, 2012, Petitioner reported that his energy level was good, but he did complain of shortness of breath with overexertion. Petitioner was seen on June 20, 2012, in follow up. Review of systems respiratory revealed no cough or shortness of breath. Physical examination of the chest revealed the lungs to be clear to auscultation bilaterally. On July 31, 2012, physical examination of the chest revealed no rales or rhonchi. Petitioner related being tired and having no energy to do anything the past six weeks. He denied shortness of breath. Petitioner was seen for a preoperative examination for anticipated cataract removal on August 1, 2012. On that date Petitioner related the ability to walk a mile without shortness of breath. It was also recorded that he could walk three blocks or climb two flights of stairs without shortness of breath. COPD was denied. Physical examination of the chest revealed Petitioner's lungs to be clear to auscultation. Petitioner was seen on September 7, 2012. His review of systems respiratory revealed no complaint of shortness of breath or cough. Physical examination of the chest revealed the lungs to be clear to auscultation bilaterally. Petitioner was seen on March 12, 2013. His past medical history was not significant for any pulmonary problem. Review of systems respiratory was negative for shortness of breath or cough. Physical examination of the chest revealed the lungs

to be clear to auscultation bilaterally. He was seen on July 29, 2013. Review of systems respiratory revealed no shortness of breath or cough. Petitioner had no dyspnea on exertion. Physical examination of the chest revealed the lungs to be clear to auscultation bilaterally. RX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made 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.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment with Respondent, and issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

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

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator relies, in part, upon the findings of the two NIOSH B-readers that Petitioner's x-ray of May 4, 2007, 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 January 19, 2000, and January 29, 2003, to be negative for coal workers' pneumoconiosis. However, the Arbitrator gives less weight to these interpretations, due to the temporal remoteness of those x-rays to Petitioner's date of accident and last date of exposure. 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.

The Arbitrator recognizes that Petitioner's alleged condition of coal workers' pneumoconiosis may have developed in the time period subsequent to his final NIOSH x-ray of May 4, 2007. Nonetheless, the Arbitrator finds the reverberation of opinions amongst B-readers Dr. Meyer and Dr. Selby compelling in conjunction with the significant number of negative x-ray interpretations performed at the behest of NIOSH, discussed above. The Arbitrator notes that the totality of the evidence demonstrates that a significant majority of B-readers concur that Petitioner does not have coal workers' pneumoconiosis.

Further, the Arbitrator finds the B-reading interpretations and opinions of Drs. Meyer and Selby to be more persuasive than the B-reading interpretations of Drs. Smith and Alexander. The Arbitrator gives no weight to Dr. Paul's x-ray interpretations, as in his testimony he did not properly describe the findings on the chest x-ray for it to be a competent interpretation. The Arbitrator notes that both Dr. Meyer and Dr. Selby reviewed the chest x-ray of May 4, 2007,

interpreted by NIOSH as negative, and likewise found the films to be negative for pneumoconiosis. Dr. Meyer and Dr. Selby also found the February 21, 2012, chest x-ray to be negative for pneumoconiosis. Dr. Meyer noted in his report that he compared the 2012 film to the May 2007 film, and that it was unchanged. Dr. Selby further found the July 31, 2013, chest x-ray to be negative for pneumoconiosis. The interpretations by Drs. Meyer and Selby were consistent with the independent readings by the NIOSH physicians.

The Arbitrator does not find Dr. Paul's conclusion that Petitioner had a decreased diffusing capacity caused by inhalation of coal mine dust to be credible. Dr. Paul attributed the decrease in diffusing capacity to scarring of the lungs by pneumoconiosis. He testified that this scarring would be permanent. Dr. Selby testified that if the reduction of diffusing capacity is due to scarring, the reduction will not go away. When Dr. Selby measured Petitioner's diffusing capacity on July 31, 2013, his diffusing capacity was normal. The Arbitrator finds Dr. Paul's diagnosis of decreased diffusing capacity related to coal mine dust exposure to not be persuasive.

The Arbitrator notes there are treatment records for Petitioner which were admitted into evidence. During his treatment with SIMCA from 2002 through January 4, 2010, Petitioner did not have any respiratory complaints other than on February 21, 2005, when he complained that it hurt to take a deep breath. He was hospitalized on that date for pneumonia. He continued to have a dry cough for some weeks after the pneumonia. Petitioner underwent simple spirometry on January 29, 2003, prior to Petitioner's employment with Respondent and same was interpreted as normal. Dr. Selby testified that there was essentially no change between this spirometry performed in January 2003 and the one performed at Dr. Selby's examination in July 2013. Petitioner complained of shortness of breath with overexertion when seen at the VA on March 9, 2012, and March 30, 2012. He denied shortness of breath when seen for preoperative examination on August 1, 2012. At that time he related an ability to walk a mile without shortness of breath. He did not have any complaints of shortness of breath when seen on September 7, 2012, March 12, 2013, and July 29, 2013. There was nothing in the treatment records indicating that Petitioner suffered from an occupational disease.

The Arbitrator finds the reverberation of opinions amongst B-readers Drs. Meyer and Selby, in conjunction with the aforementioned opinions of the NIOSH B-readers, to be compelling. Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers; pneumoconiosis and/or reduced pulmonary capacity that arose out of and in the course of his exposures in the coal mine, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELIZABETH COOK,

Petitioner,

17IWCC0553

vs.

NO: 12 WC 29262
15 WC 14744
15 WC 14745
15 WC 14746
15 WC 14747
15 WC 14748

RAINBOW BOOK COMPANY,

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 expenses, TTD, and PPD and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes Arbitrator Douglas Steffenson, in enumerating the reasons why he found Petitioner failed to prove a causal relationship between her bilateral carpal tunnel syndrome and her employment, wrote, "First, the Petitioner's testimony about her employment activities does not show that her work activities were highly repetitive or forceful." The Commission finds Arbitrator Steffenson required a higher standard of proof by requiring

17IWCC0553

Petitioner show that her work activities were "highly" repetitive or forceful rather than is currently necessary under Illinois case law. The Commission, therefore, strikes the word "highly" from above-quoted section of the Decision of the Arbitrator. Even with the lower standard of proof, for the reasons articulated by Arbitrator Steffenson in said Decision of the Arbitrator, the Commission finds Petitioner still fails to prove that a causal relationship exists between her bilateral carpal tunnel syndrome and her work activities.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 21, 2016, is hereby affirmed and adopted except as modified.

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

Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

SEP 7 - 2017

DATED:
KWL/mav
O: 07/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0553

COOK, ELIZABETH
Employee/Petitioner

Case# **12WC029262**

15WC014744
15WC014745
15WC014746
15WC014747
15WC014748

RAINBOW BOOK COMPANY
Employer/Respondent

On 9/21/2016, 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 0.50% 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:

0274 HORWITZ HORWITZ & ASSOC
MARC A PERPER
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2837 LAW OFFICE JOSEPH MARCINIAK
ROBERT SABETTO
TWO N LASALLE ST SUITE 2510
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 17IWCC0553

ELIZABETH COOK
Employee/Petitioner

v.

RAINBOW BOOK COMPANY
Employer/Respondent

Case # 12 WC 29262

Consolidated cases: 15 WC14744, 15 WC 14745, 15WC 14746, 15 WC 14747, and 15 WC 14748

An *Application for Adjustment 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 S. STEFFENSON**, Arbitrator of the Commission, in the city of **WAUKEGAN**, on **JULY 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. ☒ 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 _____

17IWCC0553

FINDINGS

On **6/8/12, 5/22/12, 7/27/12, 8/16/12, and 8/30/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$48,880.00**; the average weekly wage was **$940.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$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**.

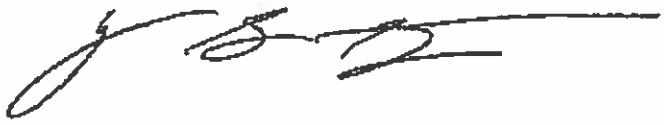
Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet her burden of proving a causal connection between her employment and her bilateral wrist conditions. Accordingly, her claims for compensation are denied and her Applications are dismissed.

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

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



Signature of Arbitrator

SEPTEMBER 20, 2016
Date

SEP 21 2016

ELIZABETH COOK v. RAINBOW BOOK COMPANY

12 WC 29262

CONSOLIDATED WITH:

15 WC 14744, 15 WC 14745, 15 WC 14746, 15 WC 14747 & 15 WC 14748

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Douglas Steffenson in Waukegan on July 18, 2016. The issues in dispute were accident, notice, causal connection, medical care and bills, TTD, Respondent's credit, and the nature and extent of the injury.

FINDINGS OF FACT

The parties stipulated their relationship was one of employee and employer, that at the time of her alleged initial injury, the Petitioner was 47 years old, single with no dependent children, and had and Average Weekly Wage of $940.00. (Arbitrator's Group Exhibit 1). Additionally, the parties requested a written decision and further stipulated to receipt of this Arbitration Decision and any subsequent Decision and Opinion on Review via e-mail. (Arbitrator's Group Exhibit 1).

The Petitioner testified she is right hand dominant and began working for the Respondent in the fall of 1998. (Transcript at 16, 51). She worked as an administrative assistant until approximately 2008, when she was promoted to office manager. (Transcript (*hereinafter*, T.) at 16, 40). She was responsible for training new employees, handling invoices, customer service, filing, and helping with entering purchase orders in the processing department. (T. at 16-17, 41-42). During slow times in the summer, she also packed boxes of old papers to be stored in the warehouse. (T at 17). Her work day was eight hours with a lunch break. (T. at 18-19, 44).

The Petitioner prepared invoices by entering dates and order information into a computer. (T. at 43-44). She printed invoices and folded them into three, placing them into envelopes and sealing them. (T. at 17, 43-44). The invoice could be anywhere from one to a dozen pages. (T. at 17). The Petitioner used her wrist or hand to apply "a lot of" pressure to seal and crease the envelopes before she ran them through the postage meter. (T. at 18). She estimated that she spent the last hour of the day performing this task. (T. at 19). Although it

varied, she estimated that she folded between six or seven and 50 invoices per day. (T. at 42). The Petitioner testified that it took her 45 seconds to a minute to fold each invoice. (T. at 43).

The Petitioner also acted as "second backup" for customer service, a function that involved phone work. (T. at 44). Although it varied, she estimated that she spent 20% to 30% of her work day on the phone. (*Id.*). The Petitioner further described carrying stacks of paper and shuffling through them with her fingers to insert files where they needed to go. (T. at 19). She compared it to typing. (*Id.*) She held the drawer open or the paper she was filing in her left hand and moved the contents of the drawer with her right. (T. at 20). She estimated that her time filing could range from 10% to 80% of her work day, or up to three or four hours. (T. at 20, 49).

The Petitioner described using a keypad and mouse to enter orders on a computer terminal. (T. at 21, 45). She testified that she spent most days helping the processing department in the spring and fall when they were busy, about four months of the year. (T. at 22). She entered addresses, moved boxes, and placed labels on boxes. (T. at 22-23). However, she also testified her time in the processing department slowed down after she was promoted. (T. at 23).

The Petitioner testified she used a telephone, a mouse, and a keyboard to perform her job duties. (T. at 45). She used a desktop computer for her job duties, used her hands to type, reported her typing speed to be 42 words per minute, and indicated she was allowed to type at her own pace and not in a forceful manner. (T. at 45-46). She also was able to push the keyboard back and forth, and adjust her chair. (T. at 47). When asked whether she had to extend her wrists in an uncomfortable position to type, the Petitioner responded that typing was just uncomfortable for her. (T. at 46-47). She also indicated she would arch her wrist when using a mouse because it hurt her wrist to contact the desktop. (T. at 50-51).

The Petitioner testified that around 2008, she noticed numbness and tingling in her fingers and wrist while she performed her work activities and her right hand was worse than her left hand. (T. at 23-24). She subsequently testified that she connected her symptoms to her employment activities in 2008. (T. at 61). She first sought treatment for her symptoms from Dr. Spears, her primary care physician, in May of 2012. (T. at 25).

The Petitioner stated she told the Respondent's owner, Mike Sherman, that she was having a problem with her hands and wrists after she first sought treatment on June 8, 2012, but she did not remember what either party said. (T. at 27). She subsequently admitted she did not know when she told Mr. Sherman of her hand difficulties. (T. at 62). She provided written work restrictions limiting her keyboard work from Dr. Thomas Burnstine, a neurologist, on August 16, 2012, and tendered that doctor's note to Mr. Sherman. (T. at 28-29). Thereafter, the

Petitioner worked until August 31, 2012, when she took a leave of absence. (T. at 29). She also testified the Respondent paid the premium for group medical benefits until her employment ended in March of 2015. (T. at 64).

The Petitioner admitted she has written poetry and children's stories "seriously' for approximately five years. (T. at 52). She also has been working on a memoir. (*Id.*) She uses a pen to write story boards on three-by-five cards and then uses a keyboard and a mouse on her home computer to type a draft. (T. at 52-53). She testified she did recall the Section 12 medical examination with Dr. Sanjay Patari, but also denied that she told Dr. Patari that she wrote for three hours a night. (T. at 54). She was published in the 1990s and took a journalism class while working for the Respondent. (T. at 54-55). She further testified she currently is working on a memoir of poems, essays, and rants. (T. at 65 and Respondent's Exhibit 8).

The Petitioner acknowledged she lost a considerable amount of weight from working out in the 2000s, but she attributed that result to clean eating and running. (T. at 56). She admitted that she lifted weights, but stated her exercise regimen focused on her lower body as she was not concerned with her arms. (T. at 56). She has had a home gym for about ten years, consisting of a treadmill and an elliptical machine. (T. at 57).

Mike Sherman was called to testify by the Respondent. (T. at 71). He has worked for the Respondent since 2000 and currently is its president. (T. at 72). Mr. Sherman is familiar with the Petitioner from working with her since he joined the company. (*Id.*). Mr. Sherman testified the Petitioner did minimal order entering by the time she assumed her position as office manager in 2008. (T. at 73). He stated the amount of filing the Petitioner did varied, but she only would have spent an hour to an hour and a half filing during busy periods. (T. at 74). The filing consisted of anywhere between three and 40 pages stapled together. (T. at 73). Mr. Sherman testified that 45 invoices per week would be sent out to customers during the busiest time. (T. at 75). He also explained that purchase invoices were prepared via a computer program called "Activate" into which the Petitioner entered dates, item numbers, and quantities into spreadsheet cells on her computer. (T. at 76-77). Mr. Sherman further testified that the first time the Petitioner reported to him any problems with her hands was when she brought a note to him in mid-August 2012. (T. at 81-82). He also was aware that the Petitioner enjoyed writing and exercised outside of work. (T. at 82-83).

Dr. Jonathan Gamze treated the Petitioner off and on for conditions unrelated to her upper extremity from 2000 through 2012. (Respondent's Exhibit (*hereinafter*, RX) 5). Dr. Gamze's first note on January 11, 2000, indicates that "Patient is now starting to weightlift again and tone up her muscles[.]" (RX 5 at 5). On August 7, 2000, Dr. Gamze noted that she had lost 28 pounds and was "lifting weights and exercising regularly." (*Id.*). On December 29, 2005, he noted that "[The Petitioner] works out at the YMCA regularly, and she has been able to lose

some weight in fair amount[.]" (RX 5 at 6). On July 10, 2006, he noted that she had recently gotten a home gym and "will start working out again, something she has done previously." (RX 5 at 8).

The Petitioner also presented to Dr. Reginald Spears complaining of pain, numbness, and tingling in her right ring and little fingers on May 22, 2012. (Petitioner's Exhibit 1). Dr. Spears cited found the Petitioner to have a positive Tinel and Phalen sign in the right upper extremity. However, Dr. Spears did not document any recommendations, and he did not see her again for her upper extremities. (Petitioner's Exhibit (*hereinafter*, PX) 1).

The Petitioner then consulted Dr. Mark J. Gould, a chiropractor, on June 4, 2012. (PX 2). She completed a Patient Health Information form indicating that she had been working for the Respondent in a sedentary clerical position for 13 years. She also indicated that she exercised three to six times a week. The Petitioner identified her "main concern" as numbness in her right and left hands, painful and swollen right pinky, and her lower back. She checked a box to indicate her condition as "chronic" and left another box for "work injury" blank. She described an inability to hold or grip a pen or mouse for very long, and stated that "hold[ing] weights becomes painful." She stated that she had carpal tunnel symptoms for five years that were worsening. (PX 2).

Dr. Gould then reviewed the Petitioner's provided health information form and further discussed her history and complaints. He then opined the Petitioner to be suffering from bilateral carpal tunnel syndrome and elbow entrapment. (PX 2). Dr. Gould recommended an EMG/NCV study and, on June 8, 2012, such testing was positive for bilateral median and left-sided radial neuropathies. (PX 2 and PX 3).

The Petitioner then turned her medical care to Dr. Thomas Burnstine for further medical care. (PX 4). During an August 16, 2012, examination, Dr. Burnstine reported a history of pain in both hands that had progressed since June, and that interfered with activities during the day, especially when holding objects. He noted that the Petitioner walked dogs with four leashes in her hand and worked on a keyboard. He wrote a note indicating that she was being evaluated for carpal tunnel syndrome, and it would be in her best interest not to use a keyboard if possible until her evaluation was complete. (PX 4). Dr. Burnstine ordered a second EMG/NCV study that was positive for bilateral carpal tunnel syndrome. On August 17, 2012, he recommended surgery and referred the Petitioner to Dr. Scott Rubenstein at Illinois Masonic Hospital.

The Petitioner met with Dr. Rubenstein on September 10, 2012 regarding her bilateral wrist complaints. (PX 5). Dr. Rubenstein performed a physical examination of the Petitioner and noted her history of working in an office for 13 years and doing "a lot of typing and office-type

work[.]" (PX 5). However, he did not cite any of the Petitioner's other activities, whether employment or personal. After a physical exam, Dr. Rubenstein opined that "[t]here could indeed be some relationship between [bilateral carpal tunnel syndrome] and her workplace activities." (*Id.*)

The Petitioner attended a Section 12 examination with Dr. Sanjay Patari on September 26, 2012. (RX 4). The Petitioner reported sending between three and 20 emails a day, and writing children's books and nonfiction for two to three hours a night using a keyboard. She told him she has been writing for "many years." (RX 4 at 2). Dr. Patari, while confirming the Petitioner to be suffering from carpal tunnel syndrome ("right greater than left") and mild right cubital tunnel syndrome, also opined her work lacked both the repetitive nature and "high-force type of activity enough to be causally related" to the (Petitioner's) conditions. (RX 4 at 3-4). Furthermore, he identified the Petitioner's non-work related writing hobbies as a contributing factor and also endorsed surgical intervention if injection therapy was not helpful. (RX 4 at 4).

Subsequently, Dr. Rubenstein did provide splinting and injection therapy for the Petitioner before moving forward with a left carpal tunnel release on January 8, 2013. (PX 5 and PX 6). He then indicated the Petitioner, following her surgical recovery, could return to work on February 25, 2013. However, Dr. Rubenstein also noted the Petitioner to be a candidate for a right carpal tunnel release should she wish to do so. (PX 5).

On March 12, 2013, Dr. Rubenstein performed the right carpal tunnel release. (PX 5 and PX6). Thereafter, the Petitioner moved through surgical recovery and therapy. Dr. Rubenstein's final chart note of November 22, 2013 documents his recommendation the Petitioner continue with work hardening and conditioning. (PX 5). However, the Petitioner testified that she chose not to pursue that recommended rehabilitation program due to the time involved. (T. at 36-37). She currently is receiving Social Security disability benefits for an unrelated condition. (T. at 66).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

It is axiomatic that a claimant, not an employer, bears the burden of proving by a preponderance of the credible evidence *all* of the elements of her claim in order to recover benefits under the Workers' Compensation Act. First Cash Financial Services v. Industrial Commission, 367 Ill. App. 3d. 102, 106 (2006), Illinois Bell Telephone Co. v. Industrial Commission, 265 Ill. App. 3d. 681, 685 (1994) (Emphasis added). The claimant's burden

includes proving an accident that arose out of and in the course of her employment, Parro v. Industrial Commission, 167 Ill. 2d. 385, 393 (1995), and a causal connection between the accident and her condition of ill-being, Lee v. Industrial Commission, 656 N.E.2d 1084 (1995).

A claimant alleging a repetitive trauma injury must meet the same standard of proof as a claimant who alleges a sudden injury from a discrete event. Durand v. Industrial Commission, 224 Ill. 2d. 53, 64 (2006). A claimant who alleges an injury based on repetitive trauma must show that the condition is work related. Peoria County Bellwood Nursing Home v. Industrial Commission, 115 Ill. 2d. 524, 530 (1987). Liability cannot rest on imagination, speculation, or conjecture. First Cash, 367 Ill. App. 3d. at 106.

The Arbitrator finds, for a number of reasons, the Petitioner has failed to show by a preponderance of the credible evidence that her carpal tunnel syndrome is causally related to her employment with the Respondent. First, the Petitioner's testimony about her employment activities does not show that her work activities were highly repetitive or forceful. She testified generally about a myriad of tasks she performed throughout the day. She spent a third to half of her day on the phone. (T. at 44). The purchase orders and invoices she prepared involved entering minimal data: dates, order numbers, and addresses. (T. at 43-44). She did not type letters, and based upon her history to Dr. Patari, she sent 20 emails a day. (RX 4 at 2). By her own admission, she did type in a forceful manner. (T. at 46). She testified that when she used a mouse, the act of placing her wrist on desktop caused pain—not the act of using the mouse itself. (T. at 51). Additionally, the Petitioner indicated it took her 45 seconds to a minute to fold an invoice before she ran it through a postage meter. (T. at 18, 42-43).

Second, the medical records do not support the Petitioner's claim. Instead, they strongly suggest that her carpal tunnel syndrome developed from activities unrelated to her employment with the Respondent. The only activities she reported to those physicians who examined her involved using a mouse, a keyboard, and a pen. (PX 2 and PX 4). However, she did not advise her treating physicians of her invoicing, filing, phone, and other tasks while at work for the Respondent. By her own admission, she used these same items to write her own stories and poems. (T. at 52-53). The Petitioner downplayed the amount of writing she did on the side, testifying that she told Dr. Patari she "could" write for three hours a night because she was expressing her passion for writing. (T. at 54). Mr. Sherman indicated his awareness of her non-work related writing and the Petitioner even told him about a memoir she is writing. (T. at 82 and RX 8). The Petitioner testified her memoir merely was a compilation of poems she wrote years ago. (T. at 69-70). However, she also informed Mr. Sherman the memoir's title referenced not only poems, but also "(e)ssays and (r)ants". (RX 8).

Third, the Petitioner's non-work related exercise program, as documented both by Dr. Gamze and Dr. Gould, show that the Petitioner lifted weights for years, was doing so when her

bilateral upper extremity symptoms developed, and still was doing so when she finally sought treatment. (RX 5 and PX 2). Dr. Gamze noted as early as January 2000 that she was lifting weights to lose weight and seeing positive results. (RX 5). The Petitioner She set up a home gym in 2006 (T. at 57) and informed Dr. Gould during her initial visit she had difficulty holding weights during her workouts. (PX 2). These medical records contradict the Petitioner's testimony that she did not focus on her upper extremities while exercising. (T. at 56).

Fourth, the Petitioner presented the medical records and opinions of Dr. Rubenstein to establish causal connection between her condition of ill-being and her work for the Respondent. (PX 5). However, in finding "(t)here *could* indeed be *some* relationship between (carpal tunnel syndrome) and her work place activities," Dr. Rubenstein only based such an opinion on his understanding the Petitioner "has been doing *a lot* of typing and office-type work ..." (PX 5, *emphasis added*). Dr. Rubenstein failed to cite with any specificity the frequency of the offending typing and other work activities, the amount of force used by the Petitioner in typing and other duties, and any irritating flexion or movement of her wrists while working. Additionally, he made no comment as to her non-work related activities (exercising and writing) and their role in her bilateral hand symptoms. (*Id.*).

Fifth, the Arbitrator is persuaded by Dr. Patari's opinion that the Petitioner's condition of ill-being is not causally related to her work for the Respondent. (RX 4 at 3-4). Dr. Patari reported on the Petitioner's history and work duties in a detailed fashion that cannot be found in the records of her treating physicians, including Dr. Rubenstein. (RX 4 at 2). Furthermore, Dr. Patari did not refute the Petitioner's need for carpal tunnel surgery if conservative measures did not improve her symptoms. (RX 4 at 4). Instead, he clearly distinguished her medical findings and symptoms from her work for the Respondent. (*Id.*).

As such, the Arbitrator denies all of the Petitioner's claims for compensation for failing to prove a causal connection between her alleged work accidents and her condition of ill-being. Such a finding renders the remaining disputed issues moot and dismisses all of the Petitioner's Applications for Adjustment of Claim.

Signature of Arbitrator

September 20, 2016
Date

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

Angela Welch,
Petitioner,

vs.

NO: 12WC 35600

State of Illinois/Tamms Corr Ctr,
Respondent,

17IWCC0569

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, 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 April 27, 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: SEP 21 2017

o:080217
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

DISSENT

A claimant who alleges injury due to repetitive trauma must meet the same standard of proof as in the case of a discrete accident. *Durand v. The Industrial Commission*, 224 Ill. 2d 53, 862 N.E.2d 918 (2006). A claimant is required to establish a causal relationship between her work duties and the resulting condition of ill-being. *Navistar International Transportation Corp. v. The Industrial Commission*, 315 Ill. App. 3d 1197, 1203, 734 N.E.2d 900 (2000). I believe Petitioner failed to prove a causal relationship as I would afford greater weight to the opinions of Dr. Anthony Sudekum over those of Dr. Steven Young. Therefore, I respectfully dissent.

Dr. Young testified as to his understanding of Petitioner's job duties and Petitioner's development of bilateral carpal tunnel syndrome. Specifically, Dr. Young testified it was Petitioner's duties of pushing buttons and lifting heavy loads (up to 40 lbs.) which either caused or aggravated Petitioner's carpal tunnel syndrome. PX14, p. 23. Dr. Young testified he reviewed the job analysis video but felt it did not provide a full assessment of Petitioner's job duties as opposed to Petitioner's description of her job. PX14, p. 27-28. Dr. Young, though, could not recall ever discussing with Petitioner her job duties and further, could not recall receiving a description from Petitioner of how the button pushing was performed. PX14, p. 42-43. Dr. Young was not even aware of which hand Petitioner utilized in pushing the buttons. *Id.* Dr. Young also testified Petitioner never reported lifting 40 pounds. PX14, p. 45. Even such Dr. Young testified the most relevant information regarding Petitioner's job duties would be the information obtained specifically from Petitioner. PX14, p. 44-45.

In contrast, Dr. Sudekum possessed a better understanding of Petitioner's job duties. Dr. Sudekum obtained a specific history from Petitioner as to her job duties in the control room pushing buttons. RX9, p. 17-18. Further, Dr. Sudekum toured correctional facilities and directly manipulated the buttons. RX9, p. 20. More importantly, Dr. Sudekum reviewed the video job analysis and relied on it accordingly. RX9, p. 17-18. As such I would afford greater weigh to Dr. Sudekum's opinions and deny the matter in its entirety. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WELCH, ANGELA
Employee/Petitioner

Case# **12WC035600**

STATE OF ILLINOIS/ TAMMS CORR CTR
Employer/Respondent

17IWCC0569

On 4/27/2016, 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 0.40% 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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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601 S UNIVERSITY AVE SUITE 102
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0498 STATE OF ILLINOIS
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1350 CENTRAL MANAGEMENT SYSTEMS
RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 27 2016

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

17IWCC0569

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

Angela Welch
Employee/Petitioner

v.

State of Illinois/Tamms Corr. Ctr.
Employer/Respondent

Case # 12 WC 35600

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 **Collinsville**, on **May 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0569

FINDINGS

On **August 30, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,628.00**; the average weekly wage was **$1,146.69**.

On the date of accident, Petitioner was **52** 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 **$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 benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $21,201.60, 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 temporary total disability benefits of $764.46/week for 2 1/7 weeks, commencing 12/21/12 through 1/4/13, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$688.01**/week for **47.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **12.5 % loss of the right hand (23.75 weeks) and 12.5 % loss of the left hand (23.75 weeks).**

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

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

Michael K. Nowak, Arbitrator

3/30/16
Date

APR 27 2016

FINDINGS OF FACT

Petitioner began her career with Respondent on January 5, 1998, at Tamms Correctional Center as a Correctional Officer (CO). She remained in that same position until 2013. Tamms was a super maximum security facility.

For the vast majority of her employment Petitioner worked the first shift, which was the busiest of the day. She spent the majority of her time at Tamms as a core control officer, mainly responsible for remotely opening and closing doors by pushing buttons. She would be seated in her work area with eight to ten panels of buttons spread out around her. Each panel was slightly smaller than two feet by three feet. The panels were arranged such that she would be required to stretch completely out to reach the buttons. She would also be required to watch 12 video monitors. These monitors would allow her to see people approaching doors within the prison. When someone would approach a door she would be required to push and maintain pressure on the proper button until the door had opened completely. When the party moving within the prison would pass through a door Petitioner would then be required to push the close button and again maintain pressure until the door was fully closed. The process would then be repeated for each door the party encountered. Petitioner testified that this process required force and sustained pressure otherwise the door would stop functioning. Petitioner is only 5'5" tall and was required to use considerable reach to press the buttons. There were between 200 to 400 inmates housed at Tamms, and rules only allowed one door to be opened at a time.

On average, Petitioner opened 4 to 5 doors per minute. It took 10 to 12 seconds to open and/or close the doors. Petitioner would perform this process for the entirety of her shift. Petitioner testified that she performed similar activities when she worked in the armory. Petitioner demonstrated the awkward arm/wrist posture which was required to perform these activities. She testified that pressing and holding these buttons down all day was difficult. She stated "Some days I would go home and actually my hands would feel broken, like they're in half, broken." (T.21). Petitioner testified that she attempted to alleviate her symptoms with Bengay, rubbing alcohol and Ibuprofen, but nothing worked.

The second most frequent position Petitioner worked was that of a wing officer. She estimated that in this position she turned over 200 keys per day. She testified that since there were no inmate workers at Tamms, the Correctional Officers performed all of the feeding and cleaning such as mopping, washroom cleaning and taking out trash. Inmates were fed through an 18-inch long door called a chuckhole, which was opened with a 4-inch Folger Adams key. Petitioner testified that these chuckholes were not easy to open because they would stick due to rust and inmates throwing substances such as food and body waste into them. She testified that while one hand was turning the key, her other hand was manipulating the door slot to try and free it. Laundry, books, medication and anything else that inmates needed were delivered through chuckholes. Petitioner testified that she opened thousands of chuckholes during her career.

The inmates as Tamms Correctional Center had to be cuffed, placed in leg irons and strip-searched at various times. Petitioner would also perform wing checks every 30 minutes and shake each cell door to make sure it was locked. Petitioner performed shakedowns, during which she lifted items and searched through entire cells, including papers, books, clothing, and underneath mattresses, sinks and toilets.

Respondent called two former employees of Tamms Correctional Center, Jason Hall and Daniel Monti. Mr. Hall currently serves as a Superintendent for the Illinois Department of Corrections in Dixon Springs. Mr.

Hall worked at Tamms Correctional Center as a Correctional Officer from 1997 until 2001. He returned in 2004, but returned as an Administrative Assistant II in the warden's office. Mr. Hall disagreed with Petitioner's testimony as to the method and frequency of certain activities performed by wing officers, such as door checks and laundry deliveries; and he did not believe that Petitioner could open 2,000 doors in a full shift. He testified that the tactical staff mostly performed shakedowns. He believed that the number of doors opened would be in the hundreds rather than thousands. Mr. Monti currently serves as an Administrative Major at Big Muddy River Correctional Center. He testified that most of the shakedowns were performed by tactical staff. He could not recall staff shaking doors during wing checks. He believed that there would be between 500 to 800 pushes of the buttons.

The record contains an extensive amount of evidence regarding Petitioner's job duties: a CorVel Job Site Analysis (JSA) procured at Respondent's request (RX6); a DVD produced at Respondent's direction which depicts the job duties of a CO (RX7); a CMS Demands of the Job (RX4); a job description prepared by Petitioner (PX12); and a deposition of Melanie Welch (PX13).

The JSA characterized the Correctional Officer position as having medium strength demands, which involved frequent lifting and/or carrying up to 25 pounds with a 50 pound maximum. (RX6). It also noted that positions, such as the control position in which Petitioner worked, required frequent finger manipulation. *Id.* Frequent was defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or between 33 to 200 repetitions per day. *Id.* Respondent's Demands of the Job form, however, reflects that Petitioner uses her hands for gross manipulation (grasping, twisting, handling) for 6 to 8 hours per day, and for fine manipulation up to 2 hours a day. (RX4). It also indicates that Petitioner uses her hands to lift up to 40 pounds for 2 to 4 hours a day. *Id.*

The JSA was generated by Melanie Welch of CorVel Corporation. Ms. Welch testified by way of deposition. (PX13). Ms. Welch toured the facility for approximately three hours and took approximately ten minutes of video. *Id.* at 30. She testified that she was restricted from filming Correctional Officers performing their regular duties. *Id.* at 13-14. She acknowledged that there was nothing in her report or video about mail delivery or the weight of the delivery bags, nursing rounds or the administration of bandages or wraps. *Id.* at 37-39. She was unaware of what a security inspection is and did not witness how an inmate is secured for movement. *Id.* at 37, 40. She did not know often shakedowns were performed. *Id.* at 42. She did not know much keying or cuffing and uncuffing was done each day and no estimate was included in her report. *Id.* at 45. Although she knew that sweeping and mopping was done by the Correctional Officers, she did not know who emptied the trash receptacles, washed the windows, cleaned the showers, toilets, ice machines, stainless steel, furniture and ducts, and stocked the janitorial closets. *Id.* at 46-51. She did not have an accurate understanding of the effort involved in Petitioner's feed duties. Ms. Welch conceded that her analysis omitted a tremendous amount of data. *Id.* at 43, 51. When asked to assume that the description of job duties given by Petitioner was true, she agreed that Petitioner had an arm-and-hand intensive, repetitive job. *Id.* at 55.

Petitioner testified that during the course of her employment at Tamms Correctional Center, she began developing symptoms in her arms and elbows. Petitioner does not suffer from gout, diabetes, or rheumatoid arthritis. Petitioner testified that her hypertension was a relatively recent development and that it is controlled by medication. Petitioner has not gained but has lost weight over the years. Petitioner further testified that she does not have any hobbies that involve repetitive use of her hands. Petitioner suffered no prior injuries to her hands, arms or elbows.

Petitioner sought treatment with her family physician, Dr. O'Connor of Dongola Rural Health on August 20, 2012. Dr. O'Connor noted Petitioner's complaints of ongoing wrist pain with numbness and tingling. (PX3, 8/20/12). Dr. O'Connor recommended nerve conduction studies. *Id.* The EMG/NCV revealed moderate bilateral carpal tunnel syndrome. (PX5). Petitioner testified that prior to the electrodiagnostic studies of Dr. Glennon she had never received a diagnosis of carpal or cubital tunnel syndrome. Petitioner testified that the day she received the results of the studies was the first day she realized that she suffered a work-related injury. Petitioner completed an incident report on September 6, 2012. (RX2).

Dr. O'Connor referred Petitioner for orthopedic evaluation with Dr. Trueblood. (PX3, 9/6/12). Dr. Trueblood saw Petitioner on September 18, 2012, and noted the positive electrodiagnostic testing as well as clinical evidence of thenar wasting and positive Tinel's signs. (PX6, 9/18/12). He performed bilateral carpal tunnel injections. *Id.* However, these afforded no relief. (PX7, 9/19/12). Petitioner's family physician, Dr. O'Connor, then referred her to Dr. Steven Young. Petitioner came under the care of Dr. Steven Young on September 19, 2012. (PX7, 9/19/12). Dr. Young noted that Petitioner's wrists felt worse following the injections, and his physical examination demonstrated flattening of the bilateral thenar eminence. *Id.* Dr. Young recommended a more conservative approach and wished to wait 4 to 6 weeks to give the injections a chance to work. *Id.* When Petitioner returned to Dr. Young on October 22, 2012 with no improvement in her persistent symptoms, Dr. Young recommended bilateral carpal tunnel releases. (PX7, 10/22/12).

Dr. Young performed the right carpal tunnel release on November 7, 2012, and the left carpal tunnel release on December 21, 2012. (PX8, 11/7/12, 12/21/12). The notes of Dr. Young reflect that Petitioner's condition improved following surgery. (PX7, 2/6/13).

Petitioner attended a §12 evaluation by Dr. Anthony Sudekum. Dr. Sudekum authored a report which indicated that he believed that Petitioner's job only involved "pushing buttons intermittently to open and close doors." (RX8). He believed that Petitioner's employment did not cause or aggravate her carpal tunnel syndrome or cause any need for treatment. *Id.* at 45, 46.

Dr. Sudekum testified by way of deposition. Dr. Sudekum did not review the deposition of Melanie Welch and was unaware of the omissions to which she admitted. *Id.* at 39, 42, 43. He did not believe that the duties performed by any Tamms Correctional Officer would cause or aggravate upper extremity repetitive stress injuries. *Id.* at 46. Dr. Sudekum was not certain of whether Petitioner had a rheumatologic evaluation; yet, he concluded that Petitioner suffered from systemic arthritis. *Id.* at 51, 52. Dr. Sudekum did not believe that surgery was indicated for Petitioner's condition. *Id.* at 53.

Petitioner's hand surgeon, Dr. Young, also testified by way of deposition. (PX14). Dr. Young testified that he regularly treats people who suffer from conditions such as carpal tunnel syndrome and CMC joint arthritis. *Id.* at 6. He performs between 300 to 400 carpal tunnel surgeries per year. *Id.* at 6. Dr. Young testified that hypertension was not a significant factor in the development of carpal tunnel syndrome, as the association between the two is weak. *Id.* at 8. Dr. Young testified that Petitioner was referred to him by Petitioner's primary care physician, Dr. O'Connor. *Id.* at 8, 9. While he candidly acknowledged that Petitioner had some slight potential non-occupational risk factors for the development of her condition; he testified that Petitioner's hobbies did not contribute to or aggravate the development of carpal tunnel syndrome. *Id.* at 13. Since Petitioner failed to improve with conservative treatment, Dr. Young recommended and performed bilateral carpal tunnel

releases. *Id.* at 18. Petitioner derived benefit from the surgery, and the thumb spica splint and anti-inflammatory medication prescribed for her thumb. *Id.* at 19. Dr. Young testified that if Petitioner's symptoms were the result of arthritis rather than carpal tunnel syndrome, she would have derived no benefit from the surgery. *Id.* at 20. Dr. Young testified that Petitioner's employment at Tamms Correctional Center could cause or aggravate carpal tunnel syndrome. *Id.* at 21. He testified that he reviewed the various written descriptions of Petitioner's job in Respondent's documentation as well as the DVD and Demands of the Job form. *Id.* at 23, 24, 26. He felt the pushing of the buttons, lifting heavy loads up to 40 pounds as much as 2 to 4 hours per day were contributory to the development of her conditions. He testified that the usage depicted on the Demands of the Job form, which indicated that Petitioner used her hands for gross manipulation (grasping, twisting, handling) for 6 to 8 hours per day, over the course of 14 years would cause or contribute to the development of carpal tunnel syndrome. *Id.* at 24. Based on the totality of the information, including that created by Respondent and that offered by Petitioner, Dr. Young believed that Petitioner's employment as a correctional officer at Tamms Correctional Center contributed to or aggravated the development of Petitioner's bilateral carpal tunnel syndrome. *Id.* at 26. He also believed Petitioner's job duties potentially aggravated her CMC joint arthritis. *Id.* at 31.

Petitioner testified that the surgery performed by Dr. Young improved her condition. Despite the improvement from surgery, however, Petitioner suffers from loss of strength in her hands. She testified that she still has problems with her right index finger. Petitioner testified that sometimes, she has to take her left hand and lift her right index finger up to get it moving. She takes Ibuprofen daily and uses Bengay for her symptoms.

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?

The Arbitrator finds that Petitioner was a credible witness. The Arbitrator notes that Petitioner was required to firmly press and hold buttons for the vast majority of her entire shift as a control officer. Even assuming the estimate of Respondent's witness is correct, and Petitioner presses and holds between 500 to 800 buttons per shift, this is still significantly repetitive. (T.95). The Arbitrator, however, finds Petitioner's testimony is supported by the estimates found in Respondent's Demands of the Job form, which indicates that Petitioner spends 6 to 8 hours using her hands for gross manipulation. (RX4). According to Respondent's own documentation completed by Petitioner's supervisor, Petitioner uses her hands for her entire shift. *Id.*

It is clear that the author of the JSA, Melanie Welch, was not fully informed regarding Petitioner's job duties. By her own admission, her analysis omitted a tremendous amount of data.

The Arbitrator finds the testimony and opinions of Dr. Young more persuasive than those of Dr. Sudekum. Dr. Young testified that Petitioner's employment at Tamms caused and/or aggravated her bilateral carpal tunnel syndrome and her CMC joint arthritis. Dr. Sudekum believed that Petitioner only pushed buttons "intermittently to open and close doors." This belief is contrary to Petitioner's testimony, Respondent's witnesses' testimony, and Respondent's Demands of the Job form.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has met her burden of establishing that she sustained accidental injuries which arose out of and in the course of her

employment with Respondent, and that her current conditions 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?

Petitioner credibly testified that the prior to the electrodiagnostic studies of Dr. Glennon she had never received a diagnosis of carpal or cubital tunnel syndrome and that the day she received the results of the studies, August 30, 2012, was the first day she realized that she suffered a work-related injury. The Arbitrator finds that August 30, 2012 is an appropriate manifestation date under the Act.

It is undisputed that Petitioner completed an incident report on September 6, 2012. Petitioner 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?

Respondent disputed liability for medical expenses based upon issues C-F above. Respondent does not dispute the reasonableness or necessity of Petitioner's medical care. (T. 4)

Based upon the above findings regarding issues C-F, Respondent shall pay reasonable and necessary medical services of $21,201.60, as set forth in Petitioner's group exhibit 1, pursuant to 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 (K): What temporary benefits are in dispute? (TTD)

Respondent disputed liability for TTD based upon issues C-F above. Respondent does not dispute the period of incapacity.

Based upon the above findings regarding issues C-F, Respondent shall pay Respondent shall pay Petitioner temporary total disability benefits of $764.46/week for 2 1/7 weeks, commencing 12/21/12 through 1/4/13, as provided in Section 8(b) of the Act.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b). the occupation of the employee. the Arbitrator notes that Petitioner is currently employed at Shawnee Correctional Center and continues to work for Respondent performing mostly security functions. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b). the Arbitrator notes that Petitioner was 52 years old at the time of the accident. She has diminished healing capacity as a result thereof, and she must live and work with her disability for a number of years. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that despite the improvement from her bilateral carpal tunnel releases and CMC joint treatment, Petitioner suffers from loss of strength in her hands. She testified that she still has problems with her right index finger. Petitioner testified that sometimes, she has to take her left hand and lift her right index finger up to get it moving. She takes Ibuprofen daily and uses Bengay for her symptoms. The Arbitrator gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of each hand pursuant to §8(e) of the Act.

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

Michael Wiegers,

Petitioner,

vs. NO: 12WC 40446

State of Illinois/Illinois State Police,

17IWCC0532

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties and proper notice given, the Commission, after considering the issues of accident, temporary disability, causal connection, permanent disability, medical expenses, motion in limine, 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 27, 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.

17IWCC0532

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: AUG 30 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
d-8/3/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIEGERS, MICHAEL
Employee/Petitioner

Case# **12WC040446**

ST OF IL/ILLINOIS STATE POLICE
Employer/Respondent

17IWCC0532

On 2/27/2017, 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 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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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5300 ASSISTANT ATTORNEY GENERAL
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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

FEB 27 2017

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

17IWCC0532

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

Michael R. Wiegers
Employee/Petitioner

v.

State of Illinois/Illinois State Police
Employer/Respondent

Case # 12 WC 40446

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on January 19, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $78,825.00; the average weekly wage was $1,505.48.

On the date of accident, Petitioner was 59 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

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

ORDER

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,003.65 per week for three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 25.625 weeks because the injuries sustained caused the five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

February 16, 2017
Date

ICArbDec p. 2

FEB 27 2017

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.

Petitioner initially sought medical treatment on October 1, 2010 (the date of manifestation alleged in the Application) from Dr. Michelle Reeves, his family physician. At that time, Dr. Reeves' findings on examination were consistent with bilateral carpal tunnel syndrome. Dr. Reeves indicated she was going to order EMG/nerve conduction studies. Dr. Reeves stated in her record she considered the condition to be work-related, but did not explain the basis for her opinion (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on October 12, 2010. The studies were consistent with mild bilateral carpal tunnel syndrome as well as chronic moderate cubital tunnel syndrome and bilateral C6-C7 radiculopathy (Petitioner's Exhibit 6).

Petitioner was subsequently seen by Dr. Edwin Card, a general surgeon, on November 8, 2010. Dr. Card examined Petitioner and noted Petitioner had recently undergone nerve conduction studies which were positive for carpal tunnel syndrome. He also indicated Petitioner worked for the State Police, did a significant amount of typing and that Petitioner's complaints were significantly worse when involved in those activities (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Reeves on May 4 and July 13, 2011, and Petitioner's symptoms had worsened. Dr. Reeves ordered new EMG/nerve conduction studies to be performed (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on August 2, 2011. The EMG/nerve conduction studies were positive for moderate chronic bilateral carpal tunnel syndrome as well as suggestive of bilateral C6-C7 radiculopathy (Petitioner's Exhibit 4; Deposition Exhibit B).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on October 3, 2012. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams agreed Petitioner had bilateral carpal tunnel syndrome; however, he opined that it was not related to Petitioner's work activities of typing. Dr. Williams referenced literature in *The Journal of Hand Surgery* which stated there was no relationship between typing and the development of carpal tunnel syndrome. He also noted Petitioner had hypertension, but opined it was more likely the carpal tunnel syndrome was of idiopathic origin (Respondent's Exhibit 4; Deposition Exhibit 2).

Dr. Reeves continued to treat Petitioner primarily for his neck condition, which was not alleged to be work-related, for several months. When Dr. Reeves saw Petitioner on December 5, 2012, she referred him to Dr. Christopher Wottowa, an orthopedic surgeon, for the bilateral carpal tunnel syndrome (Petitioner's Exhibit 7).

In regard to the bilateral carpal tunnel syndrome condition, Petitioner was initially evaluated by Dr. Wottowa on February 18, 2013. Dr. Wottowa had previously treated Petitioner in 2006 and 2007 for bilateral cubital tunnel syndrome and performed ulnar transposition surgeries. Dr. Wottowa released Petitioner from treatment and authorized him to return to work in March, 2007, following those surgeries (Petitioner's Exhibit 4; Deposition Exhibit B).

When Dr. Wottowa saw Petitioner on February 18, 2013, Petitioner advised he had numbness/tingling in both hands which he associated with typing at work. Dr. Wottowa reviewed the prior EMG/nerve conduction studies and opined Petitioner had bilateral carpal tunnel syndrome. Prior to making a decision about whether to proceed with carpal tunnel release surgeries, Dr. Wottowa ordered further EMG/nerve conduction studies. Petitioner had EMG/nerve conduction studies performed on June 13, 2013, which were positive for bilateral carpal tunnel syndrome (Petitioner's Exhibit 4; Deposition Exhibit B).

Dr. Wottowa subsequently performed carpal tunnel release surgeries on Petitioner's left and right hands on December 10, 2013, and December 16, 2014, respectively (Petitioner's Exhibit 4; Deposition Exhibit B). Following both surgeries, Petitioner was able to return to work to his regular job without restrictions.

Dr. Williams was deposed on March 10, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Williams testified Petitioner had bilateral carpal tunnel syndrome, but that the duties of typing did not cause or aggravate the condition. He based this opinion on an article contained in *The Journal of Hand Surgery* that he referenced in his report and stated the condition was likely idiopathic. Dr. Williams testified Petitioner did not have any other risk factors including increased body mass, hypertension, diabetes or thyroid dysfunction (Respondent's Exhibit 3; pp 8-11). The Arbitrator notes that in Dr. Williams report he described Petitioner as having hypertension; however, when deposed he testified that this was not a risk factor.

When cross-examined, Dr. Williams agreed he did not have knowledge of the ergonomics of Petitioner's workstation and had never seen any photographs of it. He also agreed he previously opined in another case that typing for four hours could cause carpal tunnel syndrome, but that he changed his opinion about typing as being the cause of that condition (Respondent's Exhibit 3; pp 31-38).

When cross-examined, Dr. Williams was asked what percentage of his practice consisted of performing Section 12 examinations, and he testified it was less than five percent (5%). In regard to the percentage of Section 12 examinations Dr. Williams performed for Respondent, he testified it was 30% and denied that it was over 50% in prior years. Petitioner's counsel then referenced a Decision of the Commission wherein he (Dr. Williams) performed approximately one half of his IMEs for Respondent and was asked whether this was accurate. Dr. Williams responded that it was not accurate (Respondent's Exhibit 3; pp 14-20). The preceding was the primary basis of Petitioner's counsel's Motion in Limine to exclude Dr. Williams' testimony which, as previously noted herein, was denied by the Arbitrator.

Dr. Wottowa was deposed on April 25, 2016, and his deposition testimony was received into evidence at trial. In regard to his treatment of Petitioner, Dr. Wottowa's records were tendered as an evidentiary exhibit when he was deposed. In regard to the etiology of Petitioner's bilateral carpal tunnel syndrome, Dr. Wottowa testified that Petitioner's typing would not cause the carpal tunnel syndrome condition; however, he stated Petitioner's typing activities would be an "aggravating factor" of the condition (Petitioner's Exhibit 4; pp 26-28).

On cross-examination, Dr. Wottowa was questioned about other risk factors for the development of carpal tunnel syndrome. Dr. Wottowa declined to categorize the development of carpal tunnel syndrome as being "idiopathic" but described it was "multi-factorial," and that it was possible Petitioner would have developed carpal tunnel syndrome even without his job. However, Dr. Wottowa also stated Petitioner did not have any comorbidities for development of carpal tunnel syndrome, specifically, diabetes, obesity, cigarette smoking and uncontrolled hypertension. While he noted Petitioner had hypertension, he also noted it was controlled and not a risk factor (Petitioner's Exhibit 4; pp 33-35).

In regard to the postsurgical condition of Petitioner's hands, Dr. Wottowa testified Petitioner had no work restrictions, had no condition of ill-being in regard to his carpal tunnel syndrome, normal function and an excellent prognosis. When cross-examined, Dr. Wottowa agreed Petitioner had no disability as a result of the carpal tunnel syndrome (Petitioner's Exhibit 4; pp 30, 39).

When the case was tried, Petitioner's right lower arm/hand was in a cast. Petitioner testified he recently had surgery performed on his right thumb, but it was not for a work-related condition. In regard to his right wrist/hand, Petitioner stated he had virtually no symptoms at all. In regard to his left wrist/hand, Petitioner stated he still had some pain in his left wrist, but it was very infrequent.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury to his right and left hands that manifested itself on October 1, 2010, and that his current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

The date of manifestation, October 1, 2010, was when Petitioner was examined by Dr. Reeves and the findings on examination were consistent with carpal tunnel syndrome.

There was no dispute that Petitioner had bilateral carpal tunnel syndrome.

Petitioner's testimony regarding his work activities which required the daily repetitive use of both of his hands while at work was unrebutted.

Petitioner's treating physician, Dr. Wottowa, opined that while Petitioner's work activities did not cause Petitioner's bilateral carpal tunnel syndrome, the work activities were an aggravating factor.

Petitioner did not have any of the comorbidities that contribute to the development of carpal tunnel syndrome, specifically, diabetes, obesity and cigarette smoking. Petitioner did have

hypertension; however, this was controlled with medication and thereby not considered to be a risk factor.

Respondent's Section 12 examiner, Dr. Williams, opined Petitioner's bilateral carpal tunnel syndrome condition was not work-related; however, this opinion was based largely on an article he referenced contained in *The Journal of Hand Surgery*. Dr. Williams agreed he had previously opined that typing for four hours could cause carpal tunnel syndrome. Further, Dr. Williams conceded Petitioner did not have any of the other risk factors for the development of carpal tunnel syndrome including increased body mass, hypertension, diabetes or thyroid dysfunction.

Based upon the preceding, the Arbitrator finds the opinion regarding causality of Dr. Wottowa to be more persuasive than that of Dr. Williams.

In regard to Dr. Williams' alleged "perjury" about percentage of examinations he had performed at the request of Respondent, the Arbitrator is not persuaded by this. The Arbitrator notes that Section 12 examinations amount to less than five percent (5%) of Dr. Williams' overall medical practice. While Dr. Williams may have been in error regarding the percentage of Section 12 examinations he performed for Respondent, it is insignificant if was 30% or 50% of the five percent (5%) of his overall practice. In this regard, Dr. Williams' testimony regarding same should be evaluated in the context that such examinations constitute a very small percentage of his total medical practice. Accordingly, this was not a factor in the Arbitrator's finding as to which physician was a more persuasive.

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 in regard to his bilateral carpal tunnel syndrome condition was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner was temporarily totally disabled during the aforestated periods of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

In regard to both hands, Dr. Wottowa opined Petitioner had no condition of ill-being, normal function, an excellent result and no disability.

In regard to the right hand, Petitioner had virtually no symptoms at all in regard to same.

In regard to the left hand, Petitioner had complaints of pain in the left wrist, but it was very infrequent.

Based upon the preceding, the Arbitrator finds Petitioner had an excellent surgical result and has minimal functional loss of use of both hands.

William R. Gallagher, Arbitrator

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.

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

Timothy Doogan,
Petitioner,
vs.

NO: 13 WC 00836

GG Connection Inc,
Respondent,

17IWCC0576

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 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 $5,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2017
o083117
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOOGAN, TIMOTHY
Employee/Petitioner

Case# **13WC000836**

GG CONNECTION INC
Employer/Respondent

17IWCC0576

On 2/6/2017, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0125 COHN LAMBERT RYAN & SCHNEIDER
THAD S MOGENSEN
10 S LASALLE ST 18TH FL
CHICAGO, IL 60603

4944 KOREY RICHARDSON LLC
AMY HOFFMAN
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

17IWCC0576

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

Timothy Doogan
Employee/Petitioner

v.

GG Connections
Employer/Respondent

Case # **13** WC **00836**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 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 _____

FINDINGS

On **12/4/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$18,790**; the average weekly wage was **$815.53**.

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

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

ORDER

- Respondent shall pay Petitioner TTD benefits for 8 weeks, commencing 12/4/12 through 1/29/13, as provided in section 8(b) of the Act.
- Respondent shall pay the disputed medical bills contained in Petitioner's Exhibits 3, 5 & 6 as provided in Sections 8(a) and 8.2 of the Act.
- Respondent shall pay Petitioner PPD benefits consistent with the finding that Petitioner suffered a 1% loss of the foot as provided in Section 8(e) of the Act. See attached Addendum for the Arbitrator's analysis of the factors set forth in Section 8.1b of the Act.
- Respondent shall pay Petitioner $5,000 in penalties pursuant to Section 19(l) of the Act.

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

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

Jason C. Knotts

Signature of Arbitrator

1/20/17
Date

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

17IWCC0576

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

Timothy Doogan Petitioner,	)	
	)	No. **13 WC 00936**
vs.	)	
G.G. Connections Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

On the morning of December 4, 2013, Petitioner, who was employed by Respondent as a truck driver, approached his assigned truck and found a puddle of standing water next to the driver's door. (Tr. 10-11). In order to avoid the puddle, he stepped on the fuel tank of the truck parked next to his and then "kind of hopped" approximately 3-5 feet over to the truck he was supposed to drive. (Tr. 12-13; 32). During this process, Petitioner lost his footing and twisted his left ankle. (Tr. 12-13). He nevertheless proceeded to climb into his cab and begin his workday. (TX 13).

Petitioner initially thought that he would be able to work through the injury, but soon found it increasingly difficult to operate the clutch with his left foot. (TX 14-15). Within an hour of the accident, Petitioner notified Respondent's dispatcher about the accident and requested another driver to relieve him. (TX 16, 29-31). The dispatcher told Petitioner to complete the scheduled pickup and return the truck back to the lot in Hinsdale. (TX 16).

After Petitioner returned Respondent's truck to the lot in Hinsdale, he drove to the ER at West Suburban Hospital in Oak Park where he reported an accident history consistent with his trial testimony. (PX 2 at 6). X-rays were negative for fracture and Petitioner was discharged with crutches and diagnosed with a left ankle sprain and left Achilles tendon strain. (Id. at 8-9).

On December 12, 2012, Petitioner presented to Dr. Vasilike Sandas with complaints of left ankle pain and left foot numbness. (PX 4 at 4 and 8). Dr. Sandas ordered a left foot MRI which confirmed a partial tear of the left Achilles tendon and left ankle sprain. (PX 4 at 12-15). Petitioner's left foot was placed in a cam boot and physical therapy was ordered.

Petitioner was eventually released to full-duty work on January 29, 2013 and released from medical care on February 15, 2013. He has not sought additional treatment since. (PX 4 at 53, 56).

Petitioner testified that he has not experienced any problems subsequent to his release from care. (Tr. 35).

CONCLUSIONS OF LAW

In regard to disputed issue (C), did an accident arise out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds the following:

The Arbitrator concludes that Petitioner was involved in accident that arose out of and in the course of his employment with Respondent on December 4, 2012. Petitioner credibly testified that he was injured while trying to climb into his assigned dump truck that was surrounded by several inches of standing water. To avoid having to spend an entire December workday in wet socks and boots, Petitioner instead stepped onto the neighboring truck's tank step and hopped over a three-foot gap onto his own truck's tank step. Petitioner's actions in this case were reasonable and undertaken solely in furtherance of Respondent's economic interests.

In regard to disputed issue (E), was timely notice of the accident given to Respondent?

The Arbitrator finds that Respondent was provided with timely notice of the accident. Petitioner filed his Application for Adjustment of claim on January 10, 2013—37 days after the date after the accident—and well within the 45-day reporting period mentioned in Section 6(c) of the Act.

Moreover, Petitioner credibly testified that he informed Respondent's dispatcher of his injury less than an hour after the accident. Respondent provided no rebuttal witnesses or any other evidence to challenge Petitioner's testimony.

With respect to issue (F) whether Petitioner's current condition of ill-being is causally related to the accident?

The Arbitrator concludes that Petitioner's left ankle sprain and left Achilles tendon strain are both causally related to the December 4, 2012 accident. Petitioner provided credible, unrebutted testimony that he twisted his left ankle immediately after hopping onto his truck from the adjacent vehicle which is corroborated by the medical evidence contained in the record.

(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 concludes that all of Petitioner's medical treatment from West Suburban Medical Center and Advanced Physicians was reasonable, necessary, and causally related to the December 4, 2012 work-related accident. To date, Respondent has not paid for any medical treatment that Petitioner received from these providers. Subject to Section 8(a) and 8.2 of the Act, Respondent is ordered to pay for all related medical treatment rendered by West Suburban Medical Center and Advanced Physicians up to and through February 15, 2013.

(K) Whether Petitioner is entitled to disputed TTD benefits?

The Arbitrator finds that Petitioner was temporarily totally disabled from December 4, 2012 through January 29, 2013, a period of 8 weeks. The medical records from Advanced Physicians specifically restricted Petitioner from operating a manual clutch with his left foot during the 8-week period following the accident. At trial, Petitioner testified that Respondent never provided him with any offers of light duty. Respondent produced no evidence showing whether light-duty work was ever available or offered. Accordingly, the Arbitrator concludes that Petitioner is entitled to 8 weeks of TTD benefits.

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

On the date of accident, Petitioner was a 62-year-old commercial truck driver who sustained a left ankle sprain and left Achilles heel strain. After the accident, Petitioner was unable to work for 8 weeks. He attended physical therapy 3 times per week for 10 weeks and was discharged from care on February 15, 2013 without restrictions. At trial, Petitioner testified that he no longer has any ongoing left foot or ankle pain.

With respect to the factors set forth in Section 8.1b of the Act the Arbitrator makes the following findings:

1) No AMA rating was entered into evidence, so this factor was given no weight;

2) The Arbitrator assigned greater weight to the fact that Petitioner was employed as a commercial truck driver at the time of his accident as this occupation is physical in nature;

3) The Arbitrator assigned greater weight to the fact that Petitioner was 62 years old at the time of the accident and not likely to find comparable employment;

4) Nothing was entered into evidence regarding future earning capacity so this factor is given no weight; and

5) The medical records show that Petitioner suffered from an insertional injury to his Achilles tendon and an ankle strain, both of which required physical therapy and limited duty. The Arbitrator assigned greater weight to this factor.

Based on the above factors and the record considered as a whole, the Arbitrator finds that Petitioner sustained a 1% loss of use of his left foot as a result of the December 4, 2012 workplace injury.

(M) Should 19(l) penalties be imposed upon Respondent?

The Arbitrator concludes that penalties pursuant to Section 19(l) of the Act should be imposed upon Respondent in the amount of $5,000.00.

Penalties under section 19(1), which are more in the nature of a late fee, apply when an employer "neglects, or refuses to make payment or unreasonably delays payment 'without good and just cause'." *Global Products v. Workers' Comp. Comm'n, 392 Ill. App. 3d 408, 414 (2009).*

Petitioner's Exhibit 7 contains several letters dating back to February of 2013 demanding payment of medical bills related to Petitioner's December 4, 2013 injury. Petitioner's counsel specifically requested that Respondent either pay the bills immediately or provide a written explanation for non-payment, as required under the Act. In May of 2014—over a year later—Respondent's counsel responded with a one paragraph denial letter stating that benefits were denied "based on accident and causal connection". The letter failed to articulate an objectively reasonable basis for its denial of benefits.

At trial, Respondent failed to put forth any additional evidence to clarify its earlier blanket denial of benefits. Respondent failed to demonstrate any objectively reasonable basis for refusing to pay Petitioner's medical bills from West Suburban Medical Center and Advanced Physicians back in 2014. Accordingly, the Arbitrator finds that mandated penalties in the amount of $5,000.00 pursuant to Section 19(l) of the Act are appropriate.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Beck,

Petitioner,

vs.

NO: 13WC 1858

17IWCC0538

Kemper Valve & Fitting Co, ,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, 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 August 25, 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 $56,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 6 - 2017
MJB/bm
o-8/22/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BECK, KEVIN
Employee/Petitioner

Case# **13WC001858**

17IWCC0538

KEMPER VALVE & FITTING CO
Employer/Respondent

On 8/25/2016, 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
TEN N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
ED HENNESSY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kevin Beck
Employee/Petitioner

v.

Kemper Valve & Fitting Co.
Employer/Respondent

Case # 13 WC 01858

Consolidated cases: N/A

17IWCC0538

An *Application for Adjustment 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 **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?
H. ☐ What 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, **October 25, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**24,305.42**; the average weekly wage was $**467.41**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **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 $**28,399.85** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**28,399.85**.

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 **$6,753.35** to Injured Workers' Pharmacy, **$896.00** to Illinois Bone and Joint Institute, **$2,956.00** to St. Francis Hospital, and **$7,015.48** to Illinois Physician's Network, as provided in Sections 8(a) and 8.2 of the Act.

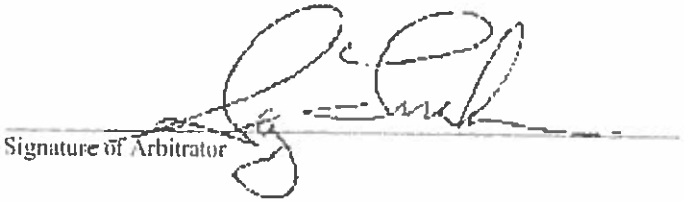
Respondents shall authorize and pay for additional reasonable and necessary treatment for Petitioner consistent with the recommendations of Dr. Rubinstein including surgery to the right shoulder, ongoing treatment recommended by Dr. Fischer for the cervical spine including a CT scan, and other reasonable and necessary care.

Respondent shall pay Petitioner temporary total disability benefits of $311.60/week for 180 1/7 weeks, commencing January 10, 2013 through June 23, 2016, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $28,399.85 for temporary total disability benefits that have been paid.

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

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

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



Signature of Arbitrator

August 24, 2016
Date

ICArbDec19(b)

AUG 25 2016

Statement of Facts 17 IWCC0538

This matter proceeded to trial on June 23, 2016 on a 19(b)/8(a) Petition. The matter had previously been heard on a 19(b) on May 9, 2014 on disputed issues of Causal Connection, Medical and TTD. In a decision entered June 30, 2014, the Arbitrator found Petitioner's right shoulder and neck conditions to be causally related to the accidental injury. She found the low back condition was not causally related. The Arbitrator awarded the cost of medical services and temporary total disability benefits through the date of hearing. The Commission adopted the decision of the Arbitrator on March 27, 2015 (15 IWCC 0232). The Arbitrator incorporates the prior decision including the Statement of Facts, Conclusions of Law and the Award as a part of this decision.

Petitioner Kevin Beck testified that he had previously testified at the earlier hearing in this matter. He identified the prior decision described above as Petitioner's Exhibit 1. Petitioner denied that at the time of that hearing his right shoulder problems had quieted. He was only under the care of Dr. Fischer for his cervical spine at that time. Petitioner testified that his prior job as a lather operator was physical in nature. It required lifting parts weighing up to 50 pounds. Prior to his accident on October 25, 2012 he did not have any problem lifting these parts. He had no prior problem with his right arm.

Following that earlier hearing, Petitioner had additional medical treatment authorized for his neck including a one level cervical discectomy and fusion surgery on August 27, 2013. The diagnosis was right upper extremity radiculopathy and a C6-7 HNP (RX 2). As of the prior trial, Petitioner had last seen Dr. Fischer on February 28, 2014. Petitioner testified he treated with Dr. Fischer for his neck only. Dr. Fischer's notes record ongoing complaints of pain in the neck and which extend into the right shoulder, and numbness in the 4th and 5th digits (RX 2). On April 28, 2014, Dr. Fischer diagnosed status post C6-7 ACDF, C4-5 herniated nucleus pulposus and right shoulder impingement. He injected the right shoulder with significant improvement within 5 minutes. Dr. Fischer noted that if Petitioner did not continue to have improvement in the next two weeks, he would order an MRI of the right shoulder and cervical spine (RX 2). Physical therapy for Petitioner's neck was performed at Total Rehab from March 26, 2014 through December 22, 2014. On May 28, 2014, Dr. Fischer first recommended referral to a shoulder specialist (RX 2). Petitioner testified he has not been released to return to work by Dr. Fischer of any of his treating doctors.

Petitioner also has been treating with Dr. Caner, his pain doctor once a month. Petitioner testified that following his fusion surgery, some of his pain and tingling in his arm went away. He still had tingling in the left arm and the right fingers. Petitioner continued to have pain in his right shoulder. Petitioner was referred to Dr. Rubinstein for his shoulder. He was first seen on October 15, 2014. Dr. Rubenstein notes the initial shoulder complaints and diagnosis of rotator cuff tendinitis but notes that it was never worked up because of the severe neck complaints. He recommended an MRI of the shoulder which was performed on November 7, 2014. He placed Petitioner on temporary total disability (PX 3). Petitioner also had a cervical spine MRI on December 9, 2014 recommended by Dr. Fischer. Dr. Rubinstein gave Petitioner an injection to the right shoulder on December 19, 2014 and recommended shoulder surgery. During this time, Petitioner continued treatment with Dr. Fischer for his neck and was continued off of work. Petitioner testified he last saw Dr. Rubinstein on April 15, 2015. He was still recommending surgery (RX 2). Petitioner has not had that surgery.

Dr. Rubinstein testified by evidence deposition taken November 18, 2015 (PX 6). He testified to his examinations, his diagnosis of chronic impingement, and his recommendation for arthroscopy and subacromial decompression as noted in his records. He opined that the initiating factor was the workplace

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injury. The need for treatment is related to the work injury. Dr. Rubinstein testified Petitioner would likely have some limitation of lifting and to avoid overhead work. Dr. Rubinstein testified he did not compare the November 7, 2014 MRI to prior studies. He does not think they would make a difference. He agreed there is no complete rotator cuff tear. His determination of the duration of the tendinitis was based upon the history provided. He testified that Petitioner did not have any resolution of his shoulder symptoms from the time of the accident to his initial visit. The symptoms were persistent.

On January 9, 2015, Dr. Fischer notes continued complaints of right sided neck and shoulder pain. He advised continued neck exercises indefinitely and commented that some of his symptoms are emanating from the shoulder and he would follow up with Petitioner after his shoulder examination (RX 2). Petitioner last saw Dr. Fischer on September 9, 2015. At that time Dr. Fischer recommended a CT scan for the neck and continued Petitioner on temporary total disability (PX 3). Petitioner has not had the CT scan. Petitioner testified he wishes to have the CT scan and the shoulder surgery. He continues to see Dr. Caner for pain medication.

Petitioner testified that Dr. Fischer gave him a 15 pound weight limit and not to move his arm over shoulder height more that he has to. He has followed those recommendations as best as he can. He can lift things above his head but it is very painful. Petitioner denied working since October 10, 2014. He has done some side work. He has done part time maintenance work painting and patching walls to pay for his apartment rent. He paints with his left arm. He did this work on and off for a six month period. This side work was performed at Pineview Apartments in Hainesville, Illinois, his residence. He did not get paid. The management just takes it off his rent. He has not done any other work or looked for work. He received Social Security disability in February, 2016.

Petitioner was examined at Respondent's request by Dr. Jay Levin on September 29, 2014. He had been examined on February 25, 2013 in conjunction with the prior hearing. Dr. Levin prepared a report of the examination (RX 1, Ex 2, 3) and supplemental reports following review of updated materials on November 11, 2014, February 13, 2015, March 4, 2015 and April 5, 2016 (RX 1, Ex. 4-7). Dr. Levin testified by evidence deposition taken April 12, 2016 (RX 1). Dr. Levin testified to his September 29, 2014 examination. He recommended updated MRIs of the right shoulder and cervical spine at that time. Dr. Levin reviewed his September 29, 2014 MRI studies. He disagreed that there was a C4-5 herniated disc. Dr. Levin opined that Petitioner was at maximum medical improvement with respect to his right shoulder and cervical spine. The shoulder MRI findings were consistent with a long standing degenerative condition. There was no evidence of a rotator cuff tear. He opined that Petitioner could return to work without restrictions. Dr. Levin testified that the review of subsequent records did not change his opinions. He further opined that the need for further medical treatment recommended by Dr. Rubinstein was non occupational factors such as obesity and diabetes. He did not have an opinion as to if Petitioner is currently a surgical candidate.

Dr. Levin testified that Petitioner showed signs of impingement on September 29, 2014. Petitioner had limited range of motion in the right shoulder. The impingement test and cross arm test were positive. Dr. Levin agreed that he previously testified that Petitioner suffered an exacerbation of his underlying subacromial impingement as a result of the injury.

Petitioner testified his social life is rather limited. He owns a motorboat and takes it on the lake. He backs it into the lake and his daughter rolls it back onto the trailer. Petitioner is able to climb in and out of the boat. He drives the boat for recreational cruising. Petitioner testified he owns a pickup truck. Petitioner is active on social media and Facebook. His wife posts pictures. On October 18, 2014 he posted an incident involving a

fight between his dog and a pit bull. Petitioner kicked the pit bull to stop the dogs fighting. Petitioner identified Respondent's Exhibit 3 as postings by his wife. On September 10, 2014, he was driving his boat and in a hot tub. Photos included in his Facebook postings show Petitioner driving his boat and in the pool. Posting also noted an emergency room visit (RX 3).

Shannon Lechner testified that she is a surveillance and claims investigator for ISG. She was assigned surveillance on Petitioner. She identified Respondent's Exhibit 4 as the report generated from her surveillance of the Petitioner. She testified that on April 21, 2015 she observed the Petitioner carrying a paint can in his right hand. She testified she also observed the Petitioner getting his mail, smoking a cigarette, walking and carrying two trash bags with his left hand. She ascertained that he was doing maintenance for the apartment complex. She testified she conducted additional surveillance on June 15 and June 16, 2015. The photographs she took are in her report. Ms. Lechner testified that the still photographs are taken from video she took. The video is not with her.

Oscar Ledesma testified he is a private investigator for ISG. He was hired to do surveillance of Petitioner on April 23, 2015. Mr. Ledesma identified three pictures in RX 4. He testified he observed Petitioner at approximately 1:55 PM open the hatch of a black Dodge hatchback with his right hand and unload groceries using both hands. He took video of that activity (RX 5). Mr. Ledesma testified he performed surveillance on Petitioner on other days. He has more video that the video contained in RX 5.

Conclusions of Law

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

This matter previously proceeded to trial pursuant to Section 19(b) of the Act on May 9, 2014. A final decision of the Commission was entered on March 27, 2015. The findings of law and fact rendered at that time became the law of the case for this matter. Under the law-of-the-case doctrine, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Miller v. Lockport Realty Group, Inc.*, 377 Ill. App. 3d 369, 374, 878 N.E.2d 171, 315 Ill. Dec. 945 (2007). The Appellate court has held that principles underlying the law-of-the-case doctrine should be applied to matters resolved in proceedings before the Commission. *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 786 N.E.2d 218, 271 Ill. Dec. 960 (2003). This doctrine has been specifically applied to determinations of causal connection. Once the first causation finding became a final judgment, it also became the law of the case and was not subject to further review. *Ming Auto Body / Ming of Decatur, Inc. v. Indus. Comm'n*, 387 Ill. App. 3d 244; 899 N.E.2d 365; 2008 Ill. App. LEXIS 1132; 326 Ill. Dec. 148 (2008).

In the prior trial, the Arbitrator's decision, affirmed by the Commission, states the Arbitrator finds the right shoulder and neck conditions as described above to be causally related to the accidental injury. The neck condition is described as a C6-7 right sided herniated disc, right arm radiculopathy in the C7 distribution and a C4-5 central herniated disc. The shoulder condition is described as a rotator cuff strain. This Arbitrator also notes that the original Request for Hearing form prepared on May 9, 2014 states that "Respondent agrees to causation for the right shoulder." Thus the original shoulder and neck injury cannot be disputed. The only question for the Arbitrator is whether the current conditions of ill being in the right shoulder including the recommendation for surgery and the condition of ill being in the neck are no longer causally connected.

Respondent presented evidence of Petitioner's subsequent activities including the part time maintenance and painting and his recreational activities including boating. There is no evidence that any of these activities rise to the level on an intervening accident. No medical opinion of intervening accident has been presented.

Petitioner's unrebutted and credible testimony is that he had no prior right shoulder complaints or treatment before the accidental injuries on October 25, 2012. He testified that he has had continued and consistent complaints in the right shoulder thereafter. The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. 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. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000).

Dr. Fischer's July 22, 2013 notes include a diagnosis of right shoulder internal derangement. The medical records document the interrelationship and overlap of the cervical complaints and treatment with the treatment for the right shoulder. While Petitioner's treatment focused primarily on the cervical spine following his surgery, the Arbitrator notes no gap in care and no resolution of the complaints to the right side. The physicians efforts to differentiate the cause of the right upper extremity symptoms between the neck and shoulder conditions convinces the Arbitrator that any gap in active shoulder treatment in no way impacts the validity and ongoing nature of the condition of ill being.

Dr. Rubinstein testified to his diagnosis of chronic impingement. He opined that the initiating factor was the workplace injury. The need for treatment is related to the work injury. Dr. Levin testified that Petitioner showed signs of impingement on September 29, 2014. Dr. Levin noted Petitioner had limited range of motion in the right shoulder. The impingement test and cross arm test were positive. Although Dr. Levin opined that Petitioner's current condition was related to non occupational factors and not causally related to the accident, he agreed that he previously testified that Petitioner suffered an exacerbation of his underlying subacromial impingement as a result of the injury.

Dr. Fischer has not released Petitioner from care on his neck. On January 9, 2015, Dr. Fischer advised continued neck exercises indefinitely and commented that he would follow up with Petitioner after his shoulder examination. When Petitioner last saw Dr. Fischer on September 9, 2015, Dr. Fischer recommended a CT scan for the neck and continued Petitioner completely off work. After reviewing the testimony and the record as a whole, the Arbitrator finds that the opinions of Dr. Fischer and Dr. Rubinstein are more persuasive that the opinions of Dr. Levin.

Based upon the record as a whole, the Arbitrator finds Petitioner's current conditions of ill being in the right shoulder and cervical spine are causally connected to the accidental injuries sustained on October 25, 2012.

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

Based upon the Arbitrator's finding with respect to Causal Connection, all reasonable and necessary medical treatment rendered to Petitioner for the conditions of ill being in the right shoulder and cervical spine are causally connected to the accidental injuries sustained on October 25, 2012 and Respondent would be responsible for payment of any such charges. Petitioner admitted unpaid medical bills from Injured Workers'

Pharmacy, Illinois Bone and Joint Institute, St. Francis Hospital and Illinois Physician's Network as Petitioner's Exhibit 1. With respect to these bills, the Arbitrator has reviewed the exhibit and the underlying medical records and finds as follows:

Injured Workers' Pharmacy: The bill of $8,893.58 reflects medication prescribed primarily by Dr. Caner. Petitioner testified that Dr. Caner coordinated his medications for the related conditions to the cervical spine and right shoulder. The Arbitrator finds the bill is reasonable, necessary and causally connected. The bill includes charges incurred prior the earlier May 9, 2014 hearing and decision. Said charges are not properly awarded in this hearing. The charges incurred after May 9, 2014 total $6,753.35.
Illinois Bone and Joint Institute: The bill of $896.00 documents charges for reasonable, necessary and causally connected treatment by Dr. Fischer and Dr. Rubenstein as documented in the medical records admitted as PX 3 and RX 2.
St. Francis Hospital: The bill of $2,956.00 is for the MRI performed on November 7, 2014 as ordered by Dr. Rubenstein. The bill is for reasonable, necessary and causally connected treatment.
Illinois Physician's Network: The bill of $7,939.94 documents charges for physical therapy performed at Total Rehab (PX 4). The Arbitrator finds the bill is reasonable, necessary and causally connected. The bill includes charges incurred prior the earlier May 9, 2014 hearing and decision. Said charges are not properly awarded in this hearing. The charges incurred after May 9, 2014 less interest charges total $7,015.48.

Based upon the record as a whole and consistent with the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,753.35 to Injured Workers' Pharmacy, $896.00 to Illinois Bone and Joint Institute, $2,956.00 to St. Francis Hospital, and $7,015.48 to Illinois Physician's Network, as provided in Sections 8(a) and 8.2 of the Act.

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

Based upon the Arbitrator's finding with respect to Causal Connection, all reasonable and necessary medical services to treat Petitioner for the conditions of ill being in the right shoulder and cervical spine would be causally connected to the accidental injuries sustained on October 25, 2012.

Dr. Fischer has not released Petitioner from care on his neck. On January 9, 2015, Dr. Fischer advised continued neck exercises indefinitely and commented that he would follow up with Petitioner after his shoulder examination. When Petitioner last saw Dr. Fischer on September 9, 2015, Dr. Fischer recommended a CT scan for the neck. Dr. Rubinstein diagnosed chronic impingement of the right shoulder and recommended arthroscopy and subacromial decompression. Dr. Levin opined that Petitioner was at maximum medical improvement with respect to his right shoulder and cervical spine. He further opines that the shoulder MRI findings were consistent with a long standing degenerative condition. He opined that Petitioner could return to work without restrictions. As discussed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Fischer and Dr. Rubinstein more persuasive that the opinions of Dr. Levin.

Based upon the record as a whole, the Arbitrator finds that Respondents shall authorize and pay for additional reasonable and necessary treatment for Petitioner consistent with the recommendations of Dr. Rubinstein including surgery to the right shoulder, ongoing treatment recommended by Dr. Fischer for the cervical spine including a CT scan and other reasonable and necessary care.

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

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner's conditions of ill being in the right shoulder and cervical spine would be causally connected to the accidental injuries sustained on October 25, 2012. As discussed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Fischer and Dr. Rubinstein more persuasive that the opinions of Dr. Levin.

Dr. Fischer has not released Petitioner from care on his neck. On January 9, 2015, Dr. Fischer advised continued neck exercises indefinitely and commented that he would follow up with Petitioner after his shoulder examination. When Petitioner last saw Dr. Fischer on September 9, 2015, Dr. Fischer recommended a CT scan for the neck and continued Petitioner completely off work. Dr. Rubenstein placed Petitioner on temporary total disability, although he testified that this was in conjunction with the opinion of Dr. Fischer based upon the cervical complaints. Dr. Rubinstein testified Petitioner would likely have some limitation of lifting and to avoid overhead work. Petitioner testified that Dr. Fischer gave him a 15 pound weight limit and not to move his arm over shoulder height more that he has to.

Respondent presented surveillance evidence that Petitioner was performing maintenance work for the apartment complex. Petitioner was also documented performing tasks such as unloading groceries from the back of his vehicle. Petitioner denied working since October 10, 2014. He has done part time maintenance work painting and patching walls to pay for his apartment rent. He did this work on and off for a six month period at his residence. He did not get paid. The management just took it off his rent. The Arbitrator finds Petitioner's testimony credible. The evidence presented does not demonstrate that Petitioner is physically capable of performing his usual and customary employment as a lather operator lifting parts weighing up to 50 pounds. None of the activities detailed by the investigators or in the Facebook posts included heavy lifting or overhead work.

Based upon the medical evidence presented and the Arbitrator's finding with respect to Prospective Medical, Petitioner is not at MMI. Pursuant to *Interstate Scaffolding v. Ill. Workers' Comp. Comm'n,* 236 Ill. 2d 132; 923 N.E.2d 266; 2010 Ill. LEXIS 12; 337 Ill. Dec. 707 (2010), the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. Respondent presented evidence that Petitioner performed some occasional maintenance work including painting at the apartment complex in which he is residing. It is clear that this was occasional employment at best. Such employment does not preclude entitlement to temporary total disability. *J.M. Jones Co. v. Industrial Comm'n,* 71 Ill. 2d 368, 375 N.E.2d 1306, 17 Ill. Dec. 22 (1978) (working approximately 1 1/2 hours per day as a hot dog vendor did not preclude a TTD award); *Zenith Co. v. Industrial Comm'n,* 91 Ill. 2d 278, 437 N.E.2d 628, 62 Ill. Dec. 940 (1982) (driving a bus for a few hours per day did not preclude a TTD award); *Mechanical Devices v. Industrial Comm'n,* 344 Ill. App.3d 752, 761-62, 800 N.E.2d 819, 828, 279 Ill. Dec. 531 (2003) (driving a shuttle bus 10 to 15 hours per week did not preclude a TTD award).

In distilling these cases the Appellate Court in *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n,* 2014 IL App (3d) 130028WC; 14 N.E.3d 16; 2014 Ill. App. LEXIS 454; 383 Ill. Dec. 184 (3rd District, 2014) stated:

> The essence of the TTD determination is as set forth by our supreme court in *Interstate Scaffolding*—whether the claimant's condition has stabilized. The existence or nonexistence of a "stable labor market" for a particular job simply is not germane to the determination of whether an individual's

condition has stabilized. However, the fact a claimant has returned to work in some capacity may be relevant to whether and to what extent the claimant's condition has stabilized. To this extent, it may well be appropriate to consider the type of work being performed, hours worked, and any income earned, all in order to ascertain whether the claimant's condition has stabilized. See *Freeman United Coal Mining Co. v. Industrial Comm'n,* 318 Ill. App. 3d 170, 178, 741 N.E.2d 1144, 1150, 251 Ill. Dec. 966 (2000) ("Among the factors to be considered in determining whether a claimant has reached maximum medical improvement include a release to return to work, with restrictions or otherwise, and medical testimony or evidence concerning claimant's injury, the extent thereof, the prognosis, and whether the injury has stabilized."). The courts in *J.M. Jones, Zenith, Mechanical Devices*, and *Dolce* considered the claimants' earnings and "work" as one factor—not necessarily the dispositive factor—in determining whether they were entitled to TTD benefits.

The Arbitrator finds that the evidence submitted establishes that Petitioner's condition has not yet stabilized. He is seeking further treatment including right shoulder surgery and a cervical CT scan and has not been released from care for either condition of ill being. The work activities which he performed were done over a short period of time for his landlord to avoid being evicted and did not require the physical demand of his previous employment. He was not paid for these services, but received a rent reduction. This maintenance work performed does not establish a stable physical condition or an ability to secure regular stable employment within the restrictions. This factor, taken in conjunction with the medical evidence, does not establish a stable condition and does not preclude Petitioner's entitlement to temporary total compensation.

Based upon the record as a whole, the previous 19(b) award of temporary total disability benefits from January 10, 2013 through May 9, 2014, and the Arbitrator's findings with respect to Causal Connection and Prospective Medical, the Arbitrator finds that Petitioner is entitled to temporary total disability for a period of 180 1/7 weeks commencing January 10, 2013 through June 23, 2016. Respondent shall receive credit for the stipulated amount paid of $28,399.85.

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

Nehemiah Nickels,
Petitioner,
vs.

NO: 13WC 5764
17IWCC0536

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 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 $13,250.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 5 - 2017

Joshua D. Luskin

o83017
JDL/wj
068

Charles J. DeVriendt

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NICKELS, NEHEMIAH
Employee/Petitioner

Case# **13WC005764**

CATERPILLAR INC
Employer/Respondent

17IWCC0536

On 3/8/2017, 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 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5411 CATERPILLAR INC
AMAMDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

NEHEMIAH NICKELS,
Employee/Petitioner

v.

CATERPILLAR,
Employer/Respondent

Case # 13 WC 5764

Consolidated cases: _____

17IWCC0536

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **2/9/17**. By stipulation, the parties agree:

On the date of accident, **6/20/12**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$35,165.52**, and the average weekly wage was **$676.26**.

At the time of injury, Petitioner was **38** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$2,254.20** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$2,254.20**.

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 $405.76/week for a further period of 37.95 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **petitioner a 15% loss of use of his right arm.**

Respondent shall pay Petitioner compensation that has accrued from **6/20/12** through **2/9/17**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

2/27/17
Date

ICArbDecN&E p.2

MAR 8 - 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner, a 38 year old forklift driver, sustained an accidental injury to his right arm that arose out of and in the course of his employment by respondent on 6/20/12.

Petitioner had prior treatment for his right elbow pain with Dr. Mahoney beginning on 9/23/11 following a relatively acute onset of pain in the posterior aspect of the right elbow. He first reported a work injury on 6/20/11. Before presenting to Dr. Mahoney he treated with the staff at Caterpillar medical. He stated that since then he had persistent pain in the posterior aspect of his right elbow. Dr. Mahoney's impression was right elbow triceps tendinitis vs. partial tear of triceps tendon. An MRI of the right elbow was ordered.

An MRI of the right elbow was performed on 9/30/11. Petitioner followed up with Dr. Mahoney on 10/7/11. Dr. Mahoney was of the opinion that the MRI demonstrated some peritendinitis and inflammation at the triceps insertion, with no signs of triceps tendon tear. Petitioner reported that he felt a little bit better with elbow motion. He reported pain when he bumps his right elbow. Dr. Mahoney's impression was right elbow triceps tendonitis. Dr. Mahoney order a course of physical therapy focusing on range of motion, strengthening and modalities.

On 6/20/12 petitioner was on a platform breaking loose a fitting on the back of a tractor with a torque wrench. While doing this he felt a pop in his right elbow and experienced immediate sharp pain in his elbow. Petitioner reported the injury and was sent to respondent's medical department for treatment. Petitioner followed-up with respondent's medical from time to time, but also began treating with Dr. Mahoney.

On 7/3/12 petitioner first returned to Dr. Mahoney. He noted weakness with elbow extension and swelling on the posterior aspect of the elbow. Dr. Mahoney examined petitioner and his impression was probably a complete tear of the triceps tendon. Dr. Mahoney recommended a repeat MRI of the elbow.

On 7/9/12 petitioner underwent a repeat MRI of the right elbow. On 7/10/12 Dr. Mahoney reviewed the results of the MRI and was of the opinion that the MRI demonstrated a complete tear of his right distal triceps tendon. Petitioner reported persistent pain and swelling in the arm. He also reported that his arm felt weak. Dr. Mahoney performed an aspiration of the bursal sac to decompress the significant fluid accumulation in his posterior elbow.

On 7/18/12 petitioner underwent a primary repair right triceps tendon avulsion. His postoperative diagnosis was right triceps tendon avulsion. Petitioner followed-up post-operatively with Dr. Mahoney and underwent a course of physical therapy.

On 10/31/12 Dr. Mahoney released petitioner to full duty work. Petitioner reported that he was doing well overall. He reported less pain. Dr. Mahoney noted numbness in the right ulnar nerve distribution following surgery. Petitioner reported no weakness in his hand. He was continued in physical therapy.

On 12/28/12 petitioner's condition was essentially unchanged. He reported that he had been working his regular job, but was still being bothered by right ulnar nerve paresthesias and wanted to do something to make it better if possible. Petitioner reported that he felt like his arm was getting stronger. Dr. Mahoney assessed cubital tunel syndrome of the right arm. Dr. Mahoney ordered an EMG/NCV to study the right ulnar nerve.

On 2/12/13 petitioner underwent an EMG/NCV of the right arm. The results were normal. There was no evidence of peripheral neuropathy; peripheral nerve entrapment, or evidence of radiculopathy.

Petitioner last followed up with Dr. Mahoney on 3/5/13. Petitioner reported that he doing better overall and had less pain. He reported intermittent numbness in the ulnar nerve distribution, despite a normal EMG/NCV. Petitioner was working his regular duty job and was no longer under supervised therapy. He even stated that he could do a push-up. Dr. Mahoney assessed a lesion of the ulnar nerve. He noted that petitioner has had consistent complaints of ulnar nerve irritation. He noted that there was no further treatment he could offer petitioner. He noted that if symptoms persist it would be reasonable to consider a repeat testing at 6 months. Otherwise, Dr. Mahoney was of the opinion that petitioner was at maximum medical improvement and released him from his care. He told petitioner to return on an as needed basis.

Petitioner returned to Dr. Mahoney on 8/5/13 with complaints of pain over the posteriomedical aspect of the right elbow. He reported that it makes it difficult to sleep at night. He stated that his right ring and small fingers were still tingly and numb. He denied any weakness. He stated that his elbow extension was still weak and he had difficulty shooting a basketball. Dr. Mahoney ultimately ordered a repeat MRI of the right elbow. Petitioner was also provided with some splinting. This was performed on 9/16/13.

On 10/25/13 petitioner returned to Dr. Mahoney. He reported no improvement after splinting. He still complained of significant pain. Dr. Mahoney noted that the MRI showed restoration of the triceps back to its insertion. He also noted tendonosis at the repair site. Dr. Mahoney was of the opinion that it is difficult to say where petitioner's pain was coming from, or if any surgery would be helpful. Dr. Mahoney told petitioner to return in a couple of months. Petitioner never followed up with Dr. Mahoney for this condition.

Currently, petitioner has continuous pain in his right elbow.

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 forklift driver at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. Because the petitioner was released to his full duty job without restrictions, 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. Because petitioner was ultimately released to full duty work for respondent and continued in his full duty capacity with respondent, 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 the petitioner offered no evidence with regard to any impact this injury had on his future earnings capacity. Because of this and the fact that petitioner was released to full duty work without restrictions, 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 a complete tear of his right distal triceps tendon as a result of his injury. For this, petitioner underwent a primary repair of a right triceps tendon avulsion. Post-operatively petitioner followed-up with Dr. Mahoney and underwent a course of physical therapy. Petitioner had complaints with respect to the right ulnar nerve, but an EMG was normal. On 3/5/13 petitioner reported that he was doing better and hand less pain. He continued to report intermittent numbness in the ulnar nerve distribution, despite a normal EMG/NCV. Dr. Mahoney placed petitioner at MMI on 3/5/13. Petitioner returned to his regular duty job. On 8/5/13 he returned to Dr. Mahoney with complaints of pain over the posteriomedial aspect of the right elbow. He denied any weakness, but stated that his right elbow extension was still weak. A repeat MRI of the right elbow could not find anything wrong consistent with his complaints. On 10/25/13 petitioner's complaints were the same. Dr. Mahoney told petitioner to follow-up in 2 months, but he never returned. The arbitrator notes that before his injury on 6/20/12 petitioner had right elbow complaints. An MRI on 9/30/11 showed some peritendinitis and inflammation at the triceps insertion, with no signs of a triceps tendon tear. Because of petitioner's surgery following the injury on 6/20/12, as well as his ongoing symptomatology following the surgery, at the time of maximum medical improvement on 3/5/13, and on 10/25/13, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of right arm pursuant to §8(e) of the Act.

13WC06279
Page1

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

Edwin Morris,

Petitioner,

vs. NO: 13 WC 06279

CTA,

Respondent, 17IWCC0575

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 9, 2017, 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.

17IWCC0575

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: SEP 25 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

MORRIS, EDWIN
Employee/Petitioner

Case# **13WC006279**

CTA
Employer/Respondent

17IWCC0575

On 1/9/2017, 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:

4376 LAW OFFICES LAWRENCE M MACK
LARRY MACK
20 S CLARK ST SUITE 1520
CHICAGO, IL 60603

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Edwin Morris
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **13** WC **6279**

Consolidated cases: _____

17IWCC0575

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **8/9/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/13/13**, Respondent **was** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being **is causally related regarding the sequelae of being sprayed with mace, his shoulder, his thorax contusion, and his forehead scratches <u>but not the cervical disk-osteophyte complexes at C3-C5 or the cervical spine stenosis that were confirmed on the April 2012 MRI</u> is not causally related to the accident.**

In the year preceding the injury, Petitioner earned **$53,354.68** ; the average weekly wage was **$1,067.09.**

On the date of accident, Petitioner was **39** years of age, **married** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services **have not been ruled on due to stipulation of the parties that it will be addressed at a later hearing.**

Respondent has paid all appropriate charges for all reasonable and necessary medical services **has not been ruled on due to stipulation of the parties that it will be addressed at a later hearing.**

Respondent shall be given a credit of **$73,483.55** for TTD, **$ 0** for TPD, **$ 0** for maintenance, and **$ 0** for other benefits, for a total credit of **$73,483.55.**

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

ORDER/CONCLUSIONS

The Arbitrator finds that the Petitioner's condition of ill-being, was, in part, causally related to the accident. See memorandum of decision, attached hereto and made part hereof as though fully set forth herein.

The Arbitrator finds that the Respondent is liable for TTD benefits from 2/14/13 to 5/7/13 for a total of 16 weeks to the Petitioner based upon the causal connection finding. See memorandum.

The Arbitrator finds that the Respondent is entitled to credit for the overpayment of TTD benefits after 5/7/13 for a total of 87 2/7 weeks to be set off against any future PPD benefits pursuant to *Messamore –vs- Industrial Commission*. See memorandum.

The Arbitrator finds that the Respondent is not liable for future medical based upon the causal connection holding. See memorandum.

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

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

1/6/17

SIGNATURE OF ARBITRATOR DATE

JAN 9 - 2017

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

17IWCC0575

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edwin Morris,	)	
	)	
Petitioner,	)	
	)	13 WC 6279
	)	
CTA,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION

I. INTRODUCTION

This MEMORANDUM OF DECISION, is attached to the ARBITRATION DECISION and is made a part thereof as though fully set forth therein. The issues in dispute in the above captioned matter were as follows:

F. Is the petitioner's current condition of ill-being causally related to the injury?
K. Is the Petitioner entitled to any future medical care?
L. What Temporary Total Disability benefits are in dispute?
N. What Credit is the Respondent entitled to?

II. STATEMENT OF FACTS

It is undisputed that on March 13, 2013 the petitioner was employed by the respondent as a bus driver. On this date, the petitioner attempted to take a U pass belong to a young female away from an adult male passenger who tried to use it to pay his bus fare resulting in the passenger spraying the driver with mace. The driver then gets into a physical altercation with the passenger; and the issue becomes what injuries the Petitioner sustained in the altercation. It is noteworthy that not only do we have the Petitioner's testimony; but we also have in evidence the video (Rx 11) of the spraying of the mace and subsequent altercation both at the start on the bus and at the continuation through conclusion once the combatants were off the bus.

The Arbitrator does not adopt Respondent's theory that there were two separate incidents the first one being the spraying of the mace in the Petitioner's face and the second the physical altercation, and that the Petitioner was the aggressor in the second incident. Rather, the Arbitrator having viewed the video finds the mere seconds that elapsed between the spraying of the mace and the start of the physical altercation to be insufficient for them to be considered separately and rather are part of the same accident. The Arbitrator also views the fact that the Petitioner was acting against CTA policy in trying to confiscate the wrongly used pass as irrelevant. That being said the Petitioner's claim that he did not know who he grabbed onto after being sprayed with the mace; and it happened to be passenger who had sprayed him to be too farfetched when there were numerous people on the bus trying to get off. While not dispositive on this issue, it does weigh on his credibility on other issues.

The crux of the matter is whether Petitioner was hit on his head with a pipe because of Dr. Dr. Kranzler's testimony (Px 6 on pages 53-54) in his evidence deposition.

Petitioner testified that during the altercation he was hit on the head with a pipe.

The contemporaneous records from the CTA including one form signed by the Petitioner do not mention him getting hit in the head with a pipe (Rx 1 and 2).

The ER records from South Shore Hospital on the day of the accident do not mention him getting hit in the head with a pipe (Rx 3).

The Concentra records from one the day after the accident does not mention him getting hit in the head with a pipe (Rx 4).

The records from his primary care physician, Dr. Frederick, do not mention him getting hit in the head with a pipe (Rx 3).

The records from Dr. Weber (Px 2) when she saw the Petitioner herself do not mention him getting hit in the head with a pipe; although one of the physicians, she referred him to, Dr. Deutsch, did record such history on October 13, 2014 some 18 months after the date of accident.

The Arbitrator did not observe the Petitioner getting hit on the head with a pipe on the video of the altercation (Rx 11).

The Petitioner according to the records attached to Dr. Kranzler's deposition (Px 6) Petitioner had a cervical MRI on 3/7/09 that showed degenerative changes at C3-C4 and C4-C5 with moderate stenosis. The report noted it was compared to a prior 12/19/07 cervical MRI. A third Cervical MRI was performed 5/4/09 and described a C3-C4 stable disc herniation at C3-C4 causing moderate-severe spinal canal stenosis.

A fourth pre-accident cervical MRI taken on 4/24/12; 10 months before the accident showed:

> **At C3-4, there is a posterior disc osteophyte complex with a superimposed central extrusion demonstrating 5 mm of inferior migration and 6 mm of superior migration... There is moderate spinal canal stenosis with severe bilateral foraminal stenosis.**
>
> **At C4-5, there is a posterior disc osteophyte complex with a superimposed right paracentral protrusion.**

The conclusion of the report states

> **Severe foraminal stenosis is seen bilaterally at C3-4 and on the right at C4-5. There is moderate to severe foraminal stenosis on the left at C4-5.**

The Petitioner was asked by several of his treating physicians about prior similar problems, some he revealed the 2009 testing to others he did not. The Arbitrator did not see where any of the treating physicians were apprised of the 2012 MRI.

Petitioner's operating surgeon, Dr. Kranzler testified by deposition (Px6)

Dr. Kranzler testified that that the history the Petitioner gave him was of being attacked on a bus in 2008; and then attacked on a bus again on 2/13/13 when:

Someone came on (to the bus) and said they maced him in the face and hit him on the head with a pipe. He had a loss of consciousness and was seen at a hospital. (Px 6 pp 12-13)

Dr. Kranzler performed surgery on May 9, 2016, performing a two level anterior cervical decompression at C3-C5 due to progression of Petitioner's herniations and increasing pain (Px 6 pp 32-33).

Dr. Kranzler also testified that from the he began treating the Petitioner in 2015 through the date of the surgery Petitioner was unable to go back to work (Px 6 pp 33-36).

When asked about causal connection Dr. Kranzler testified that he found causal connection between the 2/13/13 incident and the 2016 surgery because:

> **The symptoms – severe symptoms necessitating the surgery appears to have begun at the time of that altercation assuming it did occur. But the timing was the onset of when his severe symptoms began.**

On cross examination concerning causation Dr. Kranzler when asked if he would change is mind concerning causation if no one hit Petitioner in the head with a pipe that:

> **I would say it would change my opinion drastically. I would then say his pain in his arm is not due to being hit on the head with a pipe.** (Rx 6 p. 54).

Dr. Zelby, Respondent's Section 12 examiner, also was deposed (Rx 10).

Dr. Zelby testified that the Petitioner in the history given to him at the time of the exam denied having similar problems prior to the incident. (Rx 10 p. 19)

Dr. Zelby testified that during the exam that Petitioner's sensory exam was "neroanatomically impossible (Rx 10. p. 22). Dr. Zelby also testified that the Petitioner's claim of pain of 10/10 was inconsistent with his behaviors.

Dr. Zelby testified that the July 15, 2013 MRI report showed that there was no change from the MRI scan of 15 months earlier. (Rx 10 p. 23)

Dr. Zelby testified that the initial chart notes from Concentra had diagnoses of back strain, thoracic contusion, rotator cuff strain, scalp/face contusion and forehead contusion. (Rx 10 p. 31).

Dr. Zelby testified that the MRI findings in 2012 were essentially the same as those in 2013, and that the accident of 2/13/13 did not either aggravate or accelerate any of the preexisting cervical findings. (Rx 10 p.40).

Dr. Zelby testified that although the Petitioner had short term neck complaints after the incident they went away and did not resurface for a 3 month period and were consistent with a strain.(Rx 10 p. 41).

Dr. Zelby testified that Petitioner needed the exact same surgery in 2012 that he needed after the 2013 accident based on the MRI findings, and that he would have performed it in 2012 if not in 2008 if he were the treating doctor. (Rx 10 pp 42-42, 55).

Dr. Zelby testified that he would have as far as the neck was concerned released the Petitioner back to work as a bus driver within 8-12 weeks and that as of the time of his exam the Petition could go back to driving a bus.(Rx 10 pp. 60,80).

On cross-examination Dr. Zelby reiterated that in his opinion the need for surgery was completely due to the Petitioner's degenerative cervical complaints and not at all due to the assault; and that the altercation did not really change anything structurally (Rx 10 pp. 67, 72)

III. ANALYSIS – CONCLUSIONS OF LAW

F. CAUSAL CONNECTION

Is the Petitioner's Current Condition of Ill Being Casually Related to the Work Injury?

1. Law

The petitioner bears the burden of establishing by a preponderance of credible evidence that the medical condition at issue is causally related to the accident and not the result of the normal degenerative aging process or other causes. *Peoria County Bellwood Nursing Home v. Industrial Commission,* 115 Ill.2d 524 (1987). The requirement that the petitioner prove by a "preponderance of evidence" that her medical condition is causally related to the work accident, means the petitioner must present evidence which is more credible and convincing to the mind and when viewed as a whole establishes those facts at issue to be more probable than not. *In Re: K.O.*, 336 Ill.App.3d 98 (2002).

2. Analysis

For the reasons outlined above primarily in the medical records from 2013 as well as the videotape of the macing and the subsequent altercation , the Arbitrator finds that the petitioner has, in part, met his burden and established that there exist a causal relationship between the condition in the abrasion and lacerations, the thorax contusion, and the shoulder strains.

The overwhelming evidence is that despite the Petitioner's testimony to the contrary, that Petitioner was not hit in the head with a pipe during the altercation. No such injury was reported in any of the medical records in 2013. The video itself which was viewed by the Arbitrator shows no such action occurring.

Based on Dr. Kranzler's admission that if there were no striking with a pipe to Petitioner's head that his opinion would "change drastically " there is no valid causal connection opinion for the cervical fusion surgery.

K. FUTURE MEDICAL

What future medical is the Petitioner entitled to?

As set forth above Dr. Kranzler's causal connection opinion is invalid because it was predicated on a false history, hence his opinion on Future Medical is also invalid. Therefore, the petitioner is not entitled to any additional medical care at Respondent's expense as Dr. Zelby testified none as being necessary.

L. TEMPORARY TOTAL DISABILITY

What Temporary Benefits are in Dispute?

1. Law

Section 8(b) of the Act provides, in relevant part, as follows:

If the period of temporary total incapacity for work lasts more than 3 working days, weekly compensation as hereinafter provided shall be paid beginning on the 4th day of such temporary total incapacity and continuing as long as the total temporary incapacity lasts. 820 ILCS 305/8(b) of the Act.

2. Analysis

As the discussion set forth above amply demonstrates Dr. Kranzler's causal connection opinion is invalid because it was predicated on a false history given to him by the Petitioner, hence his opinion on the Petitioner's inability to work and receive TTD is also invalid. Therefore, the Petitioner would not have been entitled to temporary total disability benefits after the 8-12 weeks that Dr. Zelby testified to as being necessary; but since the Respondent stipulated to 16 weeks and it is bound by its stipulation, the Arbitrator awards 16 weeks.

N. CREDIT

What credit is the Respondent entitled to for overpayment of TTD?

Law

Messamore vs Industrial Commission provides that when there is an overpayment of TTD benefits that the Respondent is entitled to a credit against PPD for the amount of that overpayment.

Analysis

As noted above under TTD when there is no valid casual connection opinion there can be no payment of TTD based on the invalid opinion. In the instant matter the Arbitrator finds the Petitioner was entitled to TTD for 16 weeks to May 7, 2013 because that is what the Respondent stipulated to and it is bound by its stipulations.

As a result Respondent is given a credit against permanency for all TTD paid after the expiration of the 16 weeks from February 14, 2013 through May 7, 2013.

Therefore the Respondent is awarded a credit of $62,101.26 to be offset against any future PPD award.

IV. CONCLUSION

After examining all of the evidence presented at trial, the Arbitrator makes the following findings:

The Petitioner did sustain injuries in the altercation following the spraying of mace into his face by the passenger; but it did not aggravate or accelerate his pre-existent cervical disc disease based on the testimony of Dr. Zelby; and Dr. Kranzler's testimony that if the Petitioner was not struck in the head with a pipe that it would have drastically changed his opinion.

That without a valid causal connection opinion in his favor Petitioner cannot be awarded additional TTD beyond the date stipulated to by the Respondent and cannot be awarded future medical.

That as the Respondent continued to pay additional TTD beyond the date that they stipulated to and beyond the date that the Petitioner could have returned to work per Dr. Zelby's testimony the Respondent is given a credit under *Messamore* of $62,101.26 as an offset against any future 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.

ARBITRATOR GARY GALE **DATE** _____

ArbDec19(b)

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

Sara Wingerter,

Petitioner,

vs.

NO: 13 WC 24756

17IWCC0588

Southern Illinois Healthcare,

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 the nature and extent of Petitioner's disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 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.

17IWCC0588

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,700.00. 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: SEP 2 6 2017
TJT:yl
o 9/18/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINGERTER, SARA
Employee/Petitioner

Case# **13WC024756**

SOUTHERN ILLINOIS HEALTHCARE
Employer/Respondent

17IWCC0588

On 4/11/2017, 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 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0693 FEIRICH MAGER GREEN & RYAN
D BRIAN SMITH
2001 W MAIN ST
CARBONDALE, IL 62903

17IWCC0588

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

SARA WINGERTER
Employee/Petitioner

v.

SOUTHER ILLINOIS HEALTHCARE
Employer/Respondent

Case # **13** WC **24756**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **January 11, 2017**. By stipulation, the parties agree:

On the date of accident, **November 17, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**36,496.20**, and the average weekly wage was $**701.85**.

At the time of injury, Petitioner was **32** 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 **$421.11**/week for a further period of **75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **15% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **April 20, 2015,** through **January 11, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

April 4, 2017
Date

APR 11 2017

17IWCC0588

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

SARA WINGERTER
Employee/Petitioner

v.

Case #: **13 WC 24756**

SOUTHERN ILLINOIS HEALTHCARE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Procedural History

This case was previously tried before a different Arbitrator on January 14, 2015, pursuant to Section 19(b) of the Act on the issues of causation, liability for past and prospective medical benefits, and liability for temporary total disability benefits. Findings were in favor of Petitioner and the Commission affirmed and adopted the Arbitration Decision. PX5. The Arbitrator hereby acknowledges and incorporates herein the prior Arbitration Decision and the Commission Decision and Opinion on Review.

Issue in Dispute

The parties stipulated that the only issue currently in dispute is the nature and extent of Petitoner's permanent partial disability.

On November 17, 2012, the date of accident, Petitioner was 32 years old, married, and had no dependent children. She was a Registered Nurse for Respondent. By way of background only, Petitioner injured her low back while moving a patient in bed when the lock on the bed gave way. The bed went up and swung toward her side and she took the weight and twisted at the same time. Following conservative treatment she underwent a laminotomy with 10mm implant at L4-5 on April 29, 2014, by Dr. Matthew Gornet. She was off work for 9 6/7 weeks and returned to work on light duty.

Subsequent to the prior hearing of January 14, 2015, Petitioner returned to Dr. Gornet on two occasions. PX3. She was also evaluated by Respondent's Section 12 examiner, Dr. Andrew Zelby, who issued two separate reports. RX1, RX2.

Petitioner testified that the surgery of April 29, 2014, helped her. She was able to return to work, but in a different position. She now works in IT, rather than as a Registered Nurse on a busy unit. She testified she cannot return to the floor as a nurse, as she cannot handle the strain on her back. She has permanent restrictions of no lifting over ten pounds, no working more than an eight-hour shift, and alternate frequently between sitting and standing. A nursing shift is twelve hours, and the running and lifting of patients does not fall within her restrictions. She testified that her current position in IT is actually considered a higher professional level, and her pay increased with the position. Although she now has an increase in earning, she testified she would rather be a floor nurse. Prior to taking the IT position, she finished her Bachelor's Degree in Nursing. She also traveled to Wisconsin to receive additional training and certification for her IT position, which was paid for by Respondent.

With regard to her current complaints, Petitioner testified her symptoms are aggravated by changes in the weather, prolonged sitting, climbing stairs, and bending and lifting. She also has pain in her hip and groin after walking for long periods of time, has a consistent dull ache in her lower back, and has trouble sleeping. She testified she has gained weight, and her ability to play with her nieces and nephews has been impacted. She uses a special chair at work, which provides proper support.

On cross-examination, Petitioner confirmed that since the first hearing on January 14, 2015, she has seen Dr. Gornet on only two occasions and underwent two MRI scans. She testified she has undergone no other treatment for her symptoms, including physical therapy, stating that she reached the maximum the treatment could do for her. She occasionally uses ice and heat, performs stretches at home, and takes Ibuprofen two to three times per week. She agreed that Respondent had accommodated her work restrictions at every turn.

On April 20, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. It was noted her surgery had been April 29, 2014, so she was one year postoperative. She reported her back was doing well but that she was still having some left hip and groin pain, particularly with crossing her legs and other activities. It was noted, "These symptoms were present prior to surgery and have not gone away with the surgery itself." Dr. Gornet noted her hips appeared normal. He documented a normal physical examination, with 5/5 strength in all groups, normal reflexes, normal sensation, and a negative straight leg raise test for both back and leg pain. He noted that Petitioner was morbidly obese. PX3.

Petitioner also underwent a lumbar MRI on April 20, 2015, at MRI Partners of Chesterfield. The radiologist's impressions were: (1) interspinous distraction device at L4-5 in satisfactory position; and (2) partially decompressed posterior interspace at L4-5 with persistent central broad-based herniation resulting in mild bilateral foraminal stenosis, but no new central canal stenosis. PX4.

Dr. Gornet placed Petitioner at maximum medical improvement on April 20, 2015; however, he wanted to see her again in one year. He noted, "While she has improved with her result, she clearly is not perfect." He placed permanent restrictions on Petitioner of no lifting

more than ten pounds, no repetitive lifting, no working more than eight hours per day, and no working more than 40 hours per week. PX3.

On April 18, 2016, Petitioner returned to Dr. Gornet and was two years postoperative at that point. She reported she was doing well and was pleased with her progress. She had left the nursing field and was now in IT, working with Epic. Dr. Gornet documented a normal examination, with strength, reflexes, and sensation normal. Straight let raise was negative for both back and leg pain. A follow up MRI was conducted that day, which Dr. Gornet noted showed no significant changes or other mechanical abnormalities. He further noted, "I think she will continue to do well. She is very pleased with her progress. I believe her result has been excellent to date." He released her from care at that time, and the Arbitrator notes Petitioner testified that she had not returned since this appointment. PX3, PX4.

On October 31, 2016, Petitioner was evaluated by Respondent's Section 12 physician, Dr. Andrew Zelby of Neurological Surgery & Spine Surgery. She reported she had had no treatment for about 18 months and that she was better primarily because she refrained from doing anything strenuous. She believed her symptoms were exacerbated with sitting more than several hours, or standing more than an hour. She also reported she would not lift more than 20 pounds. She rated her pain as 1/10 on the date of the exam, but stated it could reach 7/10 depending on activities or changes in the weather. She got relief of symptoms with heat, ice, and lying supine. Dr. Zelby noted Petitioner's weight of 204 pounds. RX1.

Dr. Zelby documented a normal physical examination. Petitioner's gait and posture were normal, as was sensation, reflexes, heel/toe walking, and other testing. There were no paraspinal muscle spasms and the lower extremities were symmetric and without atrophy. RX1.

Dr. Zelby reviewed Petitioner's prior medical records, including the MRI's and CT scans. He opined that Petitioner's reported persistence and severity of complaints were inconsistent with her objective medical findings and the natural history of her objective medical condition. He further opined that Petitioner was medically qualified to work without restrictions. He stated, "Her restrictions placed by Dr. Gornet make no sense in the context of her objective medical condition and these restrictions are not reasonable or necessary." He went on to state that the nature of the DIAM device and the surgery required to insert it would not engender the need for restrictions, particularly in the context of the obviously mild degeneration in Petitoner's lumbar spine. He agreed with Dr. Gornet that Petitioner was at maximum medical improvement. RX1.

Dr. Zelby issued a second report on January 9, 2017, wherein he rendered a detailed Whole Person Impairment rating pursuant to the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition. He rated Petitioner's impairment to be 7% of the whole person, based upon her motion segment lesions, functional history, normal physical examination, and clinical studies. In detail, the Diagnostic Based Impairment was Class I for motion segment lesions, which resulted in a base of 7% WPI (Table 17-4). Functional History required a grade modifier of 2 for symptoms with normal activity (Table 17-6); Physical Examination required a grade modifier of 0 for normal spine and normal neurological exams; and Clinical Studies required a grade modifier of 2 based on the presence of the DIAM device. RX2.

Dr. Zelby concluded: "Ms. Wingerter's FH grade adds 1, her PE grade subtracts 1 and her CS grade adds 1. This gives a WPI% of 8%. However, the AMA Guides indicate that when an FH grade modifier is two or more grade modifiers greater than the PE or CS grade modifiers, the FH grade modifier is to be discarded. This gives a WPI% of 7%. There is no further modifier of spinal impairment in the calculation of the final WPI%. Therefore, the final Whole Person Impairment of Ms. Wingerter would be 7%." RX2.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Facts, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated that the only issue currently in dispute is the nature and extent of Petitoner's permanent partial disability.

With regard to the nature and extent of disability for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, Dr. Zelby opined that Petitioner sustained an impairment of 7% of the Whole Person, as detailed above. Petitioner did not offer an impairment rating. The Arbitrator recognizes that impairment and permanent partial disability as defined by the AMA Guides are not the same, and the Arbitrator makes note of this distinction when assessing the weight given to Dr. Zelby's impairment rating at issue and in determining the permanency award. The Arbitrator places significant weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as a Registered Nurse at the time of the accident. She missed 9 6/7 weeks of work due to her injury and her light duty restrictions were accommodated by Respondent at all times. She ultimately left her position as a nurse and is currently working in Respondent's IT Department.

On April 20, 2015, Dr. Gornet placed permanent light duty restrictions on Petitioner. The Arbitrator finds significant that Petitioner's objective physical examination that day was normal and her subjective complaints were minimal. In fact, she stated her back was doing well, with the exception of some hip and groin pain. One year later, on April 18, 2016, Petitioner returned to Dr. Gornet and again had a normal physical examination and minimal subjective complaints. She reported she was doing well and she was pleased with her progress. On October 31, 2016, Dr. Zelby conducted a thorough examination, which was also normal. Petitioner's subjective complaints at that time were also minimal.

The Arbitrator is mindful that the treating physician placed permanent restrictions on Petitioner. However, the Arbitrator is perplexed as to the medical reasoning behind those restrictions, given her normal physical examinations and minimal complaints. Dr. Gornet provided no basis or justification for the restrictions in his records. Dr. Zelby likewise was

perplexed by the restrictions and went so far as to state that they "make no sense in the context of her objective medical condition" and were not reasonable or necessary.

While deference to a treating physician is often given with regard to matters such as restrictions, the Arbitrator is persuaded in this case by the opinions of Dr. Zelby. The Arbitrator further notes that, according to Petitioner's testimony, her current position is "a higher professional level" and that she is earning a higher rate of pay. The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury** Petitioner was 32 years old at the time of the accident and 37 at the time of hearing. She can be expected to continue working for many more years. The Arbitrator finds that over time Petitioner's condition could improve, stay the same, or get worse. There was no evidence to indicate with any degree of likelihood how her age would impact her disability, and the Arbitrator does not speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, the Arbitrator again notes that Petitioner is now working in a higher professional job at a higher rate of pay. There was no evidence to show that Petitioner's future earning capacity has been adversely impacted. The Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner underwent a left L4-5 laminotomy and 10 mm implant on April 29, 2014. Although Petitioner testified to various ongoing complaints, Dr. Gornet's final two notes do not corroborate her testimony, which is the measure of this factor. In fact, his record of April 20, 2015, documents she was doing well, with only some left hip and groin pain. He noted she had the same pain complaints prior to surgery and that her hips were normal. Dr. Gornet's record following her final visit of April 18, 2016, documents she was "doing well" and was "very pleased with her progress".

This factor requires a showing of "evidence of disability *corroborated by the treating medical record*". There is no such corroboration in this case and the Arbitrator questions Petitoner's veracity on this point. In addition, the Arbitrator finds Petitioner's testimony regarding her subjective complaints to be out of proportion to the objective examination findings, as documented by both Dr. Gornet and Dr. Zelby. The Arbitrator gives some weight to this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 15% loss of use of the person as a whole (75 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $701.85. The Arbitrator finds that her permanent partial disability rate is $421.11 per week.

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

Luis C. Sanchez Garcia,
Petitioner,
vs.

NO: 13 WC 29782

John Deere Parts Distribution Center,
Respondent.

17IWCC0574

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, 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.

The Commission, however, corrects the clerical errors in the first and third paragraphs of the Order section on page 2 of the decision to state that "Petitioner has failed to prove . . . ."

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.

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

DATED: SEP 25 2017
o090717
DLG/mw
045

David L. Gore

Deborah L. Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA SANCHEZ, LUIS C
Employee/Petitioner

Case# **13WC029782**

JOHN DEERE PARTS DISTRIBUTION CENTER
Employer/Respondent

17IWCC0574

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:

0294 KATZ HUNTOON & FIEWEGER P C
THOMAS E CADY
1000-36TH AVE
MOLINE, IL 61265

2119 CALIFF & HARPER PC
STEVEN L NELSON
506 15TH ST SUITE 600
MOLINE, IL 61285

17IWCC0574

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

LUIS C. SANCHEZ GARCIA,
Employee/Petitioner

v.

JOHN DEERE PARTS DISTRIBUTION CENTER,
Employer/Respondent

Case # 13 WC 29782

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **6/7/16**. 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **10/2/12**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$40,826.76**; the average weekly wage was **$785.13**.

On the date of accident, Petitioner was **31** years of age, *single* with **2** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$14,246.30** for other benefits, for a total credit of **$14,246.30**.

Respondent is entitled to a credit of **$25,323.22** under Section 8(j) of the Act.

ORDER

Respondent has failed to prove by a preponderance of the credible evidence that he is entitled to any temporary total disability benefits from 9/9/13 through 5/5/14. Petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay reasonable and necessary medical services from 10/2/12 through 12/17/12 related to petitioner's left elbow; low, mid, and upper back; and upper trapezius area, as provided in Sections 8(a) and 8.2 of the Act.

Respondent has failed to prove by a preponderance of the credible evidence that he sustained any permanent disability. Petitioner's claim for permanent disability 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

6/22/16
Date

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 31 year old material handler, sustained an accidental injury that arose out of and in the course of his employment by respondent on 10/2/12. Petitioner is alleging injuries to his bilateral shoulders. Prior to this accident petitioner had sustained an injury to his cervical spine for which he underwent injections, physical therapy and a C5-C6 fusion on 6/12/12.

On 10/2/12 while driving a Taylor Dunn, stand up golf cart with a box in front to collect parts, on the main aisle, a forklift came out of a side aisle and hit his Taylor Dunn cart on the left side. Petitioner testified that the cart fell over to the left. He stated that as the cart tipped over on its side he put his left elbow out and that struck the floor as the cart hit the floor. He testified that he did not strike his left shoulder but his left shoulder was jammed when he struck his left elbow on the ground. He testified that he had complaints of bilateral shoulder pain. Petitioner reported the accident and was sent to respondent's medical department.

Petitioner presented to respondent's medical department on 10/2/12. Petitioner gave a history of heading east on the main aisle across from E zone, when a fork truck heading north struck the right side in the middle of the TD. Petitioner reported that he held onto the Taylor Dunn as it tipped over on its left side, striking his left elbow and back on the ground. He reported that the Taylor Dunn did not fall on him. Petitioner reported that he was already taking hydrocodone at night for his preexisting neck pain. Petitioner reported no real pain, just some soreness in his back, left elbow and right wrist. Petitioner was able to flex and extend his back without discomfort. He had normal range of motion and no abrasion or edema. His knees were tender, but no abrasion or edema noted. His gait was steady without deviation. He was able to flex and extend his neck without discomfort. Redness was noted at the left elbow. He was able to grip and move all digits, and flex and extend his left extremity without complaints or discomfort. He was given ice for his right wrist and mid back. He was assessed with left elbow and back pain. Petitioner stated that he felt comfortable returning to work without restrictions.

On 10/3/12 petitioner returned to the medical department for recheck of his back discomfort. He reported that his mid/upper back, and the back of his shoulders felt stiff. He denied increased symptoms in his neck and reported that it felt like it normally does. Petitioner had good range of motion of his back and neck. His gait was normal. He also reported that his elbow felt okay. Later that day he returned to medical and complained of difficulty operating the crown and with lifting half boxes. Cold packs were applied to petitioner's upper back. Petitioner's supervisor was instructed to work with petitioner and his job duties to prevent aggravation to his back.

On 10/4/12 returned to medical and was examined by the nurse and Dr. Dunbar. Petitioner reported to the nurse that his shoulders felt worse that day. He had good range of motion of his upper extremities, but reported discomfort with above the shoulder motion. Biofreeze was applied to upper back and shoulder area. Petitioner reported to Dr. Dunbar that he was a little more sore with regards to the upper back. He stated that his elbow was okay. He noted that he was working modified duty. He denied any radicular pain/paresthesias/weakness or neck pain. Petitioner was tender over the upper trapezius bilaterally. He had full range of motion of the shoulders and full strength with full grip strength. His pinprick was intact and his DTRs were symmetrical. He was assessed with soft tissue injuries only. He was told to continue the same therapeutic plan for the next 2 days and then return to usual activities. He was released to regular work on 10/6/12. Later that day he returned to medical for ice to his upper and mid back. He stated that he thought his neck and shoulders were more tender and he forgot to mention this to Dr. Dunbar.

On 10/5/12 petitioner returned to medical and was examined by the nurse for his upper back and shoulder. He reported being more sore in the upper/mid back. Petitioner had increased tone to his left lat dorsi area. He was tender to palpation. He had good range of motion. The tone in his shoulders was decreased. He was assessed with posterior shoulder/upper back discomfort. He was continued on modified regular duty. Later that day he returned for ice and muscle rub for mid back.

On 10/8/12 petitioner returned to medical for follow-up of his mid back discomfort. He reported soreness in his mid/upper back and shoulder areas. His mid/upper back was tender to palpation over soft tissue and muscles. He had good range of motion in all directions. He was assessed with mid/lower back and posterior shoulder strain. Later that day he returned to medical for ice.

On 10/12/12 petitioner returned to medical and was examined by the nurse for follow-up to his back injury. He stated that he felt a little stiff. He was assessed with mid back pain.

On 10/15/12 petitioner returned to medical and was examined by Dr. Dunbar. He stated that he was doing well until the end of the week with performing regular work on his Hyster. He stated that he began to develop left upper trap discomfort, left paraspinal upper thoracic spine discomfort and low diffuse thoracic discomfort. He reported that the bouncing coming down from a height caused discomfort over the upper back, and twisting of the trunk caused thoracic spine discomfort. Mild discomfort was noted over the right lower paraspinal thoracic spine and adjacent trunk. Also noted was discomfort with twisting of trunk. He was assessed with persistent complaints that appeared to be muscular in nature. He was given light duty restrictions of no lifting over 20 pounds, no lifting above shoulder height, no prolonged upward gaze and no picking above ground level. He was prescribed physical therapy, medications and x-rays of cervical and thoracic spine.

On 10/15/12 petitioner was examined by Dr. Sundar. On that day petitioner reported neck pain. He rated it at a 4/10 in severity and reported that it was dull and aching, and radiating into the left trapezius. He reported that his pain was worse than on previous visits. Petitioner reported that he underwent a cervical spinal fusion on 6/12/12. An examination revealed tenderness to palpation over the left trapezius. Also noted was myofascial spasm present with focal trigger points. With respect to petitioner's left and right upper extremities, the motor and sensory were intact. Petitioner was assessed with cervical whiplash/strain and myofascial strain. Dr. Sundar noted that petitioner's recent work injury has resulted in severe myofascial spasm over the left trapezius.

Petitioner began physical therapy on 10/17/12. Petitioner had therapy 2 times a week. On 10/18/12 he reported to Dr. Dunbar that his cervical and thoracic spine were better with therapy. On 10/24/12 he reported that he was doing much better. He was restricted to 4 hours regular duty and 4 hours of light duty. On 10/25/12 he reported to Dr. Dunbar that he was doing well. He complained of minor soreness over the left trapezius and cervical area. On 11/5/12 Dr. Dunbar examined petitioner. Petitioner reported that he tolerated 4 hours of regular work but then developed left trapezius discomfort. Dr. Dunbar decreased physical therapy and increased petitioner's work schedule to 6 hours of regular work and 2 hours of light duty. On 11/12/12 he recommended petitioner return to 8 hours of regular work with no overtime. On 11/19/12 petitioner returned to regular work with overtime.

On 11/15/12 petitioner returned to Dr. Dunbar. Petitioner stated that since he was last seen he developed several episodes of left upper trapezius discomfort associated with headaches causing him to leave work. He complained of radicular pain and tingling radiating from the left upper trapezius at the base of the neck, radiating down the left arm and the anterior shoulder and axilla. He denied any right sided neck/trapezius complaints. Dr. Dunlap assessed minor relapse with discomfort after advanced work duties. She noted it was a normal examination except for discomfort. Petitioner was continued in physical therapy once a week. On 11/21/12 petitioner was returned to regular duty work. On 12/3/12 petitioner reported that overall he was doing much better. He reported minimal soreness over the upper trapezius bilaterally.

On 12/17/12 petitioner was examined by Dr. Dunbar. Petitioner stated that he had been working full duty for a week. He stated that he felt well, but was a little sore all over but believed it may not be related to work duties. He denied any weakness, numbness or tingling. Petitioner was discharged from physical therapy. Petitioner had no complaints.

After 12/17/12 petitioner returned to medical on 1/4/13, 2/20/13, 4/23/13 and 4/25/13. All these visits were for complaints unrelated to his accident on 10/2/12. Petitioner made no complaints regarding his neck,

back or shoulders. However, petitioner testified at trial that the symptoms in his shoulders worsened from December of 2012 through June of 2013 with heavy lifting and overhead work while working full duty.

On 6/12/13 petitioner returned to Dr. Purighalla, who performed his cervical fusion in 2012. He complained of neck pain radiating to both upper extremities with associated tingling and numbness, and pain in the upper thoracic area. He gave a history of falling 4 months ago at work and his symptoms started approximately around that time. Dr. Purighalla noted that petitioner was neurologically intact with a few focal deficits other than some slight decreased range of motion in the neck, and tingling and numbness in the upper extremities. Petitioner's biceps reflex was also slightly decreased bilaterally. An MRI of the cervical spine was ordered.

On 6/18/13 petitioner underwent an MRI of the cervical spine. The impression was anterior cervical fusion at C5-C6, and small posterior disk osteophytes at C4-C5 and C6-C7. On 6/19/13 petitioner returned to Dr. Purighalla for follow-up of his neck and right shoulder pain. Dr. Purighalla was of the opinion that petitioner did not need any surgical intervention as it relates to his neck. He referred petitioner to Dr. Foad for his right shoulder complaints.

On 6/26/13 petitioner reported to medical, and for the first time stated in passing that he thought his right shoulder pain could be the result of his accident on 10/2/12. Petitioner denied any new injury. Petitioner stated that his computer was elevated and he had an extended reach, but the screen was lowered and he was having no further problems. Petitioner stated on two occasions that his current complaints were not work related.

On 6/27/13 petitioner presented to Dr. Foad for right shoulder pain. Petitioner gave a history of injuring his right shoulder when his Taylor Dunn forklift toppled over. He reported that he hurt both of his shoulders. X-rays of the right shoulder were normal. Based on petitioner's history, Dr. Foad was of the opinion that petitioner's right shoulder is related to his work injury. He recommended an MR arthrogram. Petitioner stated that his left shoulder was not bothering him as much as his right.

On 7/3/13 petitioner underwent an MRI arthrogram of the right shoulder. The impression was 50% undersurface partial tearing of the distal anterior fibers of the supraspinatus tendon; intact labrum; and nonspecific prominent subchondral cysts of the posterolateral humeral head. No corresponding attenuation of the posterior labrum to confirm posterior impingement was noted.

On 7/11/13 petitioner returned to Dr. Foad. He assessed a right shoulder SLAP tear. Dr. Foad offered petitioner an arthroscopic versus open SLAP repair and/or rotator cuff repair. He was of the opinion it was work related.

On 7/24/13 petitioner presented to Milan Medical Group. Petitioner was examined by Susan Alden, APN. Following an examination petitioner was assessed with shoulder joint pain. Alden noted that petitioner was unable to work on 7/23/13.

On 7/31/13 petitioner presented to ORA Orthopedics. He was examined by Dr. Wynn. His chief complaint was tear in rotator cuff and biceps on right shoulder as well as left shoulder pain. Petitioner reported that he was driving a standup Taylor Dunn fork lift and another fork truck hit him causing the Taylor Dunn to topple over, and he injured his right and left shoulders at that time. Petitioner reported that he initially had some physical therapy. He rated his pain as a 7/10, intermittent. He stated that it radiates up towards his neck down to his hand. Following an examination and record review, Dr. Wynn's impression was right and left shoulder pain. He ordered an MRI arthrogram of the left shoulder. For the right side he told petitioner he could go ahead with a surgery, but he recommended 6-8 weeks of conservative treatment that included injections and physical therapy. Dr. Wynn performed a subacromial injection. Petitioner began a course of physical therapy.

On 8/6/13 petitioner underwent an MRI arthrogram of the left shoulder. The impression was that there was significant undersurface partial tearing of the distal supraspinatus tendon exceeding 50% of the distal tendon thickness, and significant abnormal contrast tracking beneath the superior labrum concerning for a superior labral tear that extends forward through the upper half of the anterior labrum.

On 8/20/13 petitioner followed-up with Dr. Wynn. Dr. Wynn noted that it appeared that petitioner's bilateral shoulder complaints stemmed from his work related injury on 10/2/12. Petitioner reported that his right shoulder was worse than his left shoulder. Dr. Wynn assessed right shoulder biceps pain; partial thickness tear of the articular side of the supraspinatus tendon; impingement; and AC joint pain with arthropathy. Dr. Wynn also assessed a likely left shoulder superior labral tear; biceps pain; high grad partial thickness tear of the articular side of the supraspinatus tendon; impingement; and AC joint arthropathy. Based on petitioner's failed conservative treatment Dr. Wynn recommended surgical intervention for the right shoulder, followed by surgery on the left shoulder.

On 9/6/13 petitioner signed his Application for Adjustment of Claim with respect to the accident on 10/2/12. He claimed injuries to his bilateral shoulders, bilateral arms, and neck. This Application was filed on 9/11/13.

On 9/16/13 petitioner returned to Dr. Purighalla complaining of a lot of pain in the mid thoracic area radiating horizontally. He also complained of discomfort in the cervical area, but was pointing more towards the mid thoracic area. Petitioner stated that both his shoulders were "shot" and he was going to be having

surgery on both of them. An examination revealed tenderness to deep palpation on the mid thoracic area. He denied radiation of pain into the lower back. Dr. Purighalla recommended an MRI of the thoracic spine.

On 9/19/13 petitioner underwent a right shoulder arthroscopy with SLAP repair, CA ligament release, arthroscopic subacromial decompression, and arthroscopic distal clavicle excision. This procedure was performed by Dr. Wynn. Petitioner followed-up post-operatively with Dr. Wynn on 9/26/13, 10/17/13,11/22/13, and 12/17/13. This treatment included physical therapy. Petitioner was taken off work on 9/19/13.

On 11/11/13 petitioner followed-up with Dr. Purighalla. Dr. Purighalla reviewed the results of the MRI of the thoracic spine. He was of the opinion that petitioner did not require any interventions. He thought petitioner's symptoms may be muscular. Dr. Purighalla released petitioner from his care.

On 11/22/13 Dr. Wynn released petitioner to light duty work with restrictions that included no use of his right arm, no pushing, pulling, or lifting greater than 30 pounds with the left arm. On 12/17/13 petitioner had some mild tenderness over the anterior part of the shoulder and over the AC joint; near full range of motion of right shoulder; 5/5 strength throughout and no significant deficit; minimal pain with rotator cuff testing; no significant impingement findings; no AC joint instability; no glenohumeral joint instability; no axillary lymphadenopathy; and normal neurovascular status.

On 1/9/14 petitioner underwent a left shoulder arthroscopy with SLAP repair, CA ligament release, arthroscopic subacromial decompression, and arthroscopic distal clavicle excision. This procedure was performed by Dr. Wynn. Petitioner followed-up post operatively with Dr. Wynn on 1/16/14, 2/11/14, 3/11/14, 4/15/14 and 5/2/14. This treatment included physical therapy.

On 5/2/14 petitioner stated that he was doing well and really had no problems with his left shoulder. While petitioner was in physical therapy he was doing work-simulated activities, and had passed all tests and felt ready to go back to work. Dr. Wynn released petitioner on an as needed basis. He released petitioner to full duty work without restrictions.

On 9/15/15 an Arbitration Decision with respect to case 12WC9876, with a 11/16/11 date of accident with respect to petitioner's cervical spine injury was issued. Petitioner was awarded 20% loss of use man as a whole, pursuant to Section 8(d)2 of the Act.

On 12/23/15 petitioner underwent a Section 12 examination performed by Dr. Christine Deignan, at the request of the respondent. In addition to her examination, Dr. Deignan performed a record review. Petitioner claimed that he injured his right and left shoulders as part of the accident on 10/2/12. He denied his neck was injured as a result of the accident on 10/2/12. Petitioner gave a history of driving a Taylor Dunn fork lift when

his vehicle was T-boned by another vehicle. Petitioner stated that he stands up to operate the Taylor Dunn. He reported that after his vehicle was hit it tipped over to the left. He stated that he was still in the vehicle when it came down and he recalled hitting his left elbow on the ground. He reported that his right shoulder started to hurt the next day. His treatment included physical therapy. Petitioner believed that his shoulder surgeries were helpful and he is able to work with some discomfort. He stated that as his work day progresses he gets aching across the back of the shoulders and arms and across the back of the neck. He believed his shoulders are weaker. Petitioner passed the functional screen that requires the ability to lift 75 pounds, prior to returning to work.

Dr. Deignan reviewed medical records of petitioner prior to 10/2/12. She noted that on 4/5/11 petitioner was treated for back discomfort, right shoulder discomfort, and neck tenderness. He was assessed with a right trapezial strain. On 11/16/11 while driving a Hyster, a track broke, he came to an abrupt stop and suffered a contusion on the forehead and cervical spine. Petitioner underwent a cervical fusion at C5-C6 on 6/12/12.

Dr. Deignan noted that the 10/2/12 when the Taylor Dunn tipped over on the left side he struck his left elbow and back on the ground. Petitioner reported at that time that he had no real pain, just some soreness in his back, left elbow and right wrist. He stated that his knees were tender. Petitioner had normal range of motion, and no swelling or abrasions of the right wrist; no abrasion or edema of the knees; steady gait; able to flex and extend his neck without verbal complaints of discomfort; redness about the left elbow; and able to grip and move all digits, and flex and extend left extremity without complaints of discomfort. He was assessed with left elbow/back. He was returned to work without restrictions.

Dr. Deignan noted that on 7/18/13 petitioner returned to respondent's medical department. Petitioner complained of right lateral neck and upper trapezius pain. Petitioner's medical records were reviewed and he was told that there were no right shoulder complaints, as well as consistent normal shoulder findings by Dr. Dunbar and physical therapy. Because of this petitioner was told his shoulder findings were not work related or casually related to the accident on 10/2/12. When petitioner was told this he became hostile and argumentative and stated that he would seek surgery and consult with his attorney to litigate his case. Petitioner admitted having a motor vehicle accident in 2003 in which he injured left upper back and shoulder, but that those issues had resolved.

Following an examination and record review Dr. Deignan was of the opinion that petitioner had reached maximum medical improvement for his accident on 10/2/12. She diagnosed a left elbow contusion and lumbar strain, completely resolved; left shoulder SLAP lesion with resection of the distal clavicle for decompression; right shoulder SLAP lesion with resection of the distal clavicle for decompression; and past history of C5-C6

cervical fusion. Dr. Deignan performed an AMA Impairment Evaluation using the Guides to the Evaluation of Permanent Impairment, 6th Edition and found a 14% impairment of the whole body.

With respect to causation Dr. Deignan was of the opinion that on 10/2/12 petitioner complained only of left elbow and back pain. Subsequent evaluations by Dr. Dunbar through 12/17/12 did not document either right or left shoulder complaints. However, petitioner did have right shoulder complaints prior to the accident on 4/15/11. Dr. Deignan opined that to sustain bilateral shoulder glenoid labrum tears as a result of a traumatic accident, but have no complaints of shoulder pain during the 6 weeks following the incident is not medically plausible. Dr. Deignan opined that there is no causative relationship between petitioner's bilateral shoulder problems and the accident on 10/2/12.

On 3/9/16 petitioner underwent a Section 12 examination performed by Dr. Richard Kreiter, at the request of the petitioner. He also performed a record review. He opined that the forklift being tipped over when struck broad-sided, is a significant impact event, more than a minor accident. He was of the opinion that considerable forces were evident. He noted that petitioner was upright and held onto the steering mechanism during a rollover, and landed on his left elbow, jamming the upper arm into the shoulder girdle. Dr. Kreiter referenced a respondent medical department report on 10/4/12 that noted "pain with above shoulder range of motion bilaterally," along with upper back discomfort. Dr. Kreiter noted that petitioner had no treatment for his shoulders prior to 10/2/12. He was of the opinion that petitioner's preexisting shoulder conditions were aggravated, accelerated and became permanent as a result of the accident on 10/2/12. Dr. Kreiter recommended restrictions that included only occasional, or rare overhead work, and lifting from floor to bench with arms o the side, and not away from the body, as tolerated. Dr. Kreiter determined that pursuant to the AMA Guidelines, 6th Edition, petitioner would have a 39% loss of use of the upper extremities, bilaterally. Dr. Kreiter opined that the accident on 10/2/12 aggravated and accelerated the conditions in the AC joints. He opined that the joints were not dislocated, but aggravated with increased synovitis, inflammation, and pain, leading to the resection of the lateral clavicles.

Petitioner testified that he is still working and has problems with overhead reaching with both shoulders. He also reported problems with reaching out and holding heavy things in front of him. He testified that he can lift 25 pounds without pain, and can reach out and lift 30-40 pounds without pain. With respect to his shoulders he stated that the higher up he goes to get things he slows down. He testified that he has been told he would be written up for slowness. Petitioner is right hand dominant. Petitioner stated that he no longer throws accurately with baseball or basketball. He stated he when he carries a tray of food he cannot hold it for a long time. Petitioner is currently working his regular duty job without restrictions.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner alleges his current condition of ill-being as it relates to his bilateral shoulders is causally connected to the injury he sustained on 10/2/12.

On 10/2/12 petitioner was driving a Taylor Dunn golf cart down an aisle and was t-boned by another cart coming out of another aisle. Upon impact petitioner's cart fell on its left side. He sought medical care immediately after the incident. He gave a history to respondent's medical department staff that when he fell he struck his left elbow and back on the ground. He reported that the cart did not fall on him. Petitioner only had complaints of soreness in his back, left elbow and right wrist. Petitioner had no reports of real pain. He was able to grip and move all digits, and flex and extend his left extremity without complaints or discomfort. Redness was noted at the left elbow. There were no complaints of any right or left shoulder pain.

Petitioner continued to treat at the respondent's medical department and with Dr. Dunbar through 12/17/12. During this period petitioner also presented once to Dr. Sundar. Petitioner had a total of 8 visits through 12/17/12. During this period petitioner's primary complaints were to his mid/thoracic/and upper back. On the day after the accident he reported stiffness in his mid/upper back and the back of his shoulders. On 10/4/12 petitioner had good range of motion of his upper extremities, and full range of motion of his shoulders, with full strength and grip strength, despite his complaints of discomfort with above the shoulder motion. He denied any paresthesias/radicular pain/tingling. On 10/5/12 he reported soreness in his upper back, but had full range of motion. He also had mid back complaints. He was assessed with soft tissue injuries. On 10/8/12 he had mid back complaints and upper back complaints near the back of the shoulders. He was assessed with mid/lower back and posterior shoulder strain. On 10/12/12 petitioner only reported mid back pain. On 10/15/12 he stated that he developed left upper trapezius, left paraspinal upper thoracic spine and low diffuse thoracic discomfort. He was assessed with complaints muscular in nature. On 10/15/12 he reported neck pain radiating to the left trapezius. Petitioner's bilateral upper extremity motor and sensory were intact. He was assessed with cervical strain/whiplash and severe myofascial strain over the left trapezius.

On 11/15/12 he reported to Dr. Dunbar episodes of left upper trapezius discomfort associated with headaches. He reported pain radicular pain and tingling from the base of the neck on the left down the left arm and the anterior shoulder and axilla. He denied any right sided problems. Dr. Dunbar assessed a minor relapse with discomfort with advanced work duties. She stated that petitioner's examination was normal except for some discomfort. By 12/3/12 petitioner reported that overall he was doing much better and only had minimal soreness over the upper trapezius bilaterally.

Petitioner also had therapy during this time period. On 10/18/12 and 10/24/12 he reported that he was doing much better. On 10/25/12 and 11/5/12 petitioner had minor soreness over the left trapezius. On 11/19/12 he was released to full duty work with overtime.

On 12/17/12 petitioner told Dr. Dunbar that he had been working full duty and felt well. He reported that he was a little sore all over, but believed it may not be related to work duties. He denied weakness, tingling or numbness. At that time petitioner was discharged from care.

Between 12/18/12 and 6/12/13 petitioner continued to treat at the company's medical department. During this time petitioner made no complaints regarding his left or right shoulder. Despite these credible medical records petitioner testified that the symptoms in his shoulders worsened during this period. The arbitrator finds this testimony not supported by the credible medical records.

When petitioner presented to Dr. Purighalla on 6/12/13. He complained of neck pain radiating to both upper extremities with associated tingling and numbness and pain in his upper thoracic area. Dr. Purighalla had performed a cervical fusion on petitioner in 2012. Petitioner gave Dr. Purighalla an incorrect history of falling 4 months ago at work and his symptoms started around that time. The arbitrator again finds this history unsupported by the credible medical records which show the accident was 8 months ago, and petitioner only once during that period reported radiating pain from the base of his neck down his left upper extremity. Petitioner never had any complaints regarding radiating pain, tingling or numbness related to his right upper extremity.

On 6/27/12 petitioner began treating with Dr. Foad for his right shoulder. He again gave an inaccurate history of injuring his right shoulder when his cart fell over. Based on this Dr. Foad causally related petitioner's right shoulder condition to the accident on 10/2/12. He assessed a right shoulder SLAP tear and recommended an arthroscopic versus open SLAP repair and/or possible rotator cuff tear. Given that Dr. Foad's opinions are based on petitioner's inaccurate accident history, and not based on the credible medical records, the arbitrator gives no weight to Dr. Foad's opinion as it relates to causal connection.

Petitioner next presented to Dr. Wynn for his shoulder complaints. Petitioner again gave an incorrect history of the accident and associated complaints. He reported that when his cart toppled over he injured his right and left shoulders. Based on this history, Dr. Wynn was of the opinion that petitioner's bilateral shoulder complaints stemmed from his work injury. He recommended surgical intervention for petitioner's left and right shoulders. Again, the arbitrator finds this history is not supported by the credible evidence, and gives no weight to Dr. Wynn's causal connection opinion.

It was not until surgical intervention was recommended for petitioner's bilateral shoulders that petitioner filed his Application for Adjustment of Claim on 9/6/13 claiming injuries to his bilateral shoulders, arms, and neck.

On 12/23/15 Dr. Deignan examined petitioner on behalf of respondent. In addition to her examination, Dr. Deignan did perform a detailed record review. Petitioner claimed he injured his right and left shoulders as a result of this accident. Upon review of petitioner's medical records before and after the accident, she noted that petitioner had right shoulder complaints in 2011, and had sustained a shoulder injury as a result of a motor vehicle accident in 2003. She also noted that the medical records in the 8 months following the injury included no right shoulder complaints, and exams of his upper extremities were normal. She noted that when petitioner was told his bilateral shoulder findings were not causally related to the accident on 10/2/12, petitioner became hostile and argumentative and stated that he would seek surgery and consult with his attorney to litigate his case.

Dr. Deignan noted that following the accident on 10/2/12 petitioner complained only of left elbow and back pain. She also noted that subsequent evaluations by Dr. Dunbar through 12/17/12 did not include documentation regarding either the left or right shoulder complaints. Dr. Deignan opined that it is not medically plausible to sustain bilateral shoulder glenoid labrum tears as a result of a traumatic injury, and have no complaints of shoulder pain during the following 6 weeks. Based on her examination and record review, Dr. Deignan opined that there is no causative relationship between petitioner's bilateral shoulder problems and the accident on 10/2/12.

On 3/9/16 petitioner was examined by Dr. Kreiter, at the request of the petitioner. Dr. Kreiter also performed a record review. Dr. Kreiter's understanding of the accident was that petitioner was upright and holding onto the steering mechanism during a rollover, landing on his left elbow, jamming the upper arm into the shoulder girdle. The arbitrator finds this accident history is inconsistent with the credible medical records. The arbitrator notes that the credible medical records most contemporaneous to the accident do not include any history of a "rollover" of the cart, or a history of jamming his right upper arm into his shoulder girdle. The arbitrator notes that petitioner had no shoulder complaints immediately following the accident. Dr. Kreiter also had a belief that petitioner had no treatment for his shoulders before 10/2/12. The arbitrator again finds this history inaccurate. Petitioner's medical records show treatment for his right shoulder in 2011, and treatment for his shoulder in 2003 after a motor vehicle accident. Dr. Kreiter opined that petitioner's preexisting shoulder conditions were aggravated, accelerated, and became permanent as a result of the accident on 10/2/12. The arbitrator finds Dr. Kreiter's causal connection opinion was based on an inaccurate accident history and

inaccurate complaints most contemporaneous to the accident. For this reason, the arbitrator gives no weight to the causal connection opinion of Dr. Krieter.

Based on the above, as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his bilateral shoulders is causally related to the injury on 10/2/12. The arbitrator bases this on the accident history most contemporaneous to the injury, and the fact that following the injury petitioner had at most some subjective muscular complaints in the lower, thoracic , and upper back; and trapezius areas through 12/17/12. the arbitrator finds it significant that petitioner had no complaints regarding his bilateral shoulders until June of 2013. The arbitrator finds this significant given the fact that during the six months between December 2012 and June 2013 petitioner reported no shoulder complaints despite being seen many times by healthcare providers. The arbitrator also bases this opinion on the less than credible testimony of the petitioner at trial that was inconsistent with the credible medical records, and the fact that the petitioner himself told Dr. Dunbar on 12/17/12 that he believed his complaints may not be related to work duties.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his bilateral shoulders is causally related to the injury on 10/2/12, the arbitrator finds all treatment after 12/17/12 not reasonable or necessary to cure or relieve petitioner from the effects of his injury on 10/2/12. The arbitrator finds all treatment petitioner received from 10/2/12 through 12/17/12 for his left elbow; low, mid, and upper back; and upper trapezius area, was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 10/2/12.

Respondent shall pay all reasonable and necessary medical services from 10/2/12 through 12/17/12 related to petitioner's left elbow; low, mid, and upper back; and upper trapezius area. Respondent shall receive credit for all medical bills already paid.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner's current condition of ill-being after 12/17/12 is not causally related to the injury on 10/2/12, the arbitrator finds the petitioner's claim for temporary total disability benefits from 9/9/13 through 5/5/14 is denied.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his bilateral shoulders is causally related to the injury on 10/2/12, and the fact that on 12/17/12 petitioner reported that he was a little sore all over, but believed it may not be related to work, the arbitrator finds petitioner has failed to prove by a preponderance of the credible evidence that he sustained any permanent disability as a result of the accident on 10/2/12. The arbitrator finds it significant that after petitioner reported on 12/17/12 that he believed his complaints may not be related to his work, he went 6 additional months with no shoulder complaints, despite the fact that he sought medical care on at least 4 additional occasions between 12/17/12 and 6/12/13.

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

Nehemiah Nickels,
Petitioner,
vs.

NO: 13WC 37235

17IWCC0535

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2017, is hereby affirmed and adopted.

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

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

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

DATED: SEP 5 - 2017

Joshua D. Luskin

Charles J. DeVriendt

Deborah Simpson

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JDL/wj
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NICKELS, NEHEMIAH
Employee/Petitioner

Case# **13WC037235**

CATERPILLAR
Employer/Respondent

17IWCC0535

On 3/8/2017, 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 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

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

NEHEMIAH NICKELS,
Employee/Petitioner

v.

CATERPILLAR,
Employer/Respondent

Case # 13 WC 37235

Consolidated cases: _____

17IWCC0535

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **2/9/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/20/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$35,165.52**; the average weekly wage was **$676.26**.

On the date of accident, Petitioner was **39** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$8,582.76** for other benefits, for a total credit of **$8,582.76**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left elbow and bilateral shoulders due to repetitive work activities for respondent that manifested itself on 7/20/13. The petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

2/24/17
Date

MAR 8 - 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 39 year old forklift driver alleges he sustained accidental injuries to his bilateral shoulders and left elbow due to repetitive work activities for respondent that manifested itself on 7/20/13.

Petitioner began working for respondent in October of 2007. His duties while working for respondent included welding, material handler, assembly person and forklift driver. When first hired petitioner was a welder. In August of 2012 he returned to building NN in East Peoria, where his primary job was that of a forklift driver. While in NN, and through September of 2013, respondent was going through the MACH1 transition. This required moving materials from one area in NN to another location in the warehouse. Petitioner testified that on 7/20/13 he was driving a forklift and performing a number of different duties due to MACH1 changes. Petitioner testified that on or about this time everything in the building was changing to something else as part of MACH1. Petitioner testified that he was doing a lot of things including material handling and driving a forklift.

Sarah Pacheco, Section Manager for the logistic warehouse, testified on behalf of respondent. Pacheco testified that she did not become petitioner's supervisor until September of 2013. She testified that she knew petitioner was in the warehouse in 2012. She stated that petitioner's job required getting material down with a forklift, tagging it, and bringing it to another location. She testified that during the MACH1 transition she could not be sure petitioner did not push the black cart. Pacheco testified that she knew petitioner only as a forklift driver before September 2013. She did not know him ever picking individual items off the shelves for orders. She testified that from 2012-2014 there was no assembly or welding work performed in the NN warehouse, only logistics. Pacheco testified that she never knew petitioner to do any other job other than forklift driver from 2012-2014. She stated that she did not recall petitioner working in the Heavy department. Pacheco testified that if petitioner did any material handling as part of his job, it would not have exceeded 5-10%, and the lifting was not in excess of 30 pounds. She testified that all items weighing over 30 pounds went to the repacking area where they were picked up by multiple people or cranes. Pacheco testified that there is no overhead work in building NN, even during the MACH1 transition.

Pacheco testified on cross examination that she has known petitioner since the end of 2012, and from then until July of 2013 she saw him every day at work. She testified that she observed him working about 40-50% of his day. She testified that he was good hard worker. Pacheco testified that she would see petitioner in the Heavy area with Luke, but did not know if he was visiting Luke, his friend, or was working. She did see him there during break time. She also testified that petitioner's locker is in the Heavy area. Pacheco testified that she was not aware that Luke and petitioner alternated working in the Heavy area every other day. She also testified

that she was unaware of any repacking that would be done in any other area than the Heavy area. She never saw petitioner perform any repacking.

Petitioner testified that he alternated working in the Heavy area with Luke ever since he began working in building NN, because it was too much for one person. He stated that he did this even after Pacheco became his foreman. He also stated that he had to repack things in the department he worked in. He stated that there was stuff all over the floor and he had to consolidate it before he could put it away. He stated that he would bring a tub of heavy parts and take them out and stack them all up. He further testified that he would push around the black carts for order pickers. He testified that this involved pushing and pulling with both arms. He also testified that he did overhead work with both arms.

Petitioner testified that when MACH1 began he was working in the Heavy department and everything was a mess and all around. It remained like this until September of 2013. Petitioner testified that he signed a worksheet indicating that he worked in the Heavy department. He testified that he did his own repacking in that area, and would have to lift more than 75 pounds by himself because respondent just wanted him to get the job done. He testified that he did lifting, that included overhead lifting, all the time. Petitioner testified that he completed records indicating what he put away from December of 2012 through July of 2013, and he turned them into his supervisor at the end of the day. Petitioner could not remember who he turned them into. Petitioner testified that even when he was in the Heavy area he primarily used the standup forklift, but did not do any vertical shelving. Petitioner testified that when working in Heavy he lifted parts by hand 35-40% of the time. He then testified that on some days he lifted nothing by hand and other days lifted more than 35-40% of the time.

Petitioner testified that his left elbow started hurting him on 7/20/13. Then later in July he started having left shoulder problems. A few weeks later his right shoulder started hurting him. Although petitioner was seeing Dr. Mahoney for his right elbow during this period and through 10/25/13 he made no mention of his left elbow, or bilateral shoulder problems.

On 10/28/13 petitioner filed an incident report stating that his left arm and elbow had been giving him problems for the past 3 months, maybe 4. He felt the problem did not seem to getting better, but was getting worse. Petitioner complained of left elbow pain that started 2 months ago. He could not attribute it to any particular incident.

On 11/12/13 petitioner's Application for Adjustment of Claim was filed. Petitioner claimed right elbow and left arm injuries while assembling a tractor. He identified the date of accident as 5/1/13. At trial, petitioner amended the date of injury to 7/20/13.

On 12/16/13 petitioner filed an incident report stating that he was working in Building NN inside the supermarket driving a standup forklift and started feeling pain in his left shoulder, which had been getting progressively worse. He reported that he could not lift his left arm without pain. He reported that he started feeling this pain about 2 weeks ago, which would have been about 12/2/13. He reported that normal job duties of turning the steering wheel of the forklift and intermittent lifting of materials aggravated his injury. He reported slight pain (2 out of 10) a month ago, that had progressively gotten worse. Petitioner was put on light duty. Petitioner had been forklift truck driver for 2-1/2 years at this time. He reported that he would drive 90% of the time and consolidate 10% of the time. He also reported that he manually moves material from flats to tubs, etc. It was noted that historically petitioner did situps and pushups regularly for fitness. Petitioner treated at respondent's medical through 2/13/14.

Petitioner treated with Dr. Mahoney for an unrelated right elbow injury that arose out of and in the course of his employment by respondent on 6/20/12, and that claim number is 13 WC 5764, that was consolidated for hearing with this claim. Petitioner treated with Dr. Mahoney for his right elbow injury through 10/25/13. At no time, during his treatment with Dr. Mahoney, did petitioner make any complaints with respect to his right shoulder, left shoulder or left elbow.

Pacheco testified that petitioner reported a shoulder injury to her at the end of 2013, and she sent him to respondent's medical department. On 12/15/13 petitioner filed an incident report stating that he was working at boarding, driving a standup forklift when he started feeling pain in his left shoulder, which had been getting progressively worse. He reported that he could not lift his arms without pain. He stated that he started feeling pain about two weeks ago.

Petitioner first presented to Dr. Blaire Rhode on 1/15/14. He presented for consultation of left shoulder pain and left elbow pain secondary to an injury at work on 7/20/13. Petitioner testified that he was hired as a welder by respondent. He reported that he was then riffed to a forklift driver for approximately 1 year. His duties as a material handler required him to drive a standup forklift and consolidate materials. He stated that his left shoulder problems began approximately 7/20/13. He also reported that he developed right elbow pain secondary to compensation for his left elbow. He described his shoulder pain as lateral and made worse with forward reach and overhead lift. His stated that his right elbow pain was posterior and lateral. He stated that Dr. Mahoney had released him from care and he was currently seeking another opinion secondary to the fact that

his symptoms were not improving. Dr. Rhode examined petitioner and assessed shoulder pain, elbow pain and rotator cuff strain. He was of the opinion that petitioner sustained a work-related left shoulder rotator cuff injury secondary to his repetitive exposure while working as a welder and material handler for respondent. He also demonstrated right elbow triceps tendinopathy without evidence of a tear. Dr. Rhode noted petitioner had ongoing left shoulder and right elbow symptomatology. An ultrasound showed the patient's rotator cuff appeared intact with mild rotator cuff tendinopathy. It showed no evidence of palpable defects to the triceps. He ordered an MRI of the left shoulder and right elbow. He restricted petitioner to modified-medium work.

On 2/5/14 petitioner underwent an xray of the left shoulder that was normal, and x-rays of the left elbow that showed slight soft tissue swelling at the olecranon process that may represent bursitis. An MRI of the left shoulder revealed a small full thickness tear of the anterior supraspinatus tendon with minimal retraction and no muscle atrophy. An MRI of the left elbow revealed partial thickness longitudinal split tear at the insertion of the triceps tendon on the olecranon bursitis, and mild overlying olecranon bursitis.

On 2/12/14 petitioner followed-up with Dr. Rhode. He reviewed the diagnostic tests and recommended an arthroscopic left shoulder rotator cuff repair. With respect to the left elbow he decided tofollow the symptoms at this point. Dr. Rhode took petitioner off work.

On 3/26/14 petitioner followed up with Dr. Rhode. Dr. Rhode examined his left shoulder and bilateral elbows. Petitioner reported that his left shoulder was worse than the left elbow. Dr. Rhode's assessment was the same and he prescribed 60 Norco pills. He stated that he was awaiting surgical authorization. He continued petitioner off duty.

On 5/13/14 petitioner underwent a Section 12 examination performed by Dr. Phillips at the request of the respondent, primarily for his left shoulder and elbow. In addition to his examination, Dr. Phillips performed a record review. Petitioner reported towards the end of 2013 that he was welding at the time and noticed that his left elbow was bothering him when he was doing regular welding activities. He stated that he typically welds holding the welding iron with his right arm. Due to slowing work for respondent around that time, petitioner told Dr. Phillips that he was moved to a different department and began driving a forklift. He also stated that he moved parts 20-30 pounds from one box to another (consolidation). He stated that the boxes are on a pallet at knee or waist level He stated that he noticed his left elbow began bothering him and he filed a report stating this towards the end of 2013. He then noticed left shoulder pain that started 5 months ago. He stated that over the past two months his right shoulder began bothering him in the same location. He stated that his left and right shoulders bother him equally, and sometimes the right is worse than the left. Petitioner denied any prior left or right shoulder injuries.

Petitioner reported that he worked for respondent for 8 years, the first four as a welder. He held the welding tool in his right arm flexed to about 120 degrees, and stabilized the parts he was welding in his left hand. He stated that he worked 8 hours a day, 6 days a week with 45 minutes of total breaks. Petitioner then wanted to work a different shift and switched to an "assembly" job. He did this 8-12 hours a day, 5-6 days a week. He reported that he did this for 3 years until he injured his right triceps tendon, putting together tractors. He put engines in D10 and D11 trucks. He would help the hoist to put the engine in and then use a torque gun and wrench to secure the parts together. He used the gun in his right arm.

When he returned to light duty work he was sorting through garbage, pulling out cardboard with his left hand at waist level. He stated that he then returned to full duty work as a welder for 2-3 months. But because business was slow he was moved to forklift driver, which he had no problem performing. He stated that while driving the forklift he also did consolidation. He last worked in January of 2014. He stated that in consolidation he would move items to place in boxes varying from knee to waist height for 1-2 hours a day. He stated he lifted mainly to waist level, but occasionally lifted a box at shoulder level. Occasionally he pushed the boxes.

Petitioner told Dr. Phillips that he played a lot of basketball before his triceps repair, and previously performed a lot of weight lifting. Dr. Phillips noted that based on respondent's medical records petitioner had filed multiple incident reports.

Following his record review, and examination, Dr. Phillips believed petitioner's problems were tendon related. He noted petitioner told him that his shoulder problems began while driving a forklift and attributed it to "consolidating" which required lifting weights, which he stated were about 15 to 20 pounds. Dr. Phillips noted that respondent provided information that lifting was at a maximum of 13 pounds at waist level primarily. He also noted that petitioner pushed some bins short distances with his arms at his side. Dr. Phillips was of the opinion that petitioner's occupation is not one that typically causes excessive stress on either the triceps tendon of his elbows or his rotator cuff. He was of the opinion that petitioner did not perform any significant overhead activities. Dr. Phillips was of the opinion that given the manner in which the patient developed these symptoms, the patient requires workup by a rheumatologist to exclude an inflammatory cause for his symptoms. He believed petitioner should work with a 15 pound waist level restriction with activities.

On 6/2/14 petitioner returned to Dr. Rhode. He reviewed Dr. Phillips Section 12 examination report. Dr. Rhode was under the impression that petitioner's duties in consolidation and forklift driving required significant repetitive motions manipulating parts that weigh approximately 20-30 pounds. He noted that a majority of petitioner's activity is performed at waist level. Dr. Rhode ordered a rheumatologic workup based on Dr.

Phillips assessment. Dr. Rhode was of the opinion that petitioner's job exposure was an aggravating component to the petitioner's pathology because activity in the forward reach plane is a rotator cuff dependent activity based upon the fact that the lever mechanics of the shoulder require significant force generation to perform a forward reach activity. He also noted that petitioner performed the duties of a welder over the course of years working for respondent.

Petitioner followed-up with Dr. Rhode on 6/18/14, 7/16/14, 8/13/14, and 9/24/14. His complaints remained unchanged. Dr. Rhode examined petitioner's left shoulder, and bilateral elbows. No procedures were performed and no orders were listed. He released petitioner to light duty and told petitioner to follow-up in 7-10 days.

On 7/30/14 petitioner reported that he was tolerating his restricted work well and was not doing anything for respondent above chest level.

On 10/10/14 the evidence deposition of Dr. Rhode was taken on behalf of the petitioner. Dr. Rhode believed petitioner worked for 7 years as a welder for respondent, and that the consolidation position could be the straw that broke the camel's back. He stated that he would not negate that fact that the petitioner was performing a significantly manual repetitive position, performing welding activities with a dose exposure of 7 years. Dr. Rhode opined that floor to waist causes heavy exposure to the rotator cuff depending on how many times they are performing this. Dr. Rhode based his causal connection opinion on the fact that petitioner was a welder for a significant period of time, as well as performing the duties of a forklift driver and consolidation material handler holding 20 to 30 pound objects and putting them in a forward reach, while working for respondent. Dr. Rhode suspected petitioner was performing these duties primarily with his left arm. Dr. Rhode thought he had a good understanding of petitioner's welder activities. The only details he had regarding petitioner's job duties as a welder were those he saw in Dr. Phillips report.

Dr. Rhode was of the opinion that petitioner could lift weights and a weight lifter could have conditions similar to what he diagnosed for petitioner, except for the right elbow. He stated that he had seen the type of tricep pathology he saw in petitioner in weight lifters.

On cross examination Dr. Rhode was of the opinion that petitioner's left shoulder and left elbow symptoms started about 7/20/13, when petitioner was performing the forklift and consolidation position.

In November of 2014, respondent performed surveillance of petitioner in Planet Fitness. The surveillance shows petitioner lifting weights with his son and using an elliptical machine. He was also observed doing a flat bench press of 185 pounds with both arms. Petitioner testified that he had been doing these activities since Dr.

Rhode told him it would be okay to go to the gym and build up muscle. He testified that he had been doing this for about a month or two. Petitioner testified that these gym activities did not make his condition worse. He believed the work in the health club helped with strengthening.

On 11/5/14 petitioner returned to Dr. Rhode for his left shoulder and bilateral elbow pain. Although Dr. Rhode noted that petitioner continues to experience right shoulder pain, this was the first documented evidence of any right shoulder complaints. Dr. Rhode noted that he reviewed medical records from Caterpillar that included documentation of bilateral shoulder pain. Dr. Rhode examined petitioner and performed an ultrasound of the right shoulder. He saw evidence of a distal disruption of the supraspinatus. He assessed shoulder pain, elbow pain, and rotator cuff strain. An MRI of the right shoulder was ordered. Work restrictions were continued.

On 12/18/14 petitioner returned to Dr. Rhode's office and was seen by Lori Welke, PA, for reevaluation of his elbow and shoulder complaints. His assessment remained the same. He prescribed 60 Tylenol with Codeine pills for petitioner. Work restrictions were continued.

Petitioner worked with restrictions until the end of 2014. Thereafter, he worked full duty for respondent until the beginning of 2016. Since leaving Caterpillar petitioner obtained alternate work at Oberland Electric. He is an electrician and lifts heavy weights.

On 1/1/15 Dr. Phillips provided an addendum report after reviewing the surveillance video of petitioner on 11/3/14, 11/6/14, and 11/10/14, performing various activities. On 11/10/14 he viewed petitioner with a backpack on his right shoulder with his right elbow fully flexed holding the strap of the backpack. He noted petitioner's left arm was swinging at his side while he walked to a car. He viewed petitioner drinking a soda; opening the car door with his left arm; working out strenuously using an elliptical machine with his arms holding the side bars of the elliptical machine quite comfortably; wiping down the handles of the elliptical machine; doing bench press exercises multiple reps with what appears to be between 100 and 150 pounds with weights on either side of the bar; assisting others putting weights on the bar and putting weights on the bar himself; doing pectoral, latissimus and core exercises with resisted bands across his body; using resistance ropes; and leaving the gym in no distress with his backpack on his right shoulder. He also viewed pictures of petitioner doing cross arm pulls; a bench press on a machine; and a supine bench press.

After reviewing the video Dr. Phillips was of the opinion that petitioner was doing heavy weightlifting, which certainly is a more feasible explanation of why he developed rotator cuff and triceps problems, but also depicts that he is functioning in a heavy capacity while in the gym. He did not think petitioner looked like an

individual who has significant pain doing heavy activities. Dr. Phillips was of the opinion that petitioner's complaints to him were not true and accurate of what he saw in the video. Dr. Phillips was of the opinion that what he saw on the video was that petitioner was working out in a heavy strenuous activity without much discomfort or disability, which was in contradistinction to what he told him during his examination. Dr. Phillips was of the opinion that patients with severe musculotendinous pathology would refrain from doing heavy capacity without obvious pain. He believed what he saw petitioner doing in the gym was not in keeping with a strengthening program for a rotator cuff. He was of the opinion that the weights petitioner was using far exceed what he would expect a person with a torn rotator cuff and triceps tendon to be performing. Dr. Phillips did agree petitioner had a small left rotator cuff tear. Dr. Phillips thought surgery would be appropriate if petitioner had pain.

On 1/29/15, 3/9/15, 5/18/15, and 9/8/15 petitioner returned to Dr. Rhode's office and was evaluated by Welke. Petitioner reported that his right shoulder was now worse than his left. No procedures were provided. Welke examined petitioner and continued petitioner's restrictions.

Petitioner last treated at respondent's medical on 5/20/15 and did not return for a follow-up visit on 8/19/15 for restriction review.

On 10/15/15 petitioner was again examined by Welke. He reported increased right elbow pain and stiffness. He noted limitations using it. He stated that he fell at work a couple months ago and reported it. He stated that he fell backwards and tripped over welding hoses and hit his right elbow on a large steel canopy as he fell. He stated that he has had right elbow pain and pain with full extension . He also reported that his left elbow epicondylitis was bothering him more. Petitioner was prescribed Meloxicam and a wrist brace for left lateral epicondylitis. An MRI of the right elbow was ordered.

On 11/18/15 petitioner presented to Dr. Rhode for his shoulder pain and elbow pain. Petitioner reported that he was doing his normal position within his restrictions for approximately 4 months. He stated that he was performing a significant amount of pushing and pulling of objects weighing between 70 and 80 pounds. He also reported that he performed a significant amount of overhead activity although he believed he was working within his restrictions. He stated that his employer told him he needs no restrictions based on a video of him at the gym. Petitioner reported that his left shoulder was improved. Dr. Rhode examined petitioner. No procedures were ordered or performed and no meds were prescribed. Dr. Rhode did not feel petitioner's workout would be outside his restrictions, and did not consider a flat bench press an overhead activity. He restricted petitioner to lifting 10-20 pounds overhead.

On 12/16/15 Dr. Rhode reviewed the surveillance videotape and believed they were within his restrictions. He was of the opinion that the video did not change his opinion that the patient requires permanency in the form of modified light medium with an overhead restriction of 10/10 pounds. He was of the opinion that these restrictions are permanent. He believed petitioner had reached maximum medical improvement. Dr. Rhode was of the opinion that since the video demonstrated petitioner was able to bench press 180 pounds no further treatment directed at the bilateral triceps tendon would improve his current condition beyond his current state.

On 3/14/16 petitioner returned to Dr. Rhode's office for followup of his shoulder pain and elbow pain and was seen by Welke. The petitioner reported that he was continuing to improve over the last couple months and that he could do more work than his current permanent restrictions were allowing. Welke examined petitioner's bilateral shoulders and left elbow. Based on his lessening symptoms and improving strength, petitioner was placed at modified medium heavy duty permanently. He was released on an as needed basis. It was noted that petitioner was not taking any medications.

On 8/22/16 petitioner underwent a repeat Section 12 examination performed by Dr. Phillips, for his bilateral shoulders and elbows. Petitioner reported that he was currently working as an electrician. Petitioner reported that he had undergone a repair of his right triceps. Petitioner reported that he was laid off from 10/20/15 through 12/20/15 and was welding a year before he was laid off. He stated that in January of 2016 he switched to a material handler position, and quit working respondent four months ago. Petitioner has worked as an electrician since then. He stated that he still notices pain in his right elbow and weakness in his right shoulder. He stated his left shoulder improved significantly with therapy and using a trainer. His right shoulder pain became intolerable. He reported no pain in his left elbow for at least a year. Petitioner reported that his current work is outside his permanent restrictions. He stated that he does a lot of overhead activities as an electrician, 8 hours a day, 5 days a week. Petitioner reported that prior to quitting respondent he worked as a welder. Petitioner reported an incident at work where he fell and tweaked his right shoulder. He stated that he had pain in his right shoulder before that, but it got worse after the fall. He could not recall when this incident happened.

Petitioner reported that when he worked as a material handler he carried parts around that weighed up to 35 pounds. Sometimes he lifted up to 50 pounds. He stated that most things he moved were light. He stated that he worked 8 hours a day, 5 days a week.

Following a record review and physical examination Dr. Phillips was of the opinion that petitioner had chronic triceps tendinopathy in his right elbow with pain. With regards to the right shoulder, petitioner had evidence of AC joint synovitis, which Dr. Phillips opined was most likely related to distal clavicel osteolysis

from heavy weight lifting. Dr. Phillips had neither symptoms nor dysfunction referable to his left elbow and left shoulder. Dr. Phillips was of the opinion that petitioner had reached maximum medical improvement. Dr. Phillips was of the opinion that petitioner required no restrictions with respect to the left elbow and shoulder. With regards to his right shoulder, Dr. Phillips assessed AC synovitis most likely related to weightlifting. With regards to the right elbow he did not feel that petitioner could work without restrictions. Dr. Phillips did not agree with Dr. Rhode's permanent restrictions, given that petitioner was able to do very heavy lifting, up to 180 pounds, in the gym. Dr. Phillips provided a 6% impairment rating for the right arm, or 4% whole body impairment rating.

On 1/10/17 the evidence deposition of Dr. Phillips was taken on behalf of the respondent. Dr. Phillips opined that petitioner's left elbow and bilateral shoulder complaints are not causally related to his work duties for respondent, based on his history and job description. Dr. Phillips was of the opinion that occupationally related rotator cuff problems are usually due to forceful heavy overhead activities of a repetitive nature. He stated that a rotator cuff does not really activate until you get to be about at the 40 to 50 degree plane in his arm, and doesn't really undergo pathological stress until you reach the horizontal, which is in line with your body. Dr. Phillips testified that petitioner told him he did not do overhead activities frequently, and his job description stated that he primarily performed activities at waist level and knee level.

Dr. Phillips opined that petitioner's left elbow condition is not related to his job duties for respondent because none of the job activities petitioner provided were typical activities that would be associated with triceps problems. He also opined that petitioner's work activities did not aggravate either his left elbow or left shoulder conditions. Dr. Phillips testified that it was so surprising to him that petitioner was so functional on the DVD and doing so much heavy lifting and heavy lifting given his exam. He opined that the activities on the DVD were consistent with the upper extremity conditions for which he was being treated for at the time the video was taken. He was of the opinion that the activities petitioner was doing on the DVD were outside his restrictions.

Currently, petitioner has continuous pain in his right elbow. He testified that his right shoulder is painful with certain movements. He does not have any real pain in his left shoulder. He noted that his left triceps bothers him from time to time. Petitioner reported pain when working and doing super heavy lifting. He testified that with certain movements he tweaks his shoulders, especially overhead activities. Petitioner stated that his right shoulder is now worse than his left. He testified that after a hard day of work he is sore. He only takes Advil for his pain.

Petitioner's chronological job history for petitioner included Fabrication Specialist 3 from 10/15/07-3/8/09; Materials Specialist 2 from 3/9/09-10/10/10; Assembly and Test Specialist from 10/11/10 - 6/24/12; Fabrication Specialist 3 from 6/25/12-2/22/15; Materials Specialist 2 from 2/23/15-3/22/15; Fabrication Specialist 3 from 3/23/15-1/3/16; and Materials Specialist from 1/4/16-6/3/16.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner is alleging injuries to his bilateral shoulders and left elbow due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 7/20/13.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case ... where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to his bilateral shoulders and left elbow, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

Petitioner alleges that he sustained accidental injuries to his bilateral shoulders and left elbow due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 7/20/13. Petitioner had alleged an accident date of 5/1/13 on his original Application for Adjustment of Claim he filed. At trial he amended his date of injury to 7/20/13. Petitioner worked for respondent from 2007 through 6/3/16. During this period petitioner was either a Fabrication Specialist 3, Materials Specialist 2, or Assembly and Test Specialist. From 2012 through 2016 petitioner only worked as a Fabrication Specialist 3 or Material Specialist 2. He did not perform the duties of an Assembly and Test Specialist.

When proving up a repetitive trauma claim it is imperative that the petitioner place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. In the case at bar this evidence was varied and inconsistent. Petitioner testified at trial that from August of 2012, when he was returned to building NN, his primary job was that of a forklift driver. He then testified that in addition to driving the forklift he performed a number of different duties. He stated that he did a lot of things including material handling.

Later in his testimony he stated that he also worked in the Heavy department, and completed a worksheet for that department. He also testified that he alternated days working in the Heavy department with his friend Luke, but did not offer into evidence any worksheets for his work in the Heavy department. He also did not call Luke as a witness to corroborate his testimony. He testified that when he worked in the Heavy department he did his own repacking and would have to lift more than 75 pounds by himself. He testified that this included overhead lifting all the time. He testified that in the Heavy department he lifted parts by hand 35-40% of the time. He also testified that he would push around the black carts for order pickers and this involved pushing and pulling with both arms.

Pacheco testified that she never knew petitioner to do any other job than forklift driver from 2012-2014. She never saw him picking individual items off the shelf for orders. She also did not recall petitioner working in the Heavy Department. She stated that if he did any material handling as part of his job, it would not have exceeded 10%, and would not be more than 30 pounds. She testified that the only time she saw petitioner in the Heavy department was to visit Luke, or go to his locker, which is located in the Heavy department. She was not aware of petitioner alternating work in the Heavy department with Luke every other day.

Petitioner's description of his job duties varied based on the histories he provided his health care providers. When petitioner first presented to Dr. Rhode on 1/15/14 for his left shoulder and left elbow, Dr. Rhode assessed a work related left shoulder rotator cuff injury secondary to his repetitive exposure while working as a welder and material handler for respondent. The arbitrator notes that petitioner had not done any

welding for respondent for years before the alleged injury, and Dr. Rhode did not have a description of the "material handler" duties petitioner was allegedly performing. Petitioner saw Dr. Phillips on 5/13/14 and told him he was welding towards the end of 2013 and noticed that his left elbow was bothering him while he was doing regular welding activities. The Arbitrator notes that from 2012 until the date of the alleged injury petitioner was not doing any welding. Petitioner himself testified that he started working for respondent in 2007, and only did welding during the first four years.

In addition to an inconsistent history regarding his actual job duties, and his inconsistent reported job duties to his healthcare providers, the petitioner's Accident/Incident reports also contain varying inconsistent information regarding the onset of his problems and the date of injury. Petitioner is alleging injuries to his bilateral shoulders and left elbow with a manifestation date of 7/20/13.

On 10/28/13 petitioner filed an incident report stating that his left arm and elbow had been giving him trouble for three months, or maybe four, and was not getting better. On the same report, in response to a different question he complained of left elbow pain that started 2 months ago. Whether 2, 3, or 4 months ago, the petitioner did not attribute it to any particular incident.

When petitioner filed his Application for Adjustment of Claim on 11/12/13 he alleged right elbow and left arm injuries while assembling a tractor. There was no mention about the left elbow or left shoulder. He identified the date of accident as 5/1/13. He did not provide this accident history to any healthcare provider. It was not until trial that the date of accident was amended to 7/20/13.

On 12/16/13 he filed another incident report stating that he was driving a standup forklift and started feeling pain in his left shoulder, which was getting worse. He identified the onset of the pain as 2 weeks ago, or approximately 12/2/13. He reported that his normal job duties of turning the steering wheel of the forklift and intermittent lifting of materials aggravated his injury. At that time he identified his job duties as forklift driver for 2 1/2 years, with some intermittent lifting of materials. There was not mention of any work in the Heavy department, or welding. He reported that he drove a forklift 90% of the time and did material handling the remaining 10% of the time. Pacheco testified that petitioner first reported a left shoulder injury to her at the end of 2013.

When petitioner testified regarding his consolidation job, he stated that he would move items to place in boxes varying from knee to waist height for 1-2 hours a day. He stated that he only occasionally lifted a box to shoulder level. He did not mention at that time any overhead lifting.

The first documented mention of any right shoulder complaints was not until 11/5/14 when petitioner reported to Dr. Rhode that he continues to experience right shoulder pain. After this date, petitioner's complaints regarding his right shoulder increased.

In addition to the inconsistencies in job duty histories, and accident date histories, the arbitrator finds it significant that in addition to working for respondent, petitioner was a weightlifter, and did extensive weight lifting. When petitioner was to be on restricted duty, as ordered by Dr. Rhode, he was videotaped at Planet Fitness gym doing multiple reps of bench press exercises with weights that appear to be between 100 and 150 pounds. He was also seen strenuously using the elliptical machine, and placing weights on the bars for other patrons. Petitioner also had no difficulty doing pectoral, latissimus and core exercises with resisted bands across his body, and using resistance ropes without difficulty.

Based on the above as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an injury to his bilateral shoulders and left elbow due to repetitive work activities that manifested itself on 7/20/13. The arbitrator finds the petitioner has failed to place into evidence specific and detailed information concerning his work activities, especially as it relates to the frequency, duration, and manner in which he performed them. Additionally, the arbitrator finds the petitioner failed show how 7/20/13 was the date on which a connection between his alleged injury and his work activities would have been readily apparent to a reasonable person. In fact, the arbitrator finds there is no credible evidence to support a finding that 7/20/13 was the manifestation date, especially given the fact that petitioner did not amend his date of injury to 7/20/13, from 5/1/13, until trial. Lastly, given the fact that the petitioner has failed to place into evidence specific and detailed information concerning his work activities, especially as it relates to the frequency, duration, and manner in which he performed them, the arbitrator finds Dr. Phillips and Dr. Rhode also did not have had a detailed and accurate understanding of the petitioner's work activities, which is imperative when trying to prove a repetitive injury by a preponderance of the credible evidence.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury due to repetitive work activities for respondent that manifested itself on 7/20/13, the arbitrator finds these remaining issues 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)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Matthews,

Petitioner,

vs.

NO: 13 WC 37823

City of Springfield,

17IWCC0549

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 all of the issues, and being advised of the facts and law, modifies the Decision of the Arbitrator by reducing Petitioner's permanent partial disability award from a 15% loss of the use of each hand to a 10% loss of the use of each hand. The Commission replaces the analysis of Issue L with the below. The Decision of the Arbitrator, which is attached hereto and made a part hereof, is affirmed and adopted in all other respects.

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

For accidents occurring after September 1, 2011, the Commission must look to the five factor test in determining permanent partial disability. As to the first factor, an impairment rating was rendered by Dr. Lawrence Li at the request of Respondent. Dr. Li rendered an impairment rating of 1 percent whole person impairment per hand, for a total of 2 percent whole person impairment. RX2, p. 21. No contrary impairment rating evidence was presented. However, Dr. Li agrees that impairment does not equal disability. RX2, P.13. The Commission gives some weight to this factor, in Respondent's favor.

As to the second factor, nature of employment, the Commission notes that Petitioner secured a position with Respondent's traffic and metering department, and he testified that the new position imposes lesser and fewer physical demands. He continues to use many of the same tools, albeit on thinner wires that require less force, but he also continues to perform grasping and gripping work that triggers hand weakness or fatigue. The Commission places some weight on this factor, in Petitioner's favor.

17IWCC0549

On the third factor, Petitioner was 44 years old on the date of the accident. He has a significant number of working years ahead of him, and through those he will endure ongoing limitations in grip strength. The Commission places significant weight on this factor, in Petitioner's favor.

On the fourth factor, there is no evidence that this injury will affect Petitioner's future earning capacity. The Commission places some weight on this factor, in Respondent's favor.

On the fifth factor, the only treatment record corroborating Petitioner's disability is a final office note from Dr. Greatting noting left-side tenderness. The Commission places slight weight on this factor, in Respondent's favor.

In total, based on the above factors, the Commission finds that Petitioner has suffered a 10% loss of the right hand and a 10% loss of the left hand as a result of bilateral carpal tunnel syndrome. Respondent is ordered to pay Petitioner $721.66 per week for a period of 38 weeks, as provided in section 8(e) of the Act for a 10% loss of the right hand (19 weeks) and of the left hand (19 weeks)."

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 5/6/16 is modified as described herein, and to reflect Petitioner's permanent partial disability award for 10% of the loss of the use of each hand, or $721.66/week for 38 weeks.

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

DATED: SEP 7 - 2017
o:8/2/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MATHEWS, WILLIAM
Employee/Petitioner

Case# **13WC037823**

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0549

On 5/6/2016, 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 0.39% 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

17IWCC0549

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

William Matthews
Employee/Petitioner

Case # 13 WC 037823

v.

Consolidated cases: _____

City of Springfield
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 **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **March 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 **October 13, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$86,087.04**; the average weekly wage was **$1,644.52**.

On the date of accident, Petitioner was **44** years of age, married with **1** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,103.68/week for 8 and 6/7 weeks, commencing June 3, 2014 through August 4, 2014, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 3, directly to the providers, according to the fee schedule, as provided in Section 8(a) of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week (maximum rate) for 28.5 weeks, because the injuries sustained caused the 15% loss of the right hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week (maximum rate) for 28.5 weeks, because the injuries sustained caused the 15% loss of the left hand, as provided in Section 8(e) of the Act.

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

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

Edward Lee

Signature of Arbitrator

5/3/16

Date

MAY 6 - 2016

FINDINGS OF FACT

Petitioner, a 46 year old high school graduate, has worked for the Respondent since 1995. He was initially hired as a pre-apprentice and moved into a four-year apprenticeship program a year later. Since completing the apprenticeship program, Petitioner has worked as a journeyman lineman for the Respondent.

Petitioner was presented with Petitioner's Exhibit 2, which is a job description from the Respondent for a journeyman lineman. Petitioner testified that his job as a journeyman lineman varied from day to day. He would climb poles, frame cross arms, set poles, hang transformers, and install duct banks in ditches for underground wire. There were a number of different tasks that he performed. Upon reviewing Exhibit 2, Petitioner agreed that he "operates various equipment such as a digger derrick,... trenches, backhoes, crane, etc." He agreed that approximately 20 percent of his time was spent using this type of equipment, although it varied from day to day. He further agreed he was required to "assembled and disassemble, inspect and maintain, various types of electrical material or equipment in high places, below ground level, at ground level or within confined spaces." He agreed that these tasks encompassed 35 percent of his time. Petitioner agreed that he operates electric hand tools and gas powered tools including "drills, saws, tamps, etc." as well as operates "various pneumatic and hydraulic tools, including boring equipment, jackhammer drills, saw, tamps etc." and "heavy construction equipment." PX 2.

Petitioner further agreed that his job requires him to exert up to 100 pounds occasionally or 50 pounds frequently, push, pull, lift, reach on a regular basis, and further requires the ability to grasp heavy construction tools but to perform precise intricate work. When asked if his job required him to use the "upper extremities to press with steady force in order to thrust forward, downward or outward" 5 percent of the time, the Petitioner testified that he did perform those activities, but that 5 percent was probably low. He further testified that 5 percent was too low for the amount of time he spent "using the upper extremities to exert force in order to draw, drag, haul or tug objects in a sustained motion" noting "we do that quite a bit." He did agree that "picking, pinching, typing or otherwise working primarily with the fingers" was performed 15 percent of the time and "applying pressure to an object with the fingers and palm" or grasping, was performed 80 percent of the time. Petitioner agreed with the job description that his job was very heavy work, described as "exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects." PX 2.

Petitioner was next presented with Petitioner's Exhibit 4, which is a set of photographs of tools of Petitioner's trade. The first photograph Petitioner identified as depicting himself using a bypass cutter while wearing leather cowhide gloves. Petitioner testified that he always wears gloves when using this tool to protect his hands from cuts, scratches and scrapes. He testified that wearing the gloves makes using the tool more difficult. He testified the bypass cutter is used for cutting soft drawn type materials such as soft copper or aluminum. Petitioner brought both a bypass cutter and standard #2 copper with him to arbitration and demonstrated the use of the bypass cutter. He testified the force required for his demonstration was "quite a bit." Petitioner testified that he uses a bypass cutter when making up underground or subdivision transformers. PX 4.

Petitioner identified the second photograph as a chain saw. Petitioner testified that he would use a chain saw during storms if branches or trees fell down and he had to clear the trees to re-establish the electrical line. Further, around the time he first sought treatment for his accident, Petitioner had been assigned a lot of tree trimming duties as his other work was slow. He noted his tree trimming duties began in July of 2013 and he was using a chain saw daily up until he first sought treatment in October 2013. Petitioner testified that as the day would progress using a chain saw, his hand symptoms would get worse. The vibration of the chain saw would make it difficult for Petitioner to hold the saw and his symptoms would carry over into the evening. He would wake up at night "with my hands like blocks." He described the sensation as numbness. PX 4.

The third photograph depicts a jackhammer. Petitioner testified that he used a jack hammer for work. In the Spring of 2013, he had used a jackhammer to dig through 4 feet of concrete to expose a duct bank, or "back bone wire" that is run under businesses. He testified that this was a three to four hour job and that after using the jackhammer he noticed weakness in his hands and he had a hard time "getting off the device." PX 4.

The fourth photograph depicts a 200 amp load break elbow and a distribution wire. Petitioner brought a piece of the distribution wire with him to arbitration. He testified that the distribution wire runs underground through subdivisions and businesses to feed transformers. The center of the wire was 1 ot aluminum, which in the photograph is being cut with a pair of ratchet cutters. The aluminum center was covered with insulation, a semi conductive layer, a copper neutral, and finally the outer jacket. Petitioner testified that the wire was "not easy" to cut through and noted "there is some restriction to it." Petitioner further noted that he uses the ratchet cutters depicted in the photograph to cut the distribution wire when he has limited space, such as when he is in a ditch or reaching into an energized transformer. Other times, he is able to use long handled tools. PX 4.

Petitioner further noted that in photograph four he is wearing 20,000 volt rubber gloves. He testified that he wears these gloves any time he is around active electricity to prevent electrocution. He testified his tools are more difficult to use when wearing the gloves. He testified that the rubber itself has to be flexed along with the tool and places the hand in a position where he has to manipulate the fingers. PX 4.

Additionally, when installing an elbow, Petitioner testified that he has to skin back the outer jacket of the wire using a knife. He then must cut back the semi conductive layer and take it down with needle nose pliers. He then has to score it, twist it, and get the semi conductive layer off. Petitioner brought a pair of needle nose pliers with him to arbitration and demonstrated the above. He testified it takes a little bit of force because he has to get the conductive layer peeled back and it sticks to the side. Petitioner testified that once this task is done, he has to cut the insulation off with a skinning knife and crimp on a lug.

The fifth photograph is a ratchet wrench with a 5 point socket, which Petitioner testified is used for opening transformers and secondaries for house services, disconnects and reconnects. Petitioner testified that force is required in the use of the ratchet wrench on secondary connections because if they are not tight the connection will not work correctly. PX 4.

The sixth photograph depicts a skinning knife. Petitioner testified this tool is used to cut back layers on wire in order to make connections. PX 4. Petitioner identified a supporting wire, which has a steel core and holds the weight of the wire. He testified he cuts through the supporting wire with lineman's pliers or bolt pliers. He brought lineman pliers, or Klein's pliers, with him to arbitration. Petitioner testified that if he is out in the open, he would use bolt pliers to cut the wire, but if he was in a hot secondary, he would have to use the lineman pliers. He demonstrated cutting the supporting wire with the lineman pliers, which caused parts of the steel wire to break off and scatter across the room. Petitioner testified that using the lineman pliers to cut through the supporting wire requires "a tremendous amount more" force than using bolt pliers.

The seventh and eight photographs were identified as Petitioner's rubber gloves and a socket wrench, respectively, which had already been discussed. The ninth photograph is a bayonet tool, which is used to tighten a probe on the 200 amp elbow. The tenth photograph was identified as a #2 triplex wire. PX 4.

The eleventh photograph was identified as a 350 backbone wire, used in heavy load areas. PX 4. Petitioner testified that he cuts these wires with three foot arm slicers and sometimes battery cutters. He testified that cutting through the 350 backbone wire requires pulling the wire into his chest or putting it on the ground and putting his body weight behind it. The twelfth photograph was identified as channel locks, which Petitioner

testified are used to tighten down bolts on cross arms and insulators. PX 4. Petitioner testified that the use of the channel locks requires forceful gripping of the hand. The thirteenth photograph was identified as Klein's or lineman's pliers, which Petitioner testified are used for gripping and cutting cable. PX 4.

The fourteenth photograph was identified as a hand ratchet cutter. PX 4. Petitioner brought a hand ratchet with him to Arbitration. Petitioner testified he used the hand ratchet cutter for cutting wire in confined spaces, in areas large cutters cannot reach, or energized areas where larger cutters are not safe. Petitioner demonstrating cutting a 1 ot concentric wire, which he identified as photograph fifteen. He described that he wrapped the jaws of the ratchet cutter around the wire, which makes it into a ratchet mechanism. He then began squeezing the ratchet with one hand, and shifted to two hands as the conductor got tougher as it cut. Petitioner testified that he used the hand ratchet cutter on a regular basis, as he usually works inside of transformers where the big slicers will not fit.

Petitioner identified that sixteenth photograph has his winter mittens, which are thicker than his usual protective gloves and are used in cold weather. PX 4. Petitioner testified wearing these gloves makes using his tools more difficult. He identified the seventeenth photograph as his standard leather Kunz gloves, which he uses for climbing poles which prevent splinters. PX 4.

On October 30, 2013, Petitioner presented to his primary care physician, Dr. Larry Sapetti, at Springfield Clinic. PX 3. Petitioner testified that leading up to his visit with Dr. Sapetti, he had been tree trimming at work, which included running a chain saw and pole saw. Petitioner complained of numbness and tingling in his bilateral hands, right greater than left, that caused him to wake up at night. PX 3. Petitioner reported it had become bothersome at work the day before while he was trying to get a little nut on a bolt. PX 3. At that time, his hand was in an awkward position, it was going numb, and it was bothersome. PX 3. Petitioner noted that he is a lineman for the Respondent and that the condition of his hands had been an ongoing problem. PX 3. Physical examination revealed an instant positive Tinel's sign on the right and a positive Tinel's sign on the left after three taps. PX 3. Flexion of the wrists was bothersome. Dr. Sapetti recommended Petitioner use a right cock-up splint. PX 3. He further noted that if the splint did not help, Petitioner would require an EMG and surgical referral.

Petitioner testified that the splint helped with the numbness, but he was still having problems at work with weakness. Petitioner testified his symptoms would flair up during tree trimming times.

On December 16, 2013, Petitioner underwent an EMG/nerve conduction study with Dr. Claude Fortin upon referral by Dr. Sapetti. PX 3. The EMG/nerve conduction study showed left median neuropathy at the wrist, mild in nature and neuropraxic in type. There was no electrophysiologic evidence for right median neuropathy or alternate right sided neurologic lesion. PX 3. Dr. Fortin opined that Petitioner's symptoms were suggestive of carpal tunnel syndrome with corresponded to the left median neuropathy. PX 3.

Petitioner presented to Dr. Mark Greatting on January 30, 2014. PX 3. Dr. Greatting testified via his evidence deposition, which is entered into evidence as Petitioner's Exhibit 5. Dr. Greatting is a board certified orthopedic surgeon with added qualifications in hand surgery. PX 5, p. 7. The focus of Dr. Greatting's practice is upper extremity problems and approximately 15 to 20 percent of his practice constitutes treatment of carpal tunnel syndrome. PX 5, p. 7. Petitioner noted hand complaints, right more bothersome than left. PX 3. Petitioner noted that the numbness and tingling in his hands worsened with increased activities. He further noted that his symptoms were worse at night. PX 3. Petitioner reported that he had worked for Respondent as a lineman for 19 years, working primarily in the underground department. He reported that his work involved peeling back the insulation on wires. PX 3. He used lineman pliers, needle nose pliers, channel lock pliers, wrenches, and impact guns. PX 3. Petitioner further reported that the operated bucket trucks and used hydraulic tools. PX 3. He also

performed shoveling and used jackhammers and chainsaws for tree trimming activities. PX 3. He reported using a chainsaw in December after an ice storm and noting increased symptoms in his hands after using the chainsaw for a period of time. PX3. Dr. Greatting testified that he has treated at least thirty linemen for the Respondent in the past, and is acquainted with their job duties and job descriptions. PX 5, p. 8-9. Dr. Greatting testified that the job description provided by the Petitioner and the description of the tools he used was consistent with his understanding of the job duties of a lineman. PX 5, p. 20.

Dr. Greatting performed an examination, noting positive Tinel's, Phalen's, and compression tests over both carpal tunnels. PX 3. Dr. Greatting diagnosed Petitioner with bilateral carpal tunnel syndrome, noting that Petitioner's history and exam findings were consistent with the diagnosis. PX 3. Dr. Greatting recommended Petitioner undergo a corticosteroid injection to the right carpal tunnel, as it appeared to be the most symptomatic. PX 3. The injection was performed in Dr. Greatting's office that day. PX 3. He further recommended continued splinting of the right wrist at night and recommended Petitioner begin splinting the left wrist at night as well. PX 3. Dr. Greatting stated in his office note "based on the patient's history, including his work history and medical history, I feel his work activities have caused, contributed to the development or aggravated or accelerated the symptoms of his bilateral carpal tunnel syndrome." PX 3.

Dr. Greatting testified that Petitioner does not have any chronic illnesses that are causative or contributory to the etiology of carpal tunnel syndrome. PX 5. p. 15. He agreed that Petitioner is obese, but testified that he did not believe obesity causes carpal tunnel syndrome. PX 5, p. 18. Dr. Greatting testified that obese patients do have higher incidence of development of carpal tunnel syndrome. PX 5, p. 18. While Dr. Greatting agreed that Petitioner's condition could be idiopathic, he testified "I think it's more likely than not caused or related to his work activities." PX 5, p. 56.

At his deposition, Dr. Greatting was presented with Petitioner's Exhibit 2 (also Deposition Exhibit 2), the job description of a lineman. He was further presented with photographs of Petitioner's tools, which he identified as a jack hammer, "large pliers", a chain saw, a tool gripped with both hands, and a socket wrench. PX 5, p. 27-28. Dr. Greatting testified that assuming the job description in Exhibit 2 was accurate, the job description recorded in his office on January 30, 2014 was accurate, that the photographs were an accurate depiction of tools used by Petitioner in his job, and that Petitioner had performed the job of a lineman for approximately 19 years prior to presentation, it was his opinion within a reasonable degree of medical certainty that the Petitioner's position with Respondent "either caused or significantly aggravated or accelerated his symptoms to the point where he required treatment." Dr. Greatting went on to state:

> He's a 44-year-old male who is otherwise healthy. The only other potential predisposing factor he has is obesity. So I would say it's pretty unusual for a healthy, 44-year-old male to develop bilateral carpal tunnel syndrome for not - - for no known reason, and the only reason I can find or indicate that he would develop it would be related to his work.

Dr. Greatting further found it significant that Petitioner provided a history that his symptoms became worse when he was performing his work activities. He testified this history indicates that the work activities are making his symptoms worse.

Dr. Greatting further testified that use of gloves when working with tools would require more force to be used with the hands to perform the same work. PX 5, p. 42. While Dr. Greatting agreed that Petitioner did have varied activities and changed tools throughout the day he testified "if you're using different tools and you're still doing the same type of motions and activities, then it doesn't matter if it's a different tool. You're still doing the same thing." PX 5, p. 49.

Petitioner testified that he wore the recommended splints at night, which helped while he was wearing them. However, he continued to have symptoms during the day.

On March 13, 2014, Petitioner returned to Dr. Greatting, noting he had received significant symptom relief in his right wrist for about a week post injection, but that his symptoms had subsequently returned. PX 3. Examination showed a positive Tinel's sign over both carpal tunnels. PX 3. At this time, Dr. Greatting recommended Petitioner undergo bilateral carpal tunnel releases four weeks apart. PX 3.

Petitioner underwent his right sided carpal tunnel release on June 3, 2014 with Dr. Greatting. Dr. Greatting testified that he chose to perform an open procedure verses an endoscopic procedure because there is more risk of injury and having an incomplete release with the endoscopic procedure and the benefits of endoscopic verses open procedure are minimal and short term. PX 5, p. 33. Interoperatively, Dr. Greatting identified narrowing and compression of the median nerve directly under the middle third of the transverse carpal ligament. PX 3. Dr. Greatting testified that the surgical findings were consistent with Petitioner's symptomology. Subsequently, on July 2, 2014, Petitioner underwent left carpal tunnel release. PX 3. Dr. Greatting similarly identified an area of narrowing and compression under the middle third of the transverse carpal ligament of the left side. PX 3.

Dr. Greatting testified that he kept Petitioner off work for four weeks after surgery for the right hand. He then proceeded to perform surgery on the left hand before returning Petitioner to work, with the expectation of a full duty release four weeks after the left hand surgery. PX 5, p. 34. Petitioner testified that he worked up until the date of his right carpal tunnel release, and used vacation and sick time to cover his time off after his surgeries. He was not paid any temporary total disability benefits by the Respondent.

Petitioner returned to Dr. Greatting on July 15, 2014. At that time, he noted the numbness in both hands had improved. PX 3. Petitioner was returned to full duty work as of August 4, 2014. PX 3. On August 27, 2014, Petitioner returned for his final appointment with Dr. Greatting. Petitioner continued to exhibit minimal tenderness on the left side. At that time, Petitioner was released from care and placed at maximum medical improvement. PX 3.

On April 21, 2014, Petitioner was seen by Dr. Mitchell Rotman for a Section 12 Examination. Dr. Rotman testified via his evidence deposition, taken on May 21, 2015. In his evaluation of Petitioner, Dr. Rotman reviewed the job description set forth in Petitioner's Exhibit 2. He noted that Petitioner performed several different activities, and some of them were more hand-intensive than others. RX 1, p. 12. He testified that "if you worked an eight-hour day and you were gripping heavily for four hours a day, I feel that that would be significant" meaning that such activity would be an aggravating factor for Petitioner's carpal tunnel syndrome. RX 1, p. 12. Dr. Rotman agreed that the Petitioner's job description indicated that 80% of his time was spent grasping. RX 1, p. 35. Dr. Rotman testified it was significant that Petitioner was 250 pounds at 5'9", noting that being overweight can cause carpal tunnel. RX 1, p. 16. Rotman agreed that Petitioner did have bilateral carpal tunnel syndrome. RX 1, p. 20. He further agreed that Petitioner required carpal tunnel release. RX 1, p. 24. Dr. Rotman noted that if the procedure was performed endosopically, the releases could be performed simultaneously; however he also noted that an open release was a reasonable and if the releases were opened they should be staged. RX 1, p. 24; p. 39.

On February 24, 2015, Petitioner was seen by Dr. Lawrence Li for an impairment rating pursuant to the AMA Guidelines 6th Edition. Dr. Li testified via his evidence deposition taken on February 15, 2016. RX 2. Dr. Li testified that Petitioner filled out an intake form for his office, on which he indicated he continues to have burning at both wrists. RX 2, p. 10-11. Dr. Li testified that this is consistent with a person who has had carpal tunnel syndrome or undergone an open carpal tunnel release. RX 2, p. 11-12. He testified that since Petitioner

has reached MMI, it would be consistent for Petitioner to continue to have burning symptoms indefinitely. RX 2, p. 12. Further, Petitioner completed a quick dash score as part of his evaluation. In the quick dash, he indicated that he had mild difficulty opening a tight or new jar. RX 2, p. 12. Dr. Li testified that this was consistent with loss of grip strength as a result of a carpal tunnel release. RX 2, p. 12-13. Dr. Li agreed it was reasonable to say that, as Petitioner has reached MMI, that the loss of grip strength will continue indefinitely. RX 2, p. 13.

With regards to the grade modifiers, Dr. Li testified that for the first grade modifier, diagnostic studies, he relied upon Petitioner's EMG to find a grade modifier one, which indicated a conduction delay, sensory and/or motor. RX 2, p. 14. With regards to the second grade modifier, he noted Petitioner had a history of intermittent significant symptoms, and assigned a grade modifier two. RX 2, p. 14.

As to grade modifier three, Dr. Li testified that Petitioner had no positive findings on physical examination in office. RX 2, p. 7. He testified that Petitioner also had no positive objective findings on his pre-surgical physical examination with Dr. Greatting. RX 2, p. 16. The 6th Edition has two modifiers for an individual with no positive findings: zero and one. Dr. Li assigned Petitioner a grade modifier of zero. RX 2, p. 15. Dr. Li testified that he gave Petitioner a modifier of zero instead of one because of the lack of positive objective findings on his pre-surgical physical examination. RX 2, p. 16. Dr. Li was unable to identify the page or rule in the guidelines that set forth the distinction between a grade modifier one and zero or any place in the guidelines that states that pre-surgical physical examination is to be used as part of the evaluation for the physical examination grade modifier. RX 2, p. 18-20. In fact, an example in the Guidelines discusses a 55 year old woman with a normal physical examination post-surgery, with no information of her pre-surgical examination findings, and she is given a grade modifier of one RX 2, p. 15-16.

Dr. Li ultimately rendered an impairment rating of 1 percent impairment of each upper extremity, for a 1 percent whole person impairment per arm, and 2 percent whole person impairment total. RX 2, p. 21. Dr. Li agreed that impairment does not equal disability and that the guidelines state as much. RX 2, p. 13.

Petitioner is currently assigned to the traffic and metering department with Respondent. He moved to this department in August 2014 after returning from his bilateral carpal tunnel surgeries. Petitioner testified that the metering position is a lot easier on the body than the journeyman lineman position that he held prior to undergoing surgery. Petitioner testified that his job duties are limited to working on traffic lights and house meters. He testified that the tools he currently uses are similar, but he works with smaller wire.

Petitioner testified that the two days prior to arbitration he had been changing out house meters and by shortly after lunch he noticed his hands were fatigued. He testified that he was having symptoms in both of his hands, but that it was worse on the right, which is his dominant hand. He noted fatigue and weakness, and noted "my grip wasn't there and I couldn't hold on to it anymore." Petitioner testified that the meters have a type of contact paste in them that seizes up that requires him to use his body weight to remove them. He testified that a few of the meters he had recently removed were "pretty tough."

Scott Schutte was cross examined by Petitioner's counsel as an adverse witness. Mr. Schutte testified that he is a maintenance supervisor. He further testified that he was a journeyman lineman for 31 years. Mr. Schutte testified that he was present during Petitioner's testimony. He was presented with Petitioner's Exhibit 2, the job description of a journeyman lineman, and agreed that it "is as close as it can be" to the job attributes and duties of a journeyman lineman. Mr. Schutte further agreed that the Petitioner accurately described the tools set forth in Petitioner's Exhibit 4 and presented at arbitration and accurately demonstrated the use of the tools in performance of the job of a journeyman lineman. Mr. Schutte agreed that the job of a journeyman lineman is hand intensive. Mr. Schutte agreed that Petitioner's testimony regarding his job duties and how he performed his job was consistent with his own knowledge of the job of journeyman lineman.

CONCLUSIONS OF LAW

Issue C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and Issue F: Is Petitioner's current condition of ill-being causally related to the injury?

After a review of the totality of the evidence, the Arbitrator finds that the Petitioner did sustain a repetitive trauma accident that arose out of and in the course of his employment with Respondent, with a manifestation date of October 30, 2013. The Arbitrator relies primarily on the Petitioner's job description, photographs of tools, and in-hearing demonstrations, coupled with the opinions and testimony of Dr. Greatting, and to a lesser extent that of Dr. Rotman.

Petitioner's job is defined by Respondent, in its own job description, as "very heavy work" which it defines as exerting greater than 100 pounds of force occasionally, greater than 50 pounds of force frequently, and/or greater than 20 pounds of force constantly. Further, the job description notes that Petitioner is performing grasping 80% of his time and fine manipulation with the fingers 15% of the time. Additionally, he is required to use electrical, gas powered, pneumatic and hydraulic hand tools, all of which place vibratory and impact forces upon his hands and arms. In fact, Petitioner testified that from July 2013 until around the time of his manifestation date, he had been using a chain saw daily. He testified as the day would progress his hands would get worse and the vibration would make the chain saw hard to hold.

Notably, Petitioner's job often requires him to work in confined spaces, where larger and more powerful tools do not fit, and around live wires, where more powerful tools are too dangerous to use. Petitioner's Exhibit 4 shows a number of the tools Petitioner uses to perform his job for Respondent. Petitioner demonstrated using a bypass cutter, which he uses to cut soft copper and aluminum wires. He demonstrated cutting a standard # 2 copper wire and testified that the cut required "quite a bit of force." Petitioner next presented a piece of distribution wire, which has a 1 ot aluminum core covered in insulation, semi-conduit, copper neutral, and an outer jacket. The Petitioner testified that wire is "not easy" to cut through, and that he has to use ratchet cutters, which he later displayed as a small hand tool, to cut the distribution wire when in confined spaces or when working with an energized wire or transformer. Petitioner further demonstrated skinning back the outer jacket of the semi-conduit and taking it down with needle nose pliers, which he testified took a little bit of force as the semi conductive layer sticks to the side and does not come off easily.

Petitioner also demonstrated cutting a supporting wire, which is a thick wire with a steel core, with lineman's pliers. He testified that he must use lineman's pliers to cut the supporting wire if he is in a confined space or in a hot secondary. When he attempted to cut the supporting wire with the lineman pliers, parts of the steel wire broke off and scattered across the room. Petitioner testified that using the lineman's pliers to cut supporting wires requires "a tremendous amount more" force than bolt pliers.

Additionally, Petitioner often works while wearing gloves; either general protective cow hide gloves, thicker cold weather gloves, or rubber gloves around life wires. Each of these gloves require the Petitioner to exert more force through his hands to use his tools properly.

Dr. Greatting, Petitioner's treating surgeon, testified that it was his opinion within a reasonable degree of medical certainty that Petitioner's job with Respondent had caused or contributed to the development or aggravated or accelerated the symptoms of Petitioner's bilateral carpal tunnel syndrome. PX 3. Dr. Greatting had a full understanding of Petitioner's job duties. He obtained a detailed description from Petitioner of his employment at his December 16, 2013 office visit. Further, Dr. Greatting has treated at least thirty journeyman lineman employed by the Respondent in the past and testified that he is acquainted with their job duties. PX 5, p.

8-9. Finally, Dr. Greatting had the opportunity to review Petitioner's Exhibit 2, which all witnesses agree represents, at least conservatively, the requirements of Petitioner's position. Dr. Greatting testified that it did not matter that Petitioner was using different tools and doing various tasks. PX 5, p. 49. He noted what was important was that Petitioner was doing the same type of motions and activities throughout the day. PX 5, p. 49.

Further, Dr. Greatting testified that Petitioner had no chronic illnesses that would cause or contribute to the development or carpal tunnel, and that while Petitioner was obese, obesity in itself does not cause carpal tunnel syndrome. PX 5, p. 18. Dr. Greatting opined "it's pretty unusual for a healthy, 44-year-old male to develop bilateral carpal tunnel syndrome...for no known reason, and the only reason I can find or indicate that he would develop it would be related to his work." PX 5, p. 56.

Even the testimony of Dr. Rotman supports a finding of accident and causation in this matter. Although Dr. Rotman opined that the Petitioner's obesity was the cause of his carpal tunnel syndrome (RX 1, p. 12), he agreed that "if you worked and eight-hour day and you were gripping heavily for four hours a day, I feel that that would be significant," indicating that such activity would aggravate Petitioner's carpal tunnel syndrome. RX 1, p. 12. Dr. Rotman agreed that Petitioner's job description indicated that 80% of his time was spent grasping. RX 1, p. 35. Based on a review of Petitioner's job description and particularly the in hearing demonstrations, the Arbitrator finds that the Petitioner's job certainly involves a large element of heavy gripping or grasping and many of the gripping and grasping jobs Petitioner performs throughout his day require a significant use of force exerted by the hands.

For the reasons set forth above, the Arbitrator finds that the Petitioner sustained an accident arising out of and in the course of his employment with Respondent with a manifestation date of October 30, 2013, the first date Petitioner presented to Dr. Sapetti and was diagnosed with bilateral carpal tunnel syndrome. The Arbitrator further finds that Petitioner's accident was causally related to his employment with Respondent.

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 that the medical services provided to the Petitioner, as set forth above and further detailed in Plaintiff's Exhibit 3, were reasonable and necessary and causally related to the Petitioner's work related accident.

The Petitioner's medical bills are set forth in Petitioner's Exhibit 6. The Arbitrator finds that all charges set forth in Petitioner's Exhibit 6 represent reasonable and necessary medical treatment that is causally related to the October 30, 2013 accident. The Arbitrator further finds that the Respondent has not paid all appropriate charges as set forth in Petitioner's Exhibit 6.

The Respondent is ordered to pay Petitioner's medical expenses, as set forth in Petitioner's Exhibit 6, directly to the providers, according to the fee schedule provided, as they represent charges for reasonable and necessary medical treatment.

Issue K: Is the Petitioner entitled to temporary total disability benefits?

The Petitioner claims that he is entitled to temporary total disability benefits for a period of 8 6/7 weeks from June 3, 2014 to August 4, 2014, which represents the period of time from his first surgery until approximately four weeks after his second surgery, at which time he was returned to full duty work by Dr. Greatting. Respondent agrees that Petitioner did miss this period of time, but disputes their liability.

As the Arbitrator finds that the Petitioner did sustain an accident that arose out of and in the course of his employment with Respondent, and that the surgical intervention provided by Dr. Greatting was reasonable and necessary, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits during his recovery from surgery. Dr. Greatting testified in his evidence deposition that he kept Petitioner off work after the first surgery, waited four weeks before performing the second surgery, and then kept Petitioner off work another four weeks before returning him to full duty work. PX 5, p. 34. The Arbitrator finds that it was reasonable for the Petitioner to be restricted from work for this period of time post-surgically.

The Respondent is ordered to pay Petitioner $1,103.68 per week for a period of 8 and 6/7 weeks, representing temporary total disability benefits from June 3, 2014 to August 4, 2014.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability. As to the first factor, an impairment rating was rendered by Dr. Lawrence Li at the request of the Respondent. Dr. Li's testimony is entered into evidence as Respondent's Exhibit 2. Dr. Li rendered an impairment rating of 1 percent whole person impairment per hand, for a total of 2 percent whole person impairment. RX 2, p. 21. However, Dr. Li failed to appropriately explain his reasoning for giving Petitioner a modifier of zero for the physical examination grade modifier, opposed to a modifier of one. The 6th Edition provide two modifiers for an individual with no positive findings: zero and one. Dr. Li gave a grade modifier of zero without providing the proper citation to the 6th edition rule that sets for the distinction between grade modifier one and zero. Further, the explanation given by Dr. Li, that he looked to pre-surgical physical examination findings, is not supported by the example set forth in the 6th edition, which gave a grade modifier of one without discussing any pre-surgical physical examination. Further, Dr. Li agrees that impairment does not equal disability. RX 2, p. 13. For the reasons set forth above, the Arbitrator gives some weight to this factor.

As to the second factor, nature of the employment, Petitioner was moved to the traffic and metering department with Respondent after returning to full duty after his bilateral carpal tunnel surgery. Petitioner testified that this position is a lot easier on the body that the journeyman lineman position he held prior to undergoing surgery and that his current job duties are limited to working on traffic lights and meters. He continues to use the same tools, but he works with smaller wires. The Arbitrator finds it significant that Petitioner was moved to a less arduous position after his surgery, where he is cutting smaller wires which require less use of force. The Arbitrator places significant weight on this factor.

With regards to the third factor, age, Petitioner was 44 years old on the date of the accident. The Arbitrator finds that the Petitioner has a significant number of working years ahead of him, during which he will endure ongoing limitations in grip strength and weakness. As such, the Arbitrator places significant weight on this factor.

With regards to the fourth factor, future earning capacity, Petitioner has returned full duty work and, although he has changed positions with Respondent, has not suffered a decrease in wages. It is not expected he will have any decreased earning capacity in the future. The Arbitrator gives some weight to this factor.

Finally, with regards to the fifth factor, evidence of disability corroborated by treatment records, the Arbitrator looks to the final office note of Dr. Greatting, dated August 27, 2014. At that time, Petitioner's left side was still minimally tender and his strength was good. PX 3. Later, Petitioner was evaluated by Dr. Li, at which time he was having burning in his wrists and trouble opening tight jars. RX 2, p. 10-11; p. 12. Dr. Li testified that these symptoms were consistent with a person who had suffered carpal tunnel syndrome or

undergone an open carpal tunnel release. RX 2, p. 11-12; p. 12-13. He further testified that Petitioner's symptoms would likely continue indefinitely. RX 2, p. 12p p. 13. The Arbitrator places significant weight on this factor.

Taking the above factors into consideration, the Arbitrator finds that Petitioner has suffered a 15% loss of the right hand and a 15% loss of the left hand as a result of his bilateral carpal tunnel syndrome. The Respondent is order to pay Petitioner $721.66 per week for a period of 57 weeks, as provided in Section 8(e) of the Act, representing a 15% loss of the right hand and a 15% loss of the left hand.

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 Reconsider and Petitioner's Petition for Penalties.

Facts

1) This matter was originally heard by the Arbitrator on January 15, 2016.
2) The Arbitration Decision was filed on March 9, 2016.
3) 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.
4) 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.
5) On January 19, 2017 Respondent filed its Motion to Reinstate Petition for Review and Dismiss Petitioner's Petition for Penalties.
6) A hearing was held before Commissioner DeVriendt on March 7, 2017, on Respondent's Motion to Reinstate Petition for Review and to Dismiss Petitioner's Petition for Penalties.
7) On July 19, 2017, the Commission (with one Commissioner dissenting) denied Respondent's Motion to Reinstate and Respondent's Motion to Dismiss Petitioner's Petition for Penalties.
8) On August 9, 2017, Respondent filed its Notice of Intent to File for Review in Circuit Court.
9) On August 11, 2017, Oral Arguments were held before the Commission regarding Respondent's Motion to Reconsider and Petitioner's Petition for Penalties. A record was made.

The issue as to whether to reinstate Respondent's Petition for Review is pending before the Circuit Court. That issue is duplicative to, and impacts matters currently pending on Review. The Circuit Court's decision may render a decision by this Panel moot, therefore the Commission stays the matters heard before it on August 11, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Reconsider is stayed pending the ruling from the Circuit Court.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties is stayed pending the ruling from the Circuit Court.

DATED: SEP 12 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
R: 08/11/17
49

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

Jamie Kovar,
Petitioner,
vs.

NO: 14WC 6174

South Berwyn School District #100,
Respondent.

17IWCC0539

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent, herein and notice given to all parties, the Commission, after considering the issues of accident, wages 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 October 17, 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.

SEP 6 - 2017

DATED:
MJB/bm
o-8/22/17

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOVAR, JAMIE
Employee/Petitioner

Case# **14WC006174**

SOUTH BERWYN SCHOOL DISTRICT #100
Employer/Respondent

17IWCC0539

On 10/17/2016, 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 0.49% 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:

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

0863 ANCEL GLINK
ROBERT K BUSH
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)

)SS.

COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMIE KOVAR
Employee/Petitioner

Case # 14 WC 6174

v.

SOUTH BERWYN SCHOOL DISTRICT #100
Employer/Respondent

Consolidated cases:

17IWCC0539

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 13, 2016 and AUGUST 10, 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

17IWCC0539

FINDINGS

On the date of accident, **January 20, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$47,000.00**; the average weekly wage was **$1,175.00**.

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

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

Respondent ***has 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**. By stipulation, Respondent is entitled to a credit under Section 8(j) of the Act for medical benefits paid and Respondent shall hold Petitioner harmless from same.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$783.33/week** for **12 weeks**, commencing **January 21, 2014** through **April 14, 2014**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 21, 2014** through **April 14, 2014** and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner the gross reasonable and necessary medical services of **$73,235.37**, subject to Sections 8(a) and 8.2 of the Act. By stipulation, 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 **$705.00/week** for **64.50 weeks**, because the injuries sustained caused the **30%** loss of use of **left leg** pursuant to §8(e)12 of the Act.

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

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

17IWCC0539

Signature of Arbitrator

10-14-2016
Date

OCT 17 2016

FINDINGS OF FACT

Jamie Kovar ("Petitioner") alleged injuries arising out of and in the course of her employment on January 20, 2014 with her employer, South Berwyn School District #100 ("Respondent"). Px1. On June 13, 2016 and August 10, 2016, the parties proceeded to arbitration on the following disputed issues: accident, causal connection, Petitioner's earnings, liability for unpaid medical bills, temporary total disability and nature and extent of the injury. Ax1. Prior to the start of hearing, the attorneys clarified that this matter involved Petitioner driving from her home to an offsite Institute Day meeting and suffering a slip and fall on a public way resulting in a fracture. Petitioner's counsel asserted his client was a traveling employee on the date of accident. The parties further clarified that most bills were paid by group and that if found compensable, it was agreed Respondent would be entitled to a credit for medical benefits paid by Blue Cross Blue Shield and Petitioner would be entitled to be held harmless for same.

Petitioner testified she worked as a special education teacher for Respondent at Pershing School. Her yearly salary was approximately $47,000.00 for the 10 months during the school year that she worked and that her average weekly wage was about $1,160.00. Her duties included adapting a curriculum to students with special needs and attending teachers' Institute Days. She was not normally required to travel from school to school as Pershing School was her principal place. Regarding the Institute Days, she stated this was something she was used to attending and they consistent of professional development of teachers designed to assist in furthering the knowledge of professional practices and researched based curriculums. She stated a normal school day is 7:50am to 3:00pm. Petitioner stated that originally, Institute Day was scheduled for January 6, 2014 and was to start at 7:50am and end at 3:00pm at Heritage Middle School. On January 5, 2014, Marilyn McManus ("McManus") sent an email to Petitioner and others reminding that buses would be picking up at each teacher's perspective homeschools at 7:30am. Jx1. McManus advised to think twice before driving and trying to park. It further notified of the buses will be dropping off and picking up at the door thereby reducing walking through the cold, snowy streets and sidewalks.

The Institute Day scheduled for January 6 did not take place due to bad weather. On January 13, 2014, there was a district collaboration meeting where the rescheduled Institute Day was to be discussed. The meeting disclosed that Institute Day was rescheduled for Martin Luther King Day. That same night, Petitioner stated that McManus emailed Petitioner and others expressing dissatisfaction in the teachers' response to the date chosen as it was a Holiday and perhaps personal plans had been made. The email indicated that if someone did not wish to attend the Institute day for January 20th they may do so and record the absence of sick or personal without any required documentation. Px9. Then, on January 14, 2014, Adrianna Caballero ("Caballero") sent an email informing teachers that the make-up date for the Institute Day was January 20, 2014 and that members were free to take a sick day for previously scheduled doctor's appointments or a personal day subject to notification. Px10. On January 16, 2014, McManus sent another email notifying teachers, including Petitioner, that buses would begin picking up at home schools at 7:30am. Jx2.

Petitioner testified that on January 20, 2014, she did not take the school bus from Pershing to Heritage because it was closer for her to simply drive from home directly to Heritage. On that morning, she left home around 7:35am, droving approximately 10 minutes to Heritage Middle School. The parking lot for the school was full so she parked around the corner from the lot that the school provides. Petitioner stated that where she parked was a public street adjacent to a public sidewalk. She parked her car, exited on the street side and walked to the corner where the sidewalk begins. She wore gym shoes. She noted other teachers were also walking. Petitioner stated that she then slipped and fell on a patch of ice. Teachers rushed to help and Petitioner could not get up. An ambulance was called and she was taken to Loyola.

On January 20, 2014, Petitioner presented to Loyola's emergency department via Berwyn Fire Department. Px3:23. Petitioner related that she had fallen on the ice and was positive for pain and limited movement of the leg. She also complained of left hip pain and noted that she heard a pop when she fell. X-rays determined that Petitioner suffered a left hip fracture and an orthopedist was notified. Petitioner consulted with Dr. Tim Schnettler, who noted Petitioner had a past medical history significant for lupus, chronic steroids with current left groin pain following a mechanical fall on ice and landing directly on the left hip. It was noted that she may need further workup as to why a young otherwise healthy female had a hip fracture. The doctor opined that Petitioner was suffering from a left intertrochanteric femur fracture that would benefit from operative fixation.

On January 21, 2014, Petitioner underwent and Dr. Summers performed a left femur intramedullary nailing for her intertrochanteric femur fracture. Px3:49. Pre and post-operative diagnosis was left displaced intertrochanteric femur fracture with sub-trochanteric extension. Intraoperatively, the doctor noted significant displacement of the intertrochanteric left femur fracture. On January 22, 2014, Petitioner underwent occupational therapy assessment.

On February 5, 2014, Petitioner followed up at Loyola. She was on Norco for pain and aspirin daily for DVT prophylaxis. On exam, she was able to fully extend her knee and had the ability to flex the knee to 90°. She had no pain with internal or external rotation about the hip. The plan was for suture removal and to continue to remain at 30 pounds touchdown weight-bearing on the left lower extremity. Additional follow-up with Dr. Summers was ordered.

On March 3, 2014, Petitioner followed up with Dr. Summers. She was able to flex her hip but with 3 out of 5 muscle strength. There was no pain with internal or external rotation she was neurovascularly intact. Imaging studies demonstrated stable fixation with intramedullary nail with no signs of collapse. The plan was to begin a partial progressive weight-bearing plan to transition off crutches. She was to continue Tylenol as well as follow-up.

On April 14, 2014, Petitioner returned to Loyola in follow-up. She was fully weight-bearing but admitted to having some weakness toward the end of the day in her hip strength been primarily affected. She wished to continue physical therapy for strengthening. She denied numbness, tingling or groin pain. On exam, gait was relatively smooth although when taking large steps it was noted she had evidence of a Trendelenburg gait. She had good sensation and motor function throughout the left lower extremity. Her abductor strength was 4/5 on examination. X-rays demonstrated stable fixation of the nail in the left femur. There were no broken screws in her fracture was healing and in a stable position. The plan was for physical therapy to focus on gate training, strengthening and abductor strengthening and stretching. She was released to return to work during the new school year. If she wished to return before the school year was over, she was to follow up. Otherwise follow-up was scheduled for three months.

On April 18, 2014, Petitioner presented for physical therapy. On gait analysis, it was noted that she was full weight-bearing on both the right and left side without assistive device. She had decreased step length on the left side, decreased stance on the left side and decreased push off on the left side Trendelenburg gait pattern was positive and it was noted she had a left lateral trunk lean. The plan was for additional physical therapy.

On July 7, 2014, Petitioner followed up at Loyola. She was walking without assistive device. She denied significant pain with weight-bearing although admitted to having some pain over the lateral aspect of her hip consistent with greater trochanteric bursitis. She was working on strengthening with her physical exist physical therapy. On exam, she displayed non-antalgic gait with stepping and had good sensation and motor function with five out of five muscle strength. She was quite tender to palpation over her greater trochanteric bursa without any signs of infection. Radiographs demonstrated well-heeled left intertrochanteric femur fracture with stable hardware. The nail was intact without any broken screws. The plan was for injection however Petitioner preferred to start a course of anti-inflammatories and see how she does. If she did not respond, Petitioner would undergo a Cortisone injection. Otherwise, she was to follow up with Dr. Summers on an as needed basis.

On July 10, 2014, Blue Cross Blue Shield notified Petitioner's counsel of an outstanding reimbursement of medical expenses indicating that he had no interest in the cause and they were free to proceed without any further concern. Px2.

On July 31, 2014, Petitioner returned to Loyola. Petitioner was still positive for trochanteric bursitis of the hip. She reported pain with walking long distances and did develop a little bit of a Trendelenburg gait. She was still tender over the greater trochanteric bursa after injection. The doctor suspected her gluteus medius was still recovering and had some weakness there. At that time, the doctor injected Petitioner in the trochanteric bursa to see if relief could be provided. The plan was for follow-up.

On August 28, 2014, Petitioner returned to Loyola for follow-up of her left intratrochanteric femur fracture. She presented complaining of continued pain in the left hip and now reported new anteromedial thigh pain just proximal to the knee. She reported she was back at school now and stated that the pain occurred when she walks up the stairs. Her hip pain occurs after exercising, walking or sitting for any length of time. On exam, she had slight tenderness to palpation over the left hip and tenderness at the distal medial thigh. Shin normal gait and normal range of motion. The plan is to continue physical therapy for iontophoresis of the hip and quad strengthening. The doctor opined that the new distal thigh pain that she was experiencing could potentially be irritation from the distal screws from her implant. The plan was for follow-up and repeat x-rays of the femur to see if the physical therapy and anti-inflammatories will help with pain before considering any sort of surgical intervention.

On September 25, 2014, Petitioner followed up with Loyola. Her current complaints included pain on the left lateral thigh as she has been working with a physical therapist to try to treat. She has had components of greater trochanteric bursitis and gluteus medius muscle weakness. Petitioner reported that her pain was worse with stairs. She denied lower extremity numbness or tingling. On exam, gait was smooth and that she had mild tenderness to palpation over the left intramedullary nail insertion site proximal to her greater trochanter. She was negative for any significant pain over the greater trochanteric bursa. She had positive mild tenderness to palpation over the proximal IT band approaching the tensor fascia lata. X-rays demonstrated well-heeled intertrochanteric femur fracture with stable hardware and no loosening screws. The plan was to continue physical therapy with modalities and strengthening of the gluteus medius muscles to help improve pain. She was to continue anti-inflammatories and was to follow up.

On October 1, 2014, x-rays of the left femur demonstrated radiographically healed fracture and very slight radio density at the central femoral head on AP view, which may represent anterior acetabular overlap. There was negative definite imaging findings of avascular necrosis (AVN).

On October 9, 2014, physical therapist at Loyola wrote to Dr. Ra-Hurka regarding Petitioners progress in physical therapy. The therapist noted that Petitioner presented with pain in the joint, pelvic region and die on the left with impairments of posture, muscle performance and gait. She has demonstrated improvements in lower extremity flexibility with minor deficits remaining and improvement in strength with hip and left extremity strength deficits remaining but improved and improvements in gate and left extremity motor control during functional tasks. Therapist noted that functional limitations included ambulating for prolonged periods, ambulating up and down hills, ascending and descending stairs and laying on the left side. Petitioner reported improvement with getting in and out of a car, performing sit to stand transfers and sleeping. She further demonstrated continued left hip irritation with high level activities and recreational activities. The therapist opined that Petitioner would benefit from continued skilled intervention by physical therapist for the impairment and functional limitations noted.

On October 30, 2014 Petitioner returned to Loyola. She continued to report chronic muscular bursitis pain which was treated with therapy, corticosteroid injection anti-inflammatories. It did not seem to be getting significantly better over time other therapy seem to improve pain and discomfort. She denied lower extremity numbness or tingling. On exam she continued mild tenderness to palpation over the insertion site adjacent to her greater trochanter with continued pain over the bursa. The plan was for Voltaren gel, physical therapy and follow up.

On December 10, 2014, Petitioner returned to Loyola for physical therapy. Therapist noted that overall the left hip was feeling better. Petitioner reported overall symptom improvement with sitting, standing, walking and sleeping. On assessment, Petitioner was able to perform five consecutive single leg squats on the left lower extremity with 4/10 pain reported. Petitioner demonstrated significantly improved left hip and knee stability with occasional queuing for core and hip stabilizer muscle activation. Petitioner's home exercise program was reviewed and upgraded. Petitioner was discharged. Overall, Petitioner attended physical therapy from April 18, 2014 through December 10, 2014.

On December 11, 2014, Petitioner returned to Loyola. The doctor noted that she along the course of pain coming from her left greater trochanteric bursa along with muscular pain in that area and at some point a component of IT band information. She previously attempted to treat with physical therapy and modalities as well as corticosteroid injection and anti-inflammatories. Petitioner reported that she was at 85% and that the primary reason she had pain or lying on her left side or sitting on her left side for prolonged periods of time she had noting this numbness or tingling. On exam she had a smooth gate and continued to have mild tenderness to palpation over the greater trochanter in the area of the nail insertion site. She had good sensation in the range of motion. The doctor found the Petitioner had exhausted all possible options for pain control and treatment. The next option would be to attempt acupuncture or to remove the nail. The doctor advised against nail removal as she would be at risk for fracture. She was given a referral to acupuncture specialist to help with chronic pain. She was to follow up on an as needed basis.

On December 31, 2014, Petitioner returned Loyola in consultation of left lateral hip pain for one year. The doctor noted that after surgery pain was improved and that Petitioner underwent therapy. The doctor further noted that pain worsened after physical therapy along her left lateral hip but she had improvement in her IT band pain at that point. Petitioner reported pain over the scar incisions along the lateral hip, dull and achy in

quality. Pain was aggravated by sleeping on the left hip, sitting for extended periods of time and getting up to stand, stairs and high-impact activities. Petitioner had attempted to proceed without relief and experience only mild improvement in pain with topical Voltaren and Advil. Previous injection to the area did not result in any improvement. On evaluation, gait was normal and non-antalgic. Surgical incisions were well-heeled without evidence of arrhythmia or swelling. She had mild tenderness to palpation over the surgical incisions over the lateral hip and mild tenderness to palpation over the greater trochanteric bursa. There was full range of motion of the hip in all planes. Faber's testing was negative. Ober's testing was positive on the left, hip strength is 3/5 with resisted hip abduction. Assessment was lateral hip pain status post intertrochanteric fracture of the femur status post fixation. The plan was for acupuncture starting with percutaneous electrical nerve stimulation with scar infiltration. Petitioner understood that it was not covered under insurance it would be out-of-pocket costs.

Petitioner confirmed that on August 15, 2014, she returned to work. She noticed difficulty using the school stairs to get to her classroom located on the 2nd floor. She also noticed extreme pain in the left leg.

Today, Petitioner testified she feels better but still has pain. She notices pain with weather changes, when it gets cold and the pain is throughout her hip area. She still cannot sleep on that side of her hip. When sitting in a certain position, it gets stiff and she will walk quite a bit to loosen up. She currently takes no prescription medications just over the counter ibuprofen. She further stated that she still cannot do the exercises, such as leg lifts for toning, she was able to do before her injury. when she does exercise, she takes meds after. Petitioner also stated that when she carries weight upstairs, she can feel the screws or hardware inside of her. There is no current plans for hardware removal.

On cross examination, Petitioner confirmed she was paid for both the cancelled and rescheduled Institute Days. She stated she has been through a number of Institute Days and that on the date in question, she chose to drive and did not ask to drive as she did not need to. Petitioner stated she was not reprimanded for driving.

Petitioner submitted a bill from Loyola University Medical Center with a balance of $0.00 for dates of service from January 20, 2014 through June 26, 2014. Px5. Petitioner submitted copies of out-of-pocket expenses incurred. Px6. There was $10 for parking at Loyola on April 14, 2014 and July 7, 2014. There was also $48.05 in monies used from Petitioner's flex spending account / health savings account at Walgreens on January 23, 2014 for a crutch. Petitioner also submitted prescriptions totaling $35.22 for 16 prescriptions given between January 2, 2014 and July 8, 2014. Px7.

Testimony of Jane Bagus

Jane Bagus ("Bagus") testified on behalf of Respondent. Bagus is the assistant superintendent for Respondent and was likely the director of special services at the time of Petitioner's accident. Bagus participated in rescheduling Institute Day and she confirmed it was decided they wanted the Institute Day rescheduled immediately. She stated arrangements made for non-attendance or attendance. She stated that the Institute Day in question was a half-day Institute Day at Heritage. She confirmed there was no prohibition or reprimand on driving one's self to the Institute Day. On cross, Bagus stated that there was also no requirement for taking a bus to Institute Day. On re-direct, Bagus stated that transportation is offered and usually teachers do not have to travel between home and another school.

Testimony of Marilyn McManus

McManus testified that she is currently the Principal of Pershing School but at the time of Petitioner's accident, she was the Director of Professional Development for Respondent. McManus has known Petitioner for 7 years

and described her as an excellent employee. She recalled the Institute Day in question and stated she organized bus drivers for teacher transportation and encouraged teachers to take buses. She stated that Heritage Middle School has one parking lot and the rest is residential area that borders the Metra train so it is difficult to find parking. McManus stated Heritage has 60 parking spots for the 380 attendees. She stated that on the day in question, Institute Day was a half-day and buses were scheduled to leave home schools at 7:30am. On cross, McManus stated there was one bus scheduled to depart Pershing School and that buses are preferred but not required.

Petitioner submitted various medical bills and out of pocket expenses alleged to be related to her injuries and for which she sought payment or reimbursement from Respondent. Px4-Px7.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner, Bagus and McManus all testified at the trial. The Arbitrator finds their testimony to be credible, forthright and believable. Further, the Arbitrator notes the testimonies appeared consistent with one another regarding the circumstances surrounding the Institute Day and the option to use school bus or personal vehicles. The parties' witnesses did differ on whether the Institute Day was mandatory or voluntary and the Arbitrator resolves this factual difference as set forth below.

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

The Arbitrator incorporates the findings of fact as though fully set forth herein. As to accident, Petitioner asserts she was a traveling employee at the time of her injuries. A "traveling employee" is one who is required to travel away from her employer's premises to perform her job. *Cox v. Ill. Workers' Comp. Comm'n*, 406 Ill. App. 3d 541, 545 (1st Dist. 2010). It is not necessary for an individual to be a traveling salesman or a company representative who covers a large geographic area to be considered a traveling employee. *Hoffman v. Indus. Comm'n*, 128 Ill. App. 3d 290, 293, 470 N.E.2d 507 (1984), *rehearing denied*, 109 Ill. 2d 194, 486 N.E.2d 889, 93 Ill. Dec. 356 (1985).

Here, Petitioner's principal place of work was Pershing School. Testimony presented by both sides established that Respondent organized and put on Institute Days and that Petitioner regularly attended them and that these were part of her duties. Testimony also established that these Institute Days usually occurred off site and away from Petitioner's principal place of work. Petitioner testified that she decided to drive from her home to Heritage Middle School rather than drive to Pershing School as the travel time was shorter. Evidence established that the decision to drive was not prohibited. Respondent introduced evidence suggesting meetings were not mandatory or otherwise required. However, the Arbitrator is not persuaded; attendees, including Petitioner, were notified that if they did not attend Institute Day, they would have been required to use personal or sick leave, suggesting to the Arbitrator that attendance was required and tied to employment. Px10. Here, Petitioner was paid for her attendance and part of her contract required her to work a minimum of 180 days in a school year. Further, Respondent's witnesses testified that it was decided the make-up Institute Day would take place immediately. Together, these facts suggest the Institute Day was required and therefore was part of Petitioner's duties. Finally, Petitioner was directed to Heritage Middle School and therefore was required to travel away from her usual principal place of work off site in order to attend the Institute Day. Put otherwise, there is no way she could have completed her Institute Day without traveling away from her normal office. In

summary, the Arbitrator finds that Petitioner's duties required her to travel off site in order to attend Institute Days. As such, she qualifies as a traveling employee.

If a traveling employee is injured, a court then considers whether the employee's activity was compensable. Injuries arising from three categories of acts are compensable: (1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his assigned duties. Considering the third category, traveling employees may be compensated for injuries incurred while performing an act they were not specifically instructed to perform. The act, however, must have arisen out of and in the course of his employment. To make this determination, the court considers the reasonableness of the act and whether it might have reasonably been foreseen by the employer. *The Venture-Newberg Perini Stone & Webster v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728, ¶ 18. In other words, conduct that "might normally be anticipated or foreseen by the employer." *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, ¶16, citing *Robinson v. Indus. Comm'n*, 96 Ill. 2d 87, 92, 449 N.E.2d 106 (1983); *Cox v. Ill. Workers' Comp. Comm'n*, 406 Ill. App. 3d 541, 545-46 (1st Dist. 2010). See also, *Howell Tractor & Equip. Co. v. Indus. Comm'n*, 78 Ill. 2d 567, 573, 403 N.E.2d 215 (1980). For a traveling employee, the determination of whether an injury occurs in an area where the general public is allowed is irrelevant, as is the "increased risk" analysis. *Love v. RGIS Inventory*, 16 IWCC 0251, 15 WC 13194 (Apr. 8, 2016). The proper analysis for a traveling employee is the reasonableness of the conduct in which the employee was engaged and whether it could be anticipated by the employer. *Id.*

Here, we deal with the third category and whether Petitioner's slip and fall was reasonably foreseeable. The Arbitrator concludes that it was. Petitioner and Respondent presented evidence that she was not required to utilize the buses provided on that date and likewise there was no prohibition on her using her own vehicle. McManus' email cautioning against using personal travel to avoid snow and ice demonstrates Respondent was aware of the possibility that teachers like Petitioner would use their own personal vehicle instead of the buses and was also aware of the potentially inclement weather affecting streets and sidewalks. McManus testified that Heritage Middle School, where the Institute Day was held, had only 60 parking spots but she expected over 300 attendees. She further stated she was aware of the parking situation near the school and noted that finding parking near there was difficult. Petitioner also testified that on before she slipped and fell, she and other teachers were parked along the street and walking toward the school. Thus, it was reasonably foreseeable teachers would not use the bus and instead use their vehicles as evidenced by Respondent's attempt to prevent same. Further, being aware of the parking situation at Heritage, it is also likely that teachers would attempt to or otherwise be forced to park on the public streets near the public sidewalks and be required to traverse same. Thus, Respondent not only was aware of these foreseeable possibilities but also acquiesced to them when it did not prohibit it in the first place. Based on the foregoing, the Arbitrator concludes Petitioner's injuries arose out of her employment.

Regarding in the course of, a traveling employee is deemed to be in the course of his employment from the time that he leaves home until he returns. Petitioner's accidental injuries were sustained in the course of her employment because, as a traveling employee, she remained in the course of her employment from the moment she left her home until the time that she returned home. Here, she was directed to travel to an offsite location for Institute Day. Accordingly, her injuries were in the course of her employment.

Respondent argues Petitioner's injuries were not sustained in the course of her employment in part because she was merely communicating from her home to work. Normally, injuries sustained while commuting from home to work are not compensable as they are not considered in the course of one's employment. Here, Petitioner

was traveling from home to an off-site location to which she was directed to by Respondent in order to attend Institute Day, for which she was paid and which was otherwise mandatory. Thus, she was not traveling from home to her normally assigned workplace. *Cf. United Airlines, Inc. v. Ill. Workers' Comp. Comm'n*, 2016 IL App 1st 151693WC (flight attendant was not in the course of her employment were she traveled from her permanent home in Denver, Colorado to her assigned base airport in New York); *Allenbaugh v. IWCC*, 2016 Ill. App. (3d) 150284WC (compensation denied where police officer injured in automobile accident while commuting from home to his normal workplace for a special meeting).

For the foregoing reasons, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her accidental injuries arose out of and in the course of her employment with Respondent.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being as it relates to her left hip is causally related to her work accident. Petitioner testified that immediately after the fall, she noticed left leg pain and had difficulty getting up and with weight bearing. She was eventually diagnosed with a left intertrochanteric femur fracture that was treated with operative fixation. Following usual post-operative care, she was diagnosed with trochanteric bursitis of the hip and a Trendelenburg gait. She continued to treat with conservative care by way of additional physical therapies, an injection into the bursa and eventual acupuncture.

The evidence established that Petitioner was in a state of good health prior to her work accident as it related to her left hip, with no prior injuries, symptoms or similar conditions. Following her work accident, there is an immediate and acute onset of pain diagnosed and treated as a hip fracture. Thus, based on a chain of events theory, the Arbitrator concludes Petitioner's current condition of ill-being as it relates to the left hip is causally related to her 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?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services provided to Petitioner were both reasonable and necessary to treat her fracture in the left hip. Respondent did not dispute reasonableness and necessity only liability. Having found in favor of Petitioner on the foregoing, the Arbitrator concludes that such medical services are causally related to her work accident and that Respondent shall be held liable for payment of same.

Petitioner submitted the following gross medical bills and out of pocket expenses in relation to her claim for payment of medical bills and liability for same:

Px4 Loyola Univ. Med. Ctr.	$58,859.38
Loyola Univ. Med. Ctr.	$14,319.00
Out of Pocket	$56.99

The record shows Petitioner underwent emergency care, pre-operative services, internal fixation and post-operative care, including medication management, physical therapy, follow up visit, an injection and

acupuncture. The Arbitrator finds such treatment reasonable and necessary to treat Petitioner's work injuries and that the tendered bills correspond to such treatment. Petitioner testified and submitted evidence that she incurred out of pocket expenses in connection with her treatment for these work related injuries. The Arbitrator also finds such out of pocket expenses reasonable, necessary and related to her treatment.

In summary, Respondent shall pay the gross reasonable and necessary medical services of **$73,235.37**, subject to Sections 8(a) and 8.2 of the Act. Because liability was disputed, Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. See, *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC. Although Respondent's group health insurance carrier, BCBS HMO, indicated it did not intend to seek reimbursement, nevertheless and by stipulation, 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. See, Px2.

ISSUE (G) What were Petitioner's earnings?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. On the request for hearing form, Petitioner's attorney wrote that Petitioner earned $46,000.00 in the year preceding her injury and that her average weekly wage was $1,150.00. Ax1. Respondent disputed the figures and demanded strict proof. Ax1.

Petitioner's unrebutted testimony was that by contract, she was required to work a minimum of at least 180 days per year, that her yearly salary was approximately $47,000.00, that she worked 10 months and that therefore here average monthly salary was $4,700.00. (T.15-16). This yields an average weekly wage of $1,175.00 but Petitioner testified she earned about $1,160.00 per week. The Arbitrator notes no contract was submitted into evidence by either party regarding Petitioner's work weeks and salary. The Arbitrator further notes that Petitioner's testimony compared to her allegations in Ax1 are different as to yearly earnings and average weekly wage. The Arbitrator resolves the conflicting information and finds that Petitioner was most credible in her statements that she earned $47,000.00 for the 10 months that she worked.

Section 10 of the Act states that average weekly wage is to be computed based on the actual earnings of the employee in the employment in which he was working at the time of the injury. Here, Petitioner's earnings as a teacher should be calculated by dividing the actual earnings by the number of weeks actually worked prior to the date of injury. *Elgin Bd. of Edu. School Dist. U-46 v. IWCC*, 409 Ill. App. 3d 943, 952, 949 N.E.2d 198 (1st Dist. 2011), citing *Washington Dist. 50 Schools v. IWCC*, 394 Ill. App. 3d 1087 (3rd Dist. 2009). Based on the record as a whole, the Arbitrator concludes that Petitioner's actual earnings were **$47,000.00** in the year preceding the injury, resulting in an average weekly wage of **$1,175.00**. ($47,000.00 ÷ 40 weeks).

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner claimed to be entitled to temporary total disability (TTD) from January 21, 2014 to August 15, 2014, representing 29-4/7th weeks. Ax1. Respondent disputed same. *Id.* Having found in favor of Petitioner on the foregoing issues and having considered the entire record, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to temporary total disability benefits for the time she was either off of work or restricted to light duty work by her treating doctors as a direct

result and consequence of her work injuries suffered on January 20, 2014. Petitioner's medical visits on January 21, February 5, March 3 and April 14, showed that Petitioner was post-surgical and demonstrate a clear inability to fully weight bear, decreased muscle strength, ongoing medication use and some evidence of a Trendelenburg gait. While the notes do not explicitly remove Petitioner from work, it is evident to the Arbitrator that she was not cleared to work and she could not work. In support thereof, the Arbitrator notes that on April 14, she was cleared to return to work full duty during the school year thus indicating she had not been cleared prior to that. She was notified that if she wished to return before the school year was over, she was to follow up. Petitioner did not testify as to when her school year ended in 2014.

Subsequently, on July 7, Petitioner again followed up for ongoing issues and was ordered to follow up as needed with Dr. Summers. Petitioner returned in the fall for trochanteric bursitis and gluteus medius muscle weakness but was never placed on any light duty restriction nor was she removed from work. The record suggests that at some time in August, Petitioner returned to her work as a school teacher as the doctor's notes reference difficulty going up and down stairs at school. Petitioner was eventually released from physical therapy in December 2014 and was later referred for acupuncture. Based on the foregoing, the Arbitrator declines to award the entire period sought by Petitioner as the requested time is not fully supported by her medical record. Additionally, the records and Petitioner's testimony suggest that Petitioner did not work over the summer period and thus to award her TTD for a time period that was neither covered by her medical records nor for which she would not have worked otherwise would yield an inconsistent result. The Commission has previously noted awards for TTD during summer break inappropriate. See, *Butler v. South Berwyn School Dist. #100*, 14 IWCC 0542, 2014 Ill. Wrk. Comp. LEXIS 586 (Jul. 8, 2014). Therefore, the Arbitrator concludes that Petitioner is entitled to TTD from January 21, 2014 through April 14, 2014, representing 12 weeks. Based on an average weekly wage of $1,175.00, Respondent shall pay Petitioner temporary total disability benefits of **$783.33/week** for **12 weeks**, commencing **January 21, 2014** through **April 14, 2014**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 21, 2014** through **April 14, 2014** and shall pay the remainder of the award, if any, in weekly payments.

ISSUE (L) ***What is the nature and extent of the injury?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to permanent partial disability. The evidence established that Petitioner last treated for her left hip on December 31, 2014. At that time, assessment was lateral hip pain status post intertrochanteric fracture of the femur status post fixation. Although Petitioner had previously been released prior to December 31, 2014, she was advised to return as needed and she did so to address ongoing hip pain. The Arbitrator finds Petitioner's left hip reached maximum medical improvement and otherwise stabilized on December 31, 2014 and relies on the medical record of Loyola in reaching this conclusion. Thus, the nature and extent of Petitioner's work related left hip is ripe for adjudication. Consistent with the Act, the Arbitrator considers the following factors and makes the following corresponding findings:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that although there is no AMA impairment rating submitted into evidence by either party with respect to Petitioner's left hip, it is but one factor to be considered and the Arbitrator is not precluded from awarding any permanency. The Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was and continues to be employed as a school teacher. Petitioner did not testify her occupation suffered as a result of the injury. She has not sought any accommodation. The Arbitrator assigns less weight to this relevant factor insofar as this factor demonstrates she is able to work in her full capacity.

With regard to subsection (iii) of §8.1b(b), Petitioner was 38 years old at the accident. Petitioner's age suggests a longer work life remaining and thus she may work with the effects of her hip injuries for a longer period of time. Her age also suggests she may feel the effects of her injuries for a longer period of time compared to an older worker. On the other hand, her age suggests she may heal quickly remain in a full work capacity longer. Overall, the Arbitrator therefore gives little weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no doctor or expert has opined Petitioner's future earnings to be impaired or that Petitioner has permanent restrictions as a result of the injury. The Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes and adopts Petitioner's treatment records from Loyola. At trial, Petitioner described feeling better but still with pain. She notices pain with weather changes and that when it gets cold, the pain is throughout her hip area. She still cannot sleep on that side of her hip. When sitting in a certain position, it gets stiff and she will walk quite a bit to loosen up. She currently takes no prescription medications, just over the counter Ibuprofen. She further stated that she still cannot do certain exercises, such as leg lifts for toning, which she was able to do before her injury. When she does exercise, she takes meds after. Petitioner also stated that when she carries weight upstairs, she can feel the screws or hardware inside of her. There is no current plans for hardware removal. Nearly all of these complaints are corroborated by Petitioner's treatment records and physical therapy visit records. The Arbitrator finds this factor the most relevant and gives the greatest weight to this factor.

Based on the above factors and the record taken as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$705.00/week** for **64.50 weeks**, because the injuries sustained caused the **30%** loss of use of **left leg** pursuant to §8(e)12 of the Act.

Signature of Arbitrator

10-14-2016
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mohammed I. Qureshi,

Petitioner,

vs. NO: 14 WC 10748

17IWCC0529

Flash Cab,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 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.

17IWCC0529

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: AUG 2 9 2017
TJT:yl
o 8/22/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

QIRESHI, MOHAMMED I
Employee/Petitioner

Case# **14WC010748**

FLASH CAB
Employer/Respondent

17IWCC0529

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1515 DWORKIN & MACIARIELLO
THOMAS GAYLE
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

4751 DEBORAH L SCHAEFFER
PO BOX 865
ELMHURST, IL 60126

17IWCC0529

☐	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

CORRECTED ARBITRATION DECISION

MOHAMMED I. QURESHI
Employee/Petitioner

Case #14 WC 10748

v.

FLASH CAB
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 17, 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 13, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, a lessor-lessee 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 $16,588.00; the average weekly wage was $319.00.
- At the time of injury, the petitioner was 47 years of age, married with two children under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $319.00/week for 10-4/7 weeks, from February 15, 2014, through April 29, 2014, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $319.00/week for a further period of 20 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 4% loss of use of the man as a whole for his low back strain and left inguinal hernia.
- The respondent shall pay the petitioner compensation that has accrued from February 13, 2014, through November 17, 2015, and shall pay the remainder of the award, if any, in weekly payments.
- The medical care rendered the petitioner for his lumbar spine and left inguinal hernia was reasonable and necessary and is awarded. 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 17, 2015
Date

DEC 22 2015

FINDINGS OF FACTS: 17IWCC0529

The petitioner, a lessee cab driver, sought medical care for back pain and sweats on February 15, 2015, with Dr. Nigam Patel. He complained of left groin pain and fever for one week. Dr. Patel noted that his physical exam was positive for a non-incarcerated left inguinal hernia and tenderness. He saw Dr. Mohamed Malas at the Advanced Medical Clinic on February 17th for lower back and left groin pain and reported experiencing immediate lower back and left groin pain lifting luggage from the trunk of his cab. It was noted that the petitioner has pus coming out of his left groin. At Advocate Lutheran General Hospital the same day, the petitioner reported back pain for three/four days starting after lifting luggage. He also reported seeing his primary medical doctor, who noted his left inguinal hernia. The diagnosis was acute low back pain and abscess in his left inguinal area. The petitioner saw Dr. Osman for his lumbar pain on February 24th and April 7th, who treated him with medication. The petitioner saw Dr. Shah at Advocate Medical Group the same day and reported feeling severe back pain lifting heavy luggage out of his trunk on February 13th and waking the next day with a swollen and painful left groin. An ultrasound on February 18th revealed a left inguinal hernia.

A lumbar MRI on March 20th revealed disc bulges from L2 through S1 and diffuse spondylosis. An EMG/NCV study on March 17th was compatible with left L4-L5-S1 radiculopathy. Dr. Shah re-evaluated the petitioner on March 24th. A CT scan of his pelvis on March 31st revealed a small left-sided inguinal hernia and spondylolysis at the lumbosacral junction. The petitioner had a left inguinal hernia repair with mesh at Advocate Hospital on April 14th by Dr. Shah. The petitioner followed up with Dr. Shah on April 21st and 30th.

FINDING REGARDING 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 he sustained an accident on February 13, 2014, arising out of and in the course of his employment with the respondent. The medical histories given by the petitioner are consistent with a lifting injury to his lower back and left groin on February 13, 2014.

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

The medical care rendered the petitioner for his lumbar spine and left inguinal hernia was reasonable and necessary and is awarded.

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 his lumbar spine and left inguinal hernia is causally related to the work injury. The petitioner's complaints, symptoms and treatment have been continuous and consistent since his injury on February 13, 2014.

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

The petitioner was unable to work and did not work from February 15, 2014, through April 29, 2014. The respondent shall pay the petitioner temporary total disability benefits of $319.00/week for 10-4/7 weeks, from February 15, 2014, through April 29, 2014, 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:

There is no AMA impairment rating or evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of some back pain with heavy lifting and on awakening. He has pain and numbness in his abdomen that is increased with movement. The treating medical records do not fully corroborate the testimony.

The respondent shall pay the petitioner the sum of $319.00/week for a further period of 20 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 4% loss of use of the man as a whole for his low back strain and left inguinal hernia.

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

Dominic Russo,
Petitioner,
vs.

NO: 14WC 14476
17IWCC0563

Illinois Dept. of Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

DATED: SEP 18 2017
MJB/bm
o-9/12/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

RUSSO, DOMINIC
Employee/Petitioner

Case# **14WC014476**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

17IWCC0563

On 10/25/2016, 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 0.47% 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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
PO BOX 6040
WOODRIDGE, IL 60517

5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOULOS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
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

OCT 25 2016

Ronetol A. Pasin
GERALD A. PASIN, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Dominic Russo
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 14 WC 14476

Consolidated cases: D/N/A

17IWCC0563

An *Application for Adjustment 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 **September 21, 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, **April, 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*** sustain an accident that arose out of and in the course of employment.

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to his claimed current post-operative right shoulder condition of ill-being. The Arbitrator also finds that Petitioner established causation as to his claimed current cervical and lumbar spine conditions and as to the need for certain conservative treatment for these conditions, as outlined in the decision. The Arbitrator further finds that Petitioner failed to establish as to his claimed left knee condition.

In the year preceding the injury, Petitioner earned **$63,072.00**; the average weekly wage was **$1,212.92**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$94,034.35** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$94,034.35**. Arb Exh 1.

ORDER

Based on the foregoing causation-related findings, the Arbitrator declines to award any medical or prescription expenses relating to left knee treatment. See pages 14-16 of the attached decision for further details concerning the Arbitrator's medical award.

The Arbitrator finds that Petitioner was temporarily totally disabled from April 15, 2014 through July 20, 2016, a period of 118 1/7 weeks, with Respondent receiving credit for the $94,034.35 in benefits it paid prior to the hearing. The Arbitrator selects July 20, 2016 as an end date for the temporary total disability award based on Respondent's binding stipulation and the Walker case. Arb Exh 1.

The Arbitrator declines to award any prospective care.

The Arbitrator declines to find Respondent liable for penalties and fees.

The Arbitrator finds Petitioner to have reached maximum medical improvement with respect to his causally related neck, back and right shoulder conditions but does not address permanency, since Petitioner elected to proceed pursuant to Section 19(b).

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

10/25/16
Date

ICArbDec19(b)

OCT 25 2016

Dominic Russo v. Illinois Department of Transportation 17IWCC0563
14 WC 14476

Summary of Disputed Issues

The parties agree Petitioner sustained an accident while working for Respondent on April 14, 2014. They also agree that Petitioner was temporarily totally disabled for a substantial period of time following that accident (with the exception of a period in late March 2015 during which Respondent contends Petitioner was in jail). Arb Exh 1. Respondent stopped paying temporary total disability benefits as of July 22, 2016, two days after Petitioner entered a plea of guilty to criminal sexual assault of a minor, possession of child pornography and unlawful videotaping of an individual under age 18. Petitioner was placed on probation after he entered this plea. RX 5. Respondent simultaneously terminated Petitioner's employment. PX 12.

In addition to temporary total disability, the disputed issues include causal connection, medical expenses and penalties/fees.

Arbitrator's Findings of Fact

Petitioner testified he began working as a sign hanger for Respondent in February 2010. T. 14. His job involved putting up signs and posts along state highways. T. 14. In the course of his work, he drove a truck and used various tools, including drills, saws and a device similar to a jackhammer. He routinely lifted very heavy wooden posts that were 12 to 14 feet long. T. 14-15.

Petitioner testified that, shortly before his accident, he pulled up to a jobsite along a four-lane highway. Traffic was very busy. T. 19. He observed a car that had stopped between his truck and another work truck to his rear. He waited a while to see whether the car would move and then decided to get out of his truck to start his assignment. As he was in the process of opening the driver's side door and getting out of his seat, the car pulled into the left lane and hit the rear of a semi. The semi then pushed the car into the rear of the truck Petitioner was in. Petitioner testified the impact caused him to be "flung forward" and then pushed back down into his seat. T. 20.

Petitioner testified he did not immediately experience pain after the accident. T. 20.

Petitioner identified PX 2 as a report he completed on the date of the accident. T. 20-21. In this report, Petitioner indicated he injured his neck and upper/lower back in the accident. Petitioner identified PX 3 as the Illinois Motorist Report concerning the accident. This report reflects that paramedics transported Petitioner to the Emergency Room at Gottlieb Memorial Hospital on the day of the accident.

The Emergency Room records set forth a consistent history of the accident. They also reflect that Petitioner reported removing his seat belt, in preparation for exiting his truck,

immediately before the impact. PX 6, p. 27. Emergency Room personnel noted complaints of 10/10 head pain and 5-6/10 upper and lower back pain. PX 6, p. 7. They noted no knee complaints and described Petitioner's gait as normal. Dr. Ahuja ordered various radiographic studies. A cervical spine CT scan showed degenerative changes and no evidence of fracture or dislocation. A CT scan of the head showed no acute intracranial process. PX 6, pp. 35-36. Petitioner was given Toradol for pain. At discharge, Petitioner was released to restricted duty, with no heavy lifting, and instructed to seek follow-up care at an occupational health facility. PX 6, p. 8.

Petitioner testified he next sought treatment on April 16, 2014. On that date, he saw Dr. Freedberg at Suburban Orthopedics. Dr. Freedberg recorded a consistent history of the accident. He indicated that Petitioner complained of very severe head pain, constant neck and back pain and right shoulder pain that had started the day after the accident. He also noted that the hospital had released Petitioner to light duty but that Petitioner was off work because no light duty was available.

Dr. Freedberg noted a history of a neck and back injury resulting from a motor vehicle accident in approximately 1997, with Petitioner reporting a 100% recovery. He also noted that Petitioner had undergone a right shoulder "pinning" procedure at age fifteen, secondary to a shoulder separation, with "no problems since." He further noted a history of right knee anterior cruciate ligament repairs in 2008 and 2009.

On right shoulder examination, Dr. Freedberg noted a reduced range of motion and positive Neer, Hawkins and Speed's tests. On neck and back examination, he noted severe tenderness and a limited range of motion. After obtaining X-rays, he diagnosed lumbar, cervical and thoracic spine strains and a right shoulder sprain with possible rotator cuff and biceps problems. He prescribed a right shoulder MRI along with gel, Protonix, Mobic, Norco, Tramadol and Flexeril. He took Petitioner off work and directed him to return in two weeks. PX 7, pp. 9 -12.

Petitioner saw Dr. Freedberg again on April 24, 2014. On this date, Petitioner complained of his left knee as well as worsening of his neck and back pain. [This is the first treatment note containing any mention of the left knee.] According to Dr. Freedberg, Petitioner indicated that he "twisted [his left knee] when he was getting out of the truck" after the accident. Petitioner also reported he had not yet undergone the right shoulder MRI.

After re-examining Petitioner and obtaining left knee and other X-rays, Dr. Freedberg again recommended a right shoulder MRI. He also prescribed a knee brace. He directed Petitioner to remain off work and return in one week. PX 7, pp. 14-19.

Petitioner returned to Dr. Freedberg on April 30, 2014 and complained of worsening head, neck, back and right shoulder pain as well as left knee pain and instability. The doctor recommended various MRI scans. He directed Petitioner to stay off work and continue using the knee brace. PX 7, pp. 20-24.

Petitioner underwent the MRIs on May 7, 2014. The cervical spine MRI showed degenerative changes and mild central stenosis at C5-C6. The left knee MRI demonstrated a small lateral effusion, no evidence of acute fracture or dislocation, intact menisci and ligaments and early degenerative changes. The right shoulder MRI showed moderate AC joint osteoarthritis, moderate to severe supraspinatus and infraspinatus tendinopathy, with high-grade, focal partial-thickness tearing of the far anterior supraspinatus tendon and diffuse degeneration but no frank tearing of the labrum. PX 7, pp. 25-28.

On May 13, 2014, Dr. Freedberg reviewed the MRI results with Petitioner. He administered a left knee injection and recommended a right shoulder arthroscopy. He referred Petitioner to his partner, Dr. Novoseletsky, and directed him to remain off work. PX 7, pp. 31-38.

Petitioner first saw Dr. Novoseletsky on June 9, 2014. Petitioner provided a history of the accident and complained of severe headaches, constant neck pain and difficulty turning his head. After examining Petitioner and reviewing the radiographic studies, Dr. Novoseletsky prescribed Norco and physical therapy. He continued to keep Petitioner off work. PX 7, pp. 39-43.

On June 11, 2014, Petitioner returned to Dr. Freedberg and complained of 7/10 left knee pain, an inability to squat, pain down the left shin, pain and weakness in the right shoulder and numbness in the right arm. He again recommended a right shoulder arthroscopy and directed Petitioner to continue wearing the knee brace and remain off work. PX 7, pp. 44-51.

Petitioner began a course of neck and back therapy at Suburban Physical Therapy on June 20, 2014.

On July 8, 2014, Dr. Novoseletsky administered prognostic medial branch blocks at C3-C5. PX 7, pp. 52-54. The following day, Petitioner reported some improvement of his neck function but only temporary relief of his headaches. The doctor again prescribed physical therapy. He directed Petitioner to remain off work. PX 7, pp. 54-59.

A therapy progress note dated August 7, 2014 reflects that Petitioner was still experiencing headaches as well as neck and back pain. The therapist recommended another four weeks of therapy. PX 7, pp. 27-28.

Dr. Novoseletsky administered additional medial branch blocks at C3-C4 on August 26, 2014, with Petitioner reporting transient improvement on August 28, 2014. The doctor recommended a third round of blocks and physical therapy. He continued to keep Petitioner off work. PX 7, pp. 60-67.

At Respondent's request, Petitioner saw Dr. Belich for purposes of a Section 12 examination on September 4, 2014. T. 25. In his report of the same date (RX 2), Dr. Belich

recorded a history of the work accident and noted complaints relative to the low back, neck, left trapezius, right forearm and right shoulder. He indicated that Petitioner described his left knee condition as "really not an issue at this point." He noted a past surgical history of a right anterior cruciate reconstruction.

Dr. Belich indicated he reviewed the Emergency Room records, records from Drs. Freedberg [starting with the April 30, 2014 note] and Novoseletsky, therapy notes and reports concerning the right shoulder, left knee and cervical spine MRIs in connection with his examination.

On examination, Dr. Belich noted a normal gait, tenderness at the LS junction and bilateral SI joints, negative straight leg raising bilaterally in the seated position, a report of back pain with straight leg raising to 80 degrees in the supine position, no left knee effusion or tenderness, bilateral trapezius and paracervical tenderness, positive Spurling's testing bilaterally with neck pain only, a 5-inch anterior scar on the right shoulder with upriding of the distal clavicle, "consistent with an old AC separation," a limited range of right shoulder motion, negative impingement testing, a slightly positive Hawkins sign, 5/5 strength and no instability.

Dr. Belich opined that the work accident resulted in the following conditions: 1) "some soft tissue type myofascial cervical and lumbar strain"; 2) a mild left knee sprain "which has resolved"; and 3) a right shoulder strain with an abnormality on MRI consistent with a partial supraspinatus tear. He found "no evidence of direct trauma to the shoulder that would be a causative factor for the rotator cuff tear on MRI." He described his right shoulder examination as showing "evidence of an old AC injury with surgery and a slightly restricted range of motion in flexion and abduction."

Dr. Belich did not find Petitioner to have reached maximum medical improvement. He recommended six to eight weeks of therapy for the neck and low back along with a steroid injection and therapy for the right shoulder. He found Petitioner capable of light duty "that would not involve any lifting or road work at least until his shoulder problems have a chance to quiet down." RX 2.

At Dr. Novoseletsky's direction, Petitioner underwent a lumbar spine MRI on September 5, 2014. The MRI demonstrated a left L5 pars defect without evidence of anterolisthesis at L5-S1, a tiny central/right disc protrusion and mild degenerative disease at T11-T12 and L2-L5. PX 7, pp. 68-69.

On September 11, 2014, Dr. Novoseletsky noted the recent examination by Dr. Belich. He also noted that Petitioner had been discharged from physical therapy the previous day due to lack of progress. He indicated that Petitioner continued to complain of neck pain radiating to his right shoulder, severe headaches and low back pain. After reviewing the lumbar spine MRI, he prescribed therapy focusing on the low back and again recommended a third round of blocks. He directed Petitioner to remain off work. PX 7, pp. 70-75.

On September 10, 2014, Petitioner's therapist recommended that Petitioner be discharged from therapy due to lack of progress. The therapist noted that Petitioner had gained 10 degrees of cervical flexion but that rotation and side bending had worsened. PX 7, p. 39.

On September 16, 2014, Dr. Novoseletsky wrote a letter "to whom it may concern" indicating that it was medically necessary for Petitioner to use a gym to perform home exercises. PX 7, p. 76.

Petitioner returned to Dr. Freedberg on September 25, 2014, and complained of worsening right shoulder pain as well as pain in his right palm and tingling in his right thumb. The doctor indicated he was awaiting Dr. Belich's report. He continued to keep Petitioner off work pending approval of the right shoulder surgery. PX 7, pp. 77-84.

On October 10, 2014, Dr. Novoseletsky noted ongoing neck, back and right shoulder complaints. He again recommended another round of blocks. He continued to keep Petitioner off work. PX 7, pp. 85-89.

On November 6, 2014, Dr. Freedberg noted complaints of increased left knee pain, with Petitioner indicating that the effects of the May injection had worn off. The doctor recommended HA [hyalourine acid] left knee injections. He continued to keep Petitioner off work. PX 7, pp. 90-96, 98.

On November 17, 2014, December 18 and 19, 2014 and January 15, 2015, Drs. Novoseletsky and Freedberg noted they were still awaiting authorization of the previously recommended injections and surgery. They continued to keep Petitioner off work. PX 7, pp. 99-126.

A handwritten note dated December 10, 2014 reflects that an adjuster contacted Suburban Physical Therapy and declined to authorize left knee therapy, stating that, "based on IME, L knee not part of WC injury." PX 7, p. 46.

On February 4, 2015, Petitioner began a course of left knee therapy at Suburban Physical Therapy, despite the dispute. PX 7, p. 51.

On February 19, 2015, Dr. Freedberg noted that Petitioner had been undergoing left knee therapy for about three weeks and reported improvement. After reviewing Dr. Belich's report, he administered a right shoulder injection and indicated he planned to hold off on further knee injections until Petitioner had completed therapy. He continued to keep Petitioner off work. PX 7, pp. 127-135.

On February 20, 2015, Dr. Novoseletsky reviewed Dr. Belich's report and noted ongoing complaints relative to the head, neck and back. He recommended a lumbar epidural steroid

injection and a third round of cervical blocks. He continued to keep Petitioner off work. PX 7, pp. 136-141.

Also on February 20, 2015, Dr. Novoseletsky issued a lengthy "rebuttal to independent medical evaluation" indicating he disagreed with Dr. Belich's diagnosis of myofascial cervical strain and soft tissue lumbosacral strain. He also indicated he disagreed with the doctor's assessment of the previously administered cervical blocks. He stated these blocks were not intended to provide lasting relief. Instead, they were indicated to "provide temporary relief only for diagnostic purposes." He again recommended a third round of blocks, noting Petitioner reported temporary relief of his symptoms following the first two rounds. He also recommended an epidural steroid injection to address Petitioner's back pain. PX 7, pp. 142-145.

On March 11, 2015, Petitioner's therapist noted that Petitioner reported being "able to do light shoveling." Petitioner was a "no show" at therapy on March 13, 18 and 20, 2015. He resumed therapy on March 31, 2015. PX 9, pp. 60-61.

On March 30, 2015, Dr. Freedberg noted that Petitioner reported missing his last two appointments with Dr. Novoseletsky "due to personal issues." The doctor also noted that Petitioner described his neck, low back, shoulder and left knee pain as unchanged. He further noted that Petitioner complained of daily headaches and requested a Norco refill. The doctor continued to keep Petitioner off work. PX 7, pp. 146-154.

On April 15, 2015, Petitioner's therapist noted that Petitioner reported improved left knee strength and balance. The therapist recommended one more therapy visit. Petitioner was discharged from therapy as of April 17, 2015. PX 7, p. 73. A discharge summary dated April 23, 2015 reflects that Petitioner denied left knee pain but was still experiencing intermittent instability. The therapist indicated that this instability "does not inhibit any activities." PX 9, p. 74.

Over the next few months, Petitioner's treatment remained in a holding pattern, with Drs. Freedberg and Novoseletsky awaiting authorization of procedures and continuing to keep Petitioner off work.

In an undated addendum that appears to have been written in April or May of 2015, Dr. Belich revisited the issues of causation and treatment needs, indicating he had reviewed additional records from Drs. Freedberg and Novoseletsky along with a surveillance video dated March 10, 2015 which showed an individual shoveling "small amounts of snow" and pushing a wheeled garbage container.

Dr. Belich reiterated that the mechanism of injury described by Petitioner was "really not consistent with a rotator cuff tear." He did not view Petitioner's tear as having occurred at the time of the accident. Instead, he believed the tear was associated with the AC separation and surgery Petitioner underwent at some point In the past, prior to the accident. He

conceded, however, that "there is no conclusive evidence to state that [the tear] did happen in that way." He expressed concern about Petitioner's March 30, 2015 complaint of worsening right shoulder pain indicating, that in his experience, a partial rotator cuff tear would not get worse "in an individual not doing a lot of lifting or physical activity." He opined that appropriate care for a partial rotator cuff tear would include an adequate trial of therapy and a subacromial injection, to be followed by an arthroscopy if the patient remained symptomatic. In Petitioner's case, he saw no need for a distal clavicle resection or biceps repair. He anticipated that Petitioner would be able to resume full duty following a rotator cuff tear repair.

Dr. Belich addressed the surveillance footage as follows:

> "His presentation on the video is consistent with subjective complaints of right shoulder pain, since nowhere on the video did he really show any excessive exertion of the shoulder or do any activities that could stress the rotator cuff to a great deal. He was not really shoveling very much snow and he was simply lifting and throwing it and this did not appear to put any additional stress on the rotator cuff. Nothing in the video would indicate that the activities that he was doing in the video were similar to what he would have to do as a highway maintenance worker for the State of Illinois."

RX 3.

On July 20, 2015, Dr. Freedberg operated on Petitioner's right shoulder at the Ashton Center for Day Surgery (T. 27), performing an arthroscopy, labrum debridement, biceps tenodesis, subscapularis and supraspinatus repairs, subacromial decompression and distal clavicle resection. In his operative report, Dr. Freedberg documented a very large anterior labral tear, a biceps insertional tear, an insertional subscapularis tear and some mild chondromalacia of the glenoid. PX 7, pp. 206-208.

At the first post-operative visit, on July 30, 2015, Dr. Freedberg noted that Petitioner reported "feeling great." He refilled the Tramadol and kept Petitioner off work. PX 7, pp. 208-211.

At Dr. Freedberg's direction, Petitioner began a course of therapy thereafter. T. 28.

Petitioner continued seeing Drs. Novoseletsky and Freedberg on a regular basis. On September 30, 2015, Dr. Novoseletsky informed Petitioner that Respondent had denied the requested epidural injection. The doctor recommended additional medial branch blocks as an alternative.

On November 5, 2015, Petitioner returned to Dr. Freedberg and complained of pain and stiffness of the right shoulder. Petitioner indicated he had finished therapy but would like to undergo more. The doctor prescribed additional therapy. He continued to keep Petitioner off work. PX 7, pp. 243-245.

Dr. Novoseletsky performed right-sided medial branch blocks at C3-C5 on December 5, 2015. Petitioner reported temporary pain relief secondary to the injection on December 11, 2015. PX 7, pp. 256-263. In subsequent notes, the doctor indicated he was awaiting authorization of "additional pain procedures."

On February 3, 2016, Petitioner complained to Dr. Freedberg of right shoulder weakness, numbness and tingling down his right arm and into his fingers and constant left knee pain. The doctor noted he was still awaiting authorization of HA knee injections. He continued to keep Petitioner off work. PX 7, pp. 285-287.

On February 16, 2016, Dr. Novoseletsky administered left-sided medial branch blocks at L3-L5. Petitioner reported transient 50% improvement of his lower back pain at the next visit, on February 18, 2016. PX 7, pp. 288-296.

On February 29, 2016, Petitioner returned to Dr. Novoseletsky and indicated he developed "excruciating pain" after the last procedure, which caused him to have to stay in bed for two weeks. PX 7, pp. 297-299.

On March 23, 2016, Dr. Novoseletsky administered right-sided medial branch blocks at C3-C5. At the next visit, on April 11, 2016, Petitioner reported improvement of his right-sided neck pain but complained of 8/10 pain in his lower back and the left side of his neck. The doctor recommended additional procedures and continued to keep him off work. PX 7, pp. 309-316.

On April 14, 2016, Dr. Freedberg advised Petitioner that the adjuster denied the recommended knee injections.

On May 16, 2016, Dr. Freedberg sent a report to Petitioner's counsel. In this report, the doctor responded to Dr. Belich's opinions and addressed knee-related treatment as follows:

> "His MRI, in my opinion, did not have an eminent surgical issue to be addressed but yet it appears that it has not resolved. We are presently awaiting approval to go ahead and perform the Hyaluronic acid injections into his knee."

Dr. Freedberg found a causal relationship between the work accident and Petitioner's condition. He indicated that Petitioner complained of his knee "very shortly after the accident" and that the mechanism Petitioner described could have caused a knee injury. PX 7, pp. 327-328.

On May 17, 2016, Dr. Novoseletsky administered left-sided medial branch blocks at C3-C5.

On May 19, 2016, Dr. Freedberg noted complaints relative to the right shoulder and left knee. He indicated he reviewed an "IME report from Dr. Cohen." PX 7, pp. 331-333. No such report is in evidence.

On June 16, 2016, Petitioner informed Dr. Freedberg that the knee injections had been approved but that he would not be able to start them that day. Petitioner complained of left knee swelling and gait-related left hip pain. The doctor continued to keep him off work. PX 7, pp. 341-343.

Dr. Freedberg administered the left knee Hyaluronic acid injections on June 30, July 7 and July 11, 2016. On July 7, 2016, the doctor found Petitioner capable of full duty with respect to the shoulder only. He continued to keep Petitioner off work with respect to his knee. PX 7, p. 356.

In a report dated July 15, 2016, Dr. Milos (identified as a board certified orthopedic surgeon) recommended non-certification of the left knee Hyaluronic acid injections, citing a lack of supporting medical information. Dr. Milos indicated that such injections are not indicated unless the patient has failed to adequately respond to aspiration and injections of corticosteroids. RX 4.

Under cross-examination, Petitioner admitted that, on July 20, 2016, he entered a guilty plea with respect to the following charges: 1) aggravated criminal sexual abuse of a victim under age 18; 2) possession of child pornography; and 3) unauthorized and unlawful videotaping of a victim under age 18. Petitioner was sentenced to a period of probation and "lifetime registration." [See Certified Statement of Conviction/Disposition, RX 5.] T. 40-41.

Respondent discontinued the payment of temporary total disability benefits on July 22, 2016. Arb Exh 1. RX 6. T. 32.

On July 23, 2016, a representative of Respondent's third party administrator, Tristar Risk Management, sent Petitioner a letter indicating it was "denying any further claim for medical and/or indemnity benefits." The representative indicated that Tristar had reviewed Petitioner's file and determined that Petitioner had "removed [himself] from the work force as well as medical care." PX 12. T. 31.

On August 18, 2016, Petitioner reported 30% improvement of his left knee pain to Dr. Freedberg. The doctor continued to keep him off work with respect to his knee. PX 7, p. 363.

On August 18, 2016, approximately a month before the hearing, Petitioner filed a Petition for Penalties and Fees. PX 11.

On August 19, 2016, Dr. Novoseletsky issued a work status note indicating that Petitioner remained "medically unable to work." PX 7, p. 364.

Petitioner testified that the physical therapy and multiple injections helped "a little bit." T. 30.

Petitioner testified he has received no temporary total disability benefits since mid-July 2016. T. 32. He has upcoming appointments with Drs. Freedberg and Novoseletsky. T. 32-33. Dr. Freedberg released him to full duty with respect to his shoulder but not with respect to his other injuries. T. 33. He has not returned to any kind of employment. T. 33. He has no insurance or funds to pay for additional care. T. 33-34.

Petitioner acknowledged having some neck and low back injuries prior to the work accident. T. 34. He has another pending workers' compensation claim. That claim involves a hand and arm condition. He finished treatment for this condition several years ago. T. 34.

Petitioner denied experiencing any other accidents after the April 14, 2014 work accident. T. 35.

Petitioner identified PX 1 as a group of his medical bills. Some of his bills remain unpaid. He incurred one out of pocket expense but could not recall exactly what that expense was for. T. 36.

Petitioner testified his left knee still hurts, especially when he rises to a standing position or uses stairs. The knee feels unstable when he is descending stairs. He cannot jog or run. T. 37. His right shoulder is "a lot better" since the surgery but it is still weak. T. 37. It is difficult for him to reach behind his back or across his chest. His shoulder hurts when he lifts bags of groceries. He is right-handed. T. 38. Both sides of his neck hurt and he experiences headaches four or five times weekly. T. 37. He also experiences very sharp pain when he turns his head to the left or right. T. 38. His back hurts when he bends, gets out of bed or uses stairs. He experiences neck and back pain even when he is at rest. He takes Aleve, which helps a little. Therapy did not help his back pain. He avoids lifting but is able to carry plastic bags containing groceries. He has not been released to return to a gym. T. 39. He has to climb 14-15 steps to get to his apartment. T. 39. He walked four blocks to the train in order to attend the hearing and experienced pain while doing this. He did not have problems "to this extent" before the April 14, 2014 work accident. T. 40.

Under cross-examination, Petitioner denied being in jail between March 21 and March 29, 2015. T. 40. In the apartment where he currently lives, he does not perform maintenance activities such as shoveling snow. It is his roommate's apartment. His roommate does the cleaning. T. 41. His [Petitioner's] wife does his laundry. T. 41. He is able to drive to a grocery store. He does not push a cart at the store. He simply carries a basket. T. 41-42.

Jeffrey Aguinaga, an investigator, testified on behalf of Respondent. Aguinaga testified he has worked as an investigator for eighteen years. T. 44-45. At the outset, he underwent training in surveillance and following vehicles. Different states have different licensing requirements for investigators. He has an Illinois PERC card, which enables him to work for an agency under the agency's state license. T. 45.

Aguinaga testified he conducted surveillance of Petitioner in Melrose Park, Illinois, in March 2015, at the request of Tristar Risk. T. 45. When he received the assignment, he was told of Petitioner had a right arm or shoulder injury. T. 46. He was also provided with Petitioner's date of birth, address and vehicle registration number. He filmed Petitioner, using a camcorder, on the morning of March 10, 2015. He arrived at the location at 5:52 AM and stayed until 11:04 AM. He did not film continuously during that time. He only filmed when he observed activity. T. 48. He filmed for a total of 3 to 3 ½ minutes. T. 49. After he finished the assignment, he put the film onto a SD card, placed the SD card in an envelope, sealed the envelope and mailed the envelope, via Federal Express, to his agency's office in Raleigh, Virginia, where the film is backed up and stored. T. 49.

Aguinaga identified RX 7 as the video showing the footage he obtained on March 10, 2015. T. 51. The video accurately depicts the activity he observed that day. T. 51.

Under cross-examination, Aguinaga testified he used a Panasonic camcorder and transferred the footage to an SD card. He loaded the contents of this card onto his computer and then mailed the card to his employer's Raleigh headquarters. A video technician at headquarters would have received the card but he does not know this individual's name. He is not sure of the current location of the card. T. 55-56.

Arbitrator's Credibility Assessment

The Arbitrator notes that Petitioner admitted pleading guilty to three very serious offenses. RX 5.

Under cross-examination, Petitioner denied being in jail during a 9-day period in late March 2015. The Arbitrator questions this denial. Petitioner was a "no show" at physical therapy on three dates in late March 2015. On March 30, 2015, Dr. Freedberg noted that Petitioner had recently missed two appointments with Dr. Novoseletsky "due to personal issues."

Respondent maintains that the March 2015 surveillance video (RX 7) undermines Petitioner's credibility insofar as his shoulder and neck complaints are concerned. The Arbitrator sustained Petitioner's "best evidence" objection to the video and marked the video as a rejected exhibit. Regardless of this ruling, Respondent's examiner, Dr. Belich, viewed the brief physical activities shown on the video as relatively innocuous and in no way analogous to the activities Petitioner would perform in the course of his sign hanger job. RX 3. [The

Arbitrator notes Petitioner did not raise any foundational or hearsay objection to RX 3. T. 74-75.]

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection as to his various claimed conditions of ill-being?

The Arbitrator, having reviewed all of the evidence, including but not limited to the opinions rendered by Drs. Freedberg, Novosoletsky and Belich, finds that Petitioner established causation as to the following current conditions: 1) a right shoulder condition of ill-being that required care, including surgery, with this condition stabilizing as of July 7, 2016; 2) a cervical spine condition of ill-being that required MRI scanning and a relatively short course of injections and therapy; and 3) a lumbar spine condition of ill-being that required MRI scanning and a relatively short course of therapy.

With respect to the right shoulder, the Arbitrator acknowledges there is evidence Petitioner underwent right shoulder surgery at some point before the work accident, secondary to a shoulder separation. In his April 16, 2014 note, Dr. Freedberg indicated Petitioner underwent this surgery at age 15 and denied subsequent problems. PX 7, p. 9. Dr. Belich noted evidence of this surgery when he examined Petitioner's right shoulder in September 2014. In his addendum, Dr. Belich indicated that the mechanism of the work accident was inconsistent with a rotator cuff tear. He went on to state that the tear could be due to the prior separation but that there was no way to be sure of this. Dr. Belich did not opine that the work accident could not have caused the underlying right shoulder condition to worsen. Nor did he opine that Petitioner did not need shoulder surgery. RX 3. There is no evidence suggesting he ever reviewed Dr. Freedberg's operative report concerning the right shoulder surgery of July 20, 2015. In that report, Dr. Freedberg documented significant pathology, including labral, biceps and subscapularis tears. Dr. Freedberg causally linked this pathology, along with the need for the surgery, to the work accident. With respect to the shoulder condition, the Arbitrator assigns greater weight to the opinions of Dr. Freedberg than to those of Dr. Belich. Dr. Freedberg treated Petitioner over a significant period while Dr. Belich examined Petitioner once. Dr. Freedberg visualized the shoulder pathology during the surgery. Dr. Belich did not even review the operative report. The Arbitrator also notes there is no evidence suggesting that Petitioner's pre-accident right shoulder condition affected his ability to perform full duty for several years before the work accident. Petitioner credibly testified he began working as a sign hanger for Respondent in 2010, with that job regularly requiring him to drive trucks and move heavy wooden posts. T. 15. The Arbitrator concludes that the work accident of April 14, 2014 caused a change in Petitioner's underlying right shoulder condition and contributed to the need for treatment, including the July 20, 2015 surgery. The Arbitrator views Petitioner as having reached maximum medical improvement for the right shoulder condition but does not address permanency as Petitioner elected to proceed under Section 19(b).

With respect to the cervical spine condition, the Arbitrator acknowledges that Petitioner had some neck problems before the work accident. The Arbitrator also acknowledges that

records in PX 7 show that Dr. Freedberg treated Petitioner for cervical radiculopathy before the work accident. Those records, however, show that the radicular symptoms were left-sided and that Petitioner was successfully performing full duty as of January 16, 2014. PX 7, pp. 6-8. The radicular symptoms that Petitioner experienced after the work accident were right-sided. The Arbitrator concludes that the work accident of April 14, 2014 caused a new cervical spine condition and new right-sided radicular symptoms that required care. The Arbitrator finds that Petitioner established causation as to the need for the cervical spine injections administered through September 4, 2014, the date of Dr. Belich's examination. The Arbitrator finds that Petitioner failed to establish causation as to the need for any medial branch blocks or other cervical injections or blocks after September 4, 2014. The Arbitrator finds Dr. Belich more persuasive than Dr. Novoseletsky on this point. The Arbitrator also notes that Petitioner described the blocks as helping only a little bit. Dr. Novoseletsky viewed the blocks as diagnostic rather than curative but it is not at all clear why he would continue to administer them over a two-year period, given the lack of response. In reliance on Dr. Belich, the Arbitrator further finds that Petitioner established causation as to the need for an additional six to eight weeks of physical therapy for his neck after September 4, 2014, the date of the Section 12 examination. It does not appear that Petitioner underwent this additional therapy, despite Dr. Belich's recommendation. Petitioner testified that the therapy he did undergo was not helpful. The Arbitrator further finds that Petitioner established causation as to the need for a cervical spine MRI. The Arbitrator finds it reasonable for an MRI to have been performed, given Petitioner's ongoing complaints. The Arbitrator views Petitioner as reaching maximum medical improvement for his neck condition as of approximately December 1, 2014. Petitioner credibly testified to some ongoing neck complaints and headaches but the Arbitrator does not address permanency, as Petitioner elected to proceed pursuant to Section 19(b).

With respect to the lumbar spine condition, the Arbitrator relies on Dr. Belich in finding that Petitioner established causation as to a soft tissue sprain or strain that required conservative care, including six to eight weeks of therapy after September 4, 2014, the date of the doctor's examination. It does not appear that Petitioner underwent this additional therapy. Petitioner testified that the therapy he did undergo was not helpful. The Arbitrator further finds that Petitioner established causation as to the need for the lumbar spine MRI. The Arbitrator finds it reasonable for an MRI to have been performed, given Petitioner's ongoing complaints. The Arbitrator views Petitioner as reaching maximum medical improvement for his lumbar spine condition as of approximately December 1, 2014. The Arbitrator finds that Petitioner failed to establish causation as to the need for any lumbar or thoracic injections or blocks. Petitioner credibly testified to some ongoing back complaints but the Arbitrator does not address permanency, as Petitioner elected to proceed pursuant to Section 19(b).

The Arbitrator finds that Petitioner failed to establish causation as to his claimed left knee condition of ill-being. Petitioner did not mention any left knee injury in the report he completed on the day of the accident (PX 2). The Emergency Room records contain no mention of a left knee injury. PX 6. When Petitioner first saw Dr. Freedberg, on April 16, 2014, the doctor noted no complaints relative to the left knee. It was not until April 24, 2014, ten days after the accident, that any medical provider documented a left knee complaint. On that date,

Dr. Freedberg indicated that Petitioner reported twisting his left knee after he got out of his truck, following the accident. Petitioner did not testify to this at the hearing. T. 20. The Arbitrator is troubled by this, particularly given the other credibility-related issues in this case. Respondent's examiner, Dr. Belich, implied that Petitioner established causation as to a mild left knee strain but it appears the doctor did not review the accident report and mistakenly believed Petitioner first saw Dr. Freedberg on April 30th, which was not the case. RX 2. The Arbitrator also notes that the left knee MRI showed no acute findings.

Is Petitioner entitled to temporary total disability benefits from March 21, 2016 through March 29, 2016 and from July 23, 2016 through the hearing of September 21, 2016?

Petitioner claims he was temporarily totally disabled from April 15, 2014, the day after his undisputed accident, through the hearing of September 21, 2016. Respondent maintains Petitioner failed to establish entitlement to temporary total disability benefits from March 21 through March 29, 2015 and after July 20, 2016. Arb Exh 1. A payment print-out (RX 6) shows that Respondent paid temporary total disability benefits through July 22, 2016.

Initially, the Arbitrator addresses the question of whether Petitioner was entitled to temporary total disability benefits from March 21 through March 29, 2015. Respondent contends Petitioner was in jail during this period and was thus not entitled to benefits. Under cross-examination, Petitioner denied being in jail in late March 2015. The Arbitrator questions this denial, based on contemporaneous medical records showing cancelled visits, but notes that Respondent did not offer any documentary evidence to support its position. The Arbitrator also notes that Dr. Freedberg continued to keep Petitioner off work in late March 2015 despite the cancelled visits. The Arbitrator finds that Petitioner was temporarily totally disabled from March 21 through March 29, 2015.

The Arbitrator turns to the question of whether Petitioner has been temporarily totally disabled since July 20, 2016. The Arbitrator has previously found that Petitioner failed to prove causation as to his left knee condition. The Arbitrator has also found that Petitioner's causally related right shoulder condition stabilized as of July 7, 2016, the date Dr. Freedberg released Petitioner to full duty with respect to the shoulder, and that the causally related cervical and lumbar spinal conditions required no treatment other than a short course of therapy after September 4, 2014.

Based on the foregoing, and in reliance on Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator finds that Petitioner failed to establish entitlement to temporary total disability benefits after July 7, 2016. The Arbitrator notes, however, that Respondent stipulated Petitioner was temporarily totally disabled through July 20, 2016. Respondent is bound by this stipulation. Walker v. Industrial Commission, 348 Ill.App.3d 1084 (4th Dist. 2004). Based solely on the binding stipulation, the Arbitrator finds Petitioner was temporarily totally disabled through July 20, 2016.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims a number of medical bills and prescription expenses. PX 1. Some of the claimed bills and expenses relate to treatment for the left knee. The Arbitrator has previously found that Petitioner failed to prove causation as to any left knee condition. The Arbitrator declines to award any medical or prescription expenses relating to that condition. The Arbitrator notes that some of the bills Petitioner claims include intermingled charges for the knee and other body parts. See further below.

With respect to the claimed Ashton Center for Day Surgery bill, the Arbitrator awards only the fee schedule charges associated with the facet injections performed on July 8 and August 26, 2014 and the right shoulder surgery performed on July 20, 2015. PX 1, pp. 3-5. Respondent shall receive credit for any payments it has made toward said charges. The Arbitrator declines to award the fee schedule charges associated with the facet injections performed on December 9, 2015 and February 16, 2016 and the radiofrequency ablation performed on March 23, 2016. PX 1, pp. 6-8.

The Arbitrator declines to award the claimed fee schedule laboratory expenses from Essential Testing, LLC because the bill in PX 1 (pp. 10-11) shows no date of service. [The bill shows a "date" of November 7, 2014 and Dr. Novoseletsky's name, but no procedure of November 7, 2014 is described.] It is not possible for the Arbitrator to link the claimed expenses to any particular care rendered to Petitioner. No treatment records in evidence are dated November 7, 2014.

With respect to the claimed Gray Medical, Inc. bill (PX 1, pp. 13-15), the Arbitrator views the CPM [continuous passive motion] equipment set-up and rental charges as reasonable, necessary and related to the right shoulder surgery and awards the claimed fee schedule charges, with Respondent receiving credit for the various payments it made to Gray Medical, Inc., as delineated in RX 6.

With respect to the claimed Gottlieb Memorial Hospital Emergency Room bill (PX 1, pp. 16-18), the Arbitrator declines to award the claimed fee schedule charges, as the bill in evidence shows a $0 balance and Respondent's payment print-out (RX 6) reflects a payment to the hospital.

With respect to the claimed Loyola Medicine bill, relating to radiographic studies performed and physician services rendered on April 14, 2014, the date of the accident, the Arbitrator declines to award the claimed fee schedule charges, as the bill in PX 1 (pp. 20-21) shows a $0 balance and Respondent's print-out (RX 6) shows a payment to Loyola.

With respect to the claimed Northlake Fire Department ambulance bill (PX 1, p. 30), the Arbitrator declines to award the claimed fee schedule charges of $286.09 and $45.67. Respondent's payment print-out (RX 6) shows that Respondent paid $329.40 toward this bill.

With respect to the first claimed NCH Service Area bill (PX 1, p. 32), the Arbitrator awards the EKG and office fee schedule charges of $66.89 and $183.72. These charges relate to pre-operative studies performed in preparation for the right shoulder surgery. Respondent is entitled to credit for the payments it made to Northwest Community Hospital, as delineated in RX 6.

With respect to the other claimed NCH Service Area bill (PX 1, p. 33), the Arbitrator awards the fee schedule charges of $469.22. These charges relate to blood work and other lab studies performed in preparation for the right shoulder surgery. Respondent is entitled to credit for the payments it made to Northwest Community Hospital, as delineated in RX 6.

With respect to the bills from Dr. Chang/Oak Brook Anesthesiologists (PX 1, pp. 35-36), the Arbitrator views the July 20, 2015 fee schedule charges as reasonable, necessary and related to the right shoulder surgery. The Arbitrator awards said charges, with Respondent receiving credit for the payments delineated in RX 6. Based on the foregoing causation-related findings, the Arbitrator declines to award any anesthesia charges associated with the service date of March 23, 2016. Those charges relate to a thoracic radiofrequency ablation procedure.

The claimed bills from Metro Solutions and Suburban Orthopedics enumerate charges relating to the knee as well as other body parts. Some of the knee-related charges are clearly identified as such but the office visit and therapy charges appear to relate to multiple body parts. The Arbitrator has previously found that Petitioner failed to establish causation as to his left knee condition. The Arbitrator declines to award any knee-related charges set forth on the subject bill. The Arbitrator awards any and all fee schedule charges relating to the right shoulder, including but not limited to injection-, surgery- and therapy-related charges. With respect to the charges relating to the neck and back, the Arbitrator awards only those charges stemming from care rendered on or prior to September 4, 2014, the date of Dr. Belich's examination. The Arbitrator recognizes that Dr. Belich recommended a course of neck and back therapy in his September 4, 2014 report, but there is no indication this therapy was ever performed. PX 1, pp. 62-99. Respondent is entitled to credit for the payments it has made to Suburban Orthopedics. RX 6.

The various claimed prescription expenses from Prescription Partners, LLC, are similarly co-mingled. It is impossible for the Arbitrator to determine which of these expenses relate to medication prescribed for the left knee as opposed to other body parts. The Arbitrator leaves it to the parties to sort out which of the charges relate to the left knee. The Arbitrator declines to award those charges, having previously found that Petitioner failed to prove causation as to his left knee condition.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found that Petitioner failed to establish causation as to any left knee condition and that he is at maximum medical improvement for his other claimed conditions. The Arbitrator declines to award any prospective care in this case.

Is Respondent liable for penalties and fees?

Petitioner maintains Respondent is liable for penalties and fees based on its failure to pay temporary total disability and medical benefits since July 22, 2016. The Arbitrator, having previously found that Petitioner's causally related right shoulder condition stabilized on July 7, 2016 and that Petitioner is entitled to temporary total disability benefits only through July 20, 2016, based on Respondent's binding stipulation, declines to find Respondent liable for penalties and fees.

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

Richard Pence,
Petitioner,

vs.

NO: 14 WC 24599

Vactor Manufacturing,
Respondent,

17IWCC0572

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, 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 January 11, 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 $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.

SEP 25 2017

DATED:
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PENCE, RICHARD
Employee/Petitioner

Case# **14WC024599**

VACTOR MANUFACTURING
Employer/Respondent

17IWCC0572

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:

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0572

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard Pence
Employee/Petitioner

v.

Vactor Manufacturing
Employer/Respondent

Case # 14 WC 24599

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 **November 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 _____

FINDINGS

On **March 5, 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 **$50,652.03**; the average weekly wage was **$974.08**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and $4,531.29 for other benefits, for a total credit of **$0**. ARB EX 1

Respondent is entitled to a credit pursuant to Section 8(j) of the Act. ARB EX 1

ORDER

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related medical condition pursuant to Sections 8(a) and 8.2 of the Act. SEE DECISION

Respondent shall pay Petitioner temporary total disability benefits of **$649.45**/week for **14 6/7** weeks, commencing **9/2/14** through **12/14/14**, as provided in Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner permanent partial disability to the extent of **5%** loss of use of the right hand and **5%** loss of use of the left hand for a total of 19 weeks at the PPD rate of **584.45** per week pursuant to Section 8(e) of the Act.

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

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

Carolyn M. Wheesy

Signature of Arbitrator

1/10/17
Date

JAN 11 2017

FINDINGS OF FACT

Petitioner, a 55 year old machine worker, testified that he began working for Respondent Vactor Manufacturing in 1979. Respondent manufactures sewer cleaning trucks. Petitioner testified that he began working in the form shop running a punch press machine referred to as a "nibbler" from 1979-1982. Petitioner testified that he moved pieces of steel through the steel punch press to make steel circles guiding the metal with both hands through the press. He testified that while doing so, the metal would bounce and jerk in the press and he felt vibrations and shock in his hands from the vibration of the press. He estimated that the press and the steel piece made contact 100 times per minute and that he would complete 30 circles per day each 38 inches in diameter working 10 to 12 hours per day. Petitioner testified that the nibbler was last used in the early 1980's and they were replaced by laser equipment.

Petitioner next moved to the chassis department where he worked for seven years from 1982 to 1989. In that department, Petitioner worked using large impact tools with both hands to put bolts on brackets of large subframes. Petitioner testified that he experienced pounding and vibration in both hands all day when using the impact tool. Petitioner also testified that he used large drills to drill holes into the frame for the bolts and that he did so by hand. Using the drill also caused vibration and catching in both hands.

In 1989, Petitioner moved to the assembly area where he assembled various truck parts running impact tools, placing bolts, and placing water tanks on trucks. He further testified that he also performed 2 man jobs including beating door seals with a large mallet which also caused bilateral hand vibration and impact. Petitioner testified that this duty required him to pound the door seal "at least 100 times" and that each seal would take about one hour. Petitioner testified that he would pound one or two door seals a day and that some days he did not pound any door seals. Petitioner was also required to repeatedly use the leather mallet to straighten metal hose reels within a ¼ inch tolerance.

Petitioner testified that he worked in the assembly area performing these duties from 1989 to 1992 and in 1992 he became a crew leader in the assembly department. As a crew leader in 1992, Petitioner readied the assembly jobs for the crew. Petitioner testified that he was a "working crew leader" and that he very often performed the manual assembly jobs filling in for missing crew members. Petitioner testified that as a crew leader he worked 10 to 12 hours per day. He estimated that he spent one half hour readying the assembly room prior to the workers' shift and that he brought materials in from the yard with a forklift using both hands while driving the forklift. He testified that he felt vibration in both hands while driving the forklift due to the bounce of the forklift driving over gravel and rough concrete in the yard outside the plant until reaching the smooth surface inside the plant. After dropping the materials in the assigned work areas, Petitioner testified that the spent the remainder of the day helping out on the job covering for missing employees. He testified that he filled in for missing employees about 3 days per week all day.

Petitioner testified that when he filled in for a missing worker he performed the assembly job duties described above including using impact tools. On cross-exam, Petitioner testified that he still uses impact tools but not as frequently due to the advances made in production and

estimated that his use of impact tools has decreased in the last 3 years. He specifically testified that he last pounded a door seal in 1997-98 when the work was transferred to the weld department. He testified that hydraulic equipment is now used to pound hose reels when necessary.

Petitioner continued to hold the job of crew leader for Respondent at the time of trial. He testified that he first noticed numbness, tingling and locking of both hands in 2005. He first sought medical attention for these symptoms on March 5, 2014, the alleged manifestation date. ARB EX 1. Petitioner testified that he simply lived with the symptoms between 2005 and 2014 because he "didn't want to cause a problem." Petitioner further testified that as a crew leader he took 3 carpal tunnel accident complaints from his crew workers and that he was aware of other crew leaders with carpal tunnel complaints.

Paul Urbanec testified on behalf of Petitioner at trial. Mr. Urbanec has worked for Respondent since 1979 and has worked with Petitioner for the same time period. He witnessed the nibbler machine shake the user, witnessed Petitioner operate the forklift over the rough outdoor surface and witnessed Petitioner using impact tools and the constant jarring and shaking of both hands while in use. Lastly, he also testified to feeling bilateral hand vibration while pounding doors seals with a mallet. He testified that only short breaks to rearrange are taken during the shifts while using the impact tools.

Respondent called Josh Malmassari to testify at trial. He testified that he has worked 9 years for Respondent, first as a production supervisor where he was responsible for operation of assembly and sub assembly lines. He testified that Petitioner was one of two crew leaders that reported to him. Petitioner's duties included ordering parts, scheduling and helping crew workers which would include occasional assembly and sub assembly work. He agreed that Petitioner would occasionally perform physical work as a crew leader but would never fill in completely for a whole shift in lieu of a worker. Rather, he testified that if they were down a shift line worker the decision would be made to either not make product, use another assembly worker or make the produce on another shift. He agreed that in 2013 -14 a crew leader would use impact tools when helping out but that the use was infrequent and not continuous. However, he agreed that he was not aware of how often Petitioner filled in for a missing worker and that Petitioner would have better knowledge of his own daily tasks.

Petitioner first sought hand treatment with his primary physician Dr. Mark Wargo on March 5, 2014. Px. 2. On that date, Dr. Wargo noted Petitioner's complaints of pain in his left thumb and in his left hand for 5-6 months. Id. Petitioner had other complaints including numbness and tingling in his right foot for one month. Upon physical examination, Dr. Wargo noted tenderness in the left 1st MCP and CMC joints, as well as a positive Tinels sign in both wrists. Id. Dr. Wargo diagnosed Petitioner with bilateral carpal tunnel and referred him to Dr. Rakesh Garg for a NCV of both wrists. Id.

Petitioner met with Dr. Garg on March 26, 2014. Px. 3. Dr. Garg's records indicate Petitioner complained of pain in both hands, numbness and tingling in the thumb, index and middle finger with difficulty sleeping at night because of the numbness. Id. Dr. Garg noted "he had this problem for a few years but now it is getting worse." A nerve conduction/EMG was performed

on both arms and demonstrated severe carpal tunnel syndrome on the right and mild carpal tunnel on the left. Id.

Petitioner reported these results to his supervisor, Roy Snyder, the next day on March 27, 2014. Px. 7. Petitioner testified that Mr. Snyder rejected his claim and as a result, the Petitioner went above him to file an Employee Incident Report on April 4, 2014. Id. The incident report indicates that Petitioner gave Roy Snyder the test results indicating bilateral carpal tunnel and that Roy Synder "turned the test results down". Petitioner further reported that two months prior to March 27 2014, he told Roy Snyder he was going to seek treatment for his hand complaints and was told by Mr. Snyder that "it does not have anything to do with my job." Lastly, on the report Petitioner indicates his belief that his symptoms developed over time during the 34 years he worked at Respondent using impact tools and hammers and "years of repetitious abuse." PX 7.

Petitioner was subsequently referred by Dr. Wargo to see Dr. Blair Rhode for consultation of bilateral wrist pain and carpal tunnel. Px. 2; 4. Dr. Rhode first evaluated the Petitioner on June 19, 2014. Px. 4. Dr. Rhode wrote, Petitioner has bilateral hand numbness and tingling secondary to repetitive work exposure. Id. He is employed at Vactor Manufacturing where he has been employed for 34 years. Id. For roughly 15-20 years he worked on the assembly line, utilized impact tools, hammers, and wrenching. Id. He began having symptoms around 2005. He has been able to tolerate his symptomatology somewhat more due to the fact that over the course of the last 6-7 years he has been performing more computer work and managerial duties but his symptoms have worsened. He was ultimately seen and an EMG was performed that revealed severe CTS to the right, with more mild condition on the left. Id. He continues to have daily symptoms which decrease his ability to perform his daily responsibilities. Id. He denies prior injury to the hands or wrists. Id.

Upon physical examination of the right wrist, Dr. Rhode noted pain on palpation over the palm, a sensation deficit in the median nerve distribution, a positive Phalen's test, and a positive Tinels sign. Id. The left wrist demonstrated a pain sensory exam of C7, C8, and T1, including peripheral distribution, a positive Phalen's test, and a positive Tinels sign for producing paresthesia in the distribution of the median nerve. Id. Dr. Rhode diagnosed Petitioner with bilateral carpal tunnel syndrome due to repetitive work exposure. Id. Dr. Rhode provided him with cock up wrist splints and ordered him to return in two weeks to discuss injections and/or further treatment options. Id.

Dr. Rhode noted the wrist splints provided Petitioner with minimal relief during his next visit on June 26, 2014. Id. He wrote, "The patient continues to demonstrate evidence of bilateral carpal tunnel syndrome. The patient has had an extended history of exposure to a highly repetitive, forceful and vibratory job exposure. He has experienced symptomatology for many years but currently is so symptomatic he seeks treatment. We will continue a conservative course. Today we dispensed oral anti-inflammatories. We demonstrated a home stretching program. We performed a left carpal tunnel steroid injection. The patient will continue his bilateral cockup wrist splints. He will continue to work full duty but will attempt to activity modify outside of work." Id. Petitioner's steroid injection only provided him temporary relief of his left carpal tunnel symptoms and, on July 10, 2014, Dr. Rhode made preparations to proceed with a left carpal tunnel release. Id. In the interim, Dr. Rhode kept Petitioner at full-duty work. Id.

Petitioner underwent a left carpal tunnel release performed by Dr. Rhode on September 2, 2014, and ordered off work. Id. During Petitioner's follow-up visits on September 21st and October 19th, Dr. Rhode noted Petitioner's left side symptoms had resolved following surgery but he continues to experience carpal tunnel symptoms on the right. Id.

In the interim, Petitioner was seen by Dr. Michael Cohen at the request of the Respondent for an IME on October 1, 2014. Rx. 1. Dr. Cohen noted the Petitioner was about a month post left carpal tunnel release and still experiencing some pain in the hypothenar eminence but has full range of motion of the hand and wrist with complete resolution of his night awakenings and numbness and tingling. Id. As for the right side, he was scheduled for a right carpal tunnel release the following week and Dr. Cohen agreed Petitioner had right carpal tunnel. Id. Dr. Cohen further noted that Petitioner had a motorcycle accident in 2007 with chronic right hand weakness, numbness and tingling since that time. He further noted that Petitioner was diagnosed with diabetes in 2012 and a possible thyroid condition in 2014. He noted that Petitioner rides a motorcycle and rehabs homes. He further noted that Petitioner reported using impact tools once or twice per week over the last four to five years. He notes Dr. Rhode's note that the symptoms started in 2005 and have increased over the last 6 to 7 years the majority of which he has been working as a supervisor, i.e., a much lower level of activity.

Dr. Cohen opined that Petitioner has multiple potential etiologies for his carpal tunnel syndrome, writing:

> He drives a motorcycle which would place him at increased risk. He also has diabetes which also places him at significant increased risk for carpal tunnel syndrome. He also has a potential thyroid issue based on the records. He does do activities at work that potentially could relate to carpal tunnel syndrome including pounding objects with mallets and the use of impact tools, however, in the last four to five years this has been relatively infrequent and he is rehabbing houses doing similar activities on a much more frequent basis. Therefore, it does not appear that the work activities he has been doing over the last several years at [Respondent] are significantly higher risk activities than those he has been doing on his own while rehabilitating houses. … Id.

Dr. Cohen opined that Petitioner would have likely developed carpal tunnel regardless of his work activity for Respondent over the last 4 to 5 years given the difficulty discerning between the activities of house rehabbing and impact tool use and vibratory exposure at work which has been fairly minimal during that time. RX 1.

Dr. Cohen, a hand and upper extremity orthopedic specialist, testified via evidence deposition taken in August 2015. He opined that Petitioner's work activities did not cause or aggravate his carpal tunnel symptoms. RX 11. He opined that Petitioner did not need further treatment on the left hand due to prior surgery and that he agreed with the prescribed and pending right carpal tunnel release although again noted that the need for surgery was not related to his job duties. Dr. Cohen cited the other risk factors noted above as a cause for his symptoms. RX 11. On cross-

exam, Dr. Cohen testified that Petitioner reported performing more vibratory activity and impact tool use while rehabbing homes in the prior 4 to 5 years than at work and did not report that he had to hire out people to do the more physical work on the rehabs. RX 11. He further testified that since Petitioner reported minimal impact and vibratory tool use at work Dr. Cohen did not detail the type or use of those tools at work with Petitioner. Dr. Cohen agreed that Petitioner reported that the symptoms began in 2005 when he was still a line worker and not a crew leader. RX 11. However, he opined that if Petitioner was performing supervisory role longer than the last 4 to 5 years then a causal relationship is "even less likely."

Dr. Rhode subsequently performed a right carpal tunnel release on October 28, 2014. Id. Dr. Rhode continued to keep Petitioner off work until December 11, 2014, following a near complete resolution of Petitioner's right carpal tunnel symptoms. Id. On January 15, 2015, Dr. Rhode noted Petitioner was doing well with the exception of mild fatigue when working. Id. Dr. Rhode declared Petitioner at MMI on February 5, 2015. Id.

On April 1, 2015, Petitioner underwent his own Section 12 exam performed by Dr. Robert Eilers. Px. 6. Dr. Eilers reviewed Petitioner's work and injury history noting that Petitioner has worked for Respondent doing a number of manual labor activities since he was 19, was diagnosed with carpal tunnel on 3/5/14 by his primary physician, had a left carpal tunnel release done on 9/2/14 and a right carpal tunnel release done on 10/28/14 with good resolution of his symptoms before returning to work on 12/15/14. Id. After a review of Petitioner's medical records, a physical examination was performed and was essentially unremarkable. Id. Dr. Eilers diagnosed Petitioner with bilateral carpal tunnel syndrome, right worse than left, in a right-hand dominant male exposed to repetitive work activities, status post bilateral carpal tunnel releases with good results. Id.

> Under the "Recommendation" section of his report, Dr. Eilers wrote:
> The patient has had bilateral carpal tunnel surgery with release with excellent results. Clearly the carpal tunnel syndrome has occurred over the years that he worked at Vactor Manufacturing for about 35 years. He operated impact hammers. He would hammer. He would use mallets. He would have to put on screws, doing fine repetitive tasks as well as gross motor skills which resulted in his carpal tunnel eventually diagnosed by his primary care physician on March 5, 2014, and a prior report to his company about 5-6 months prior to that time when he began having symptoms.
>
> The patient's medical care to date was absolutely appropriate. It was necessary to treat his carpal tunnel syndrome which would have only gotten worse and resulted in further disability. The cost of his medical care to date was reasonable. It was appropriate and necessary to treat his condition of ill being. He certainly has returned to work as of 12/15/14 and notes he has resumed his activities. His time off work was very reasonable and very short.

> His procedures were all necessary. The surgeries were necessary and appropriate.
>
> He will hopefully avoid further medical treatment since he is in a lighter job and not doing heavy, repetitive tasks. He should avoid returning to any tasks where he is hammering, operating impact hammers or other repetitive work activities that could re-aggravate and cause his carpal tunnel to progress once again. Id.

Dr. Eilers concluded, "Unquestionably the carpal tunnel syndrome was a result of his work activities and had occurred over a period of time." Id.

Dr. Eilers testified via evidence deposition taken on July 21, 2015. Dr. Eilers opined that Petitioner had bilateral carpal tunnel right worse than left and that he was right hand dominant. He opined that the diagnosis, time off and surgeries were reasonable and necessary. PX 6. He further opined that the bilateral CTS was causally related to his job duties for Respondent in that Petitioner ran impact hammers and mallets as well as pounding, pushing, pulling and twisting an forceful activity over the course of 35 years. He specified that there is a direct correlation to his work duties and that "it was gradual over five years or so that it then progressed and then he realized I have a problem and he had it treated." PX 6. He further opined that Petitioner's use of a motorcycle did not contribute to his carpal tunnel nor would the home rehab work if Petitioner was hiring contractors to do the majority of physical rehab work on the homes.

On cross-exam, when asked if his opinion would change if Petitioner had been a crew leader vs. assembly worker for the last 20 years, Dr. Eilers testified, "The repetitive task, the pounding and he's had say a 30 year history of working; and basically over time it becomes more additive and then it became symptomatic and then it just progressed..." He further testified that if Petitioner had been a crew leader for 20 years this was still sufficient to cause his carpal tunnel because of the type of activity he performed including hammering, impact tools, wrenching, lever operation and forklift driving. PX 6, p. 26. He testified that short periods of forceful hammering and torquing activities can cause the progression of carpal tunnel symptoms. PX 6, p. 26-27. He agreed that the prior motorcycle accident resulting in right hand weakness, numbness and tingling, possibly could have contributed to the right carpal tunnel. Px 6. He opined that Petitioner's diabetes and thyroid conditions were borderline and did not contribute.

On August 22, 2016, Petitioner was examined by Dr. Rhode for the purpose of determining the nature and extent of his disability. Px. 4. Following a physical examination and application of the AMA Guidelines, 6th Edition, Dr. Rhode assessed Petitioner with a final impairment rating of 1% right upper extremity, 1% left upper extremity, and 2% of his person as a whole. Id.

CONCLUSIONS OF LAW

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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? D. What was the date of the accident? F. Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator incorporates by reference the above Findings of Fact herein. The evidence and testimony presented demonstrate that Mr. Pence has worked for Respondent for over 34 years performing various manual labor duties. For approximately three years, he used both hands to pull sheet steel though a highly vibratory "Nibbler" machine. For approximately seven years, he used both hands to operate highly vibratory drills and impacts in the Chassis Department. There is no question that Petitioner has worked 22 years from 1992 to 2014 as an assembly crew leader in a supervisory capacity. The Arbitrator notes that Petitioner credibly testified at trial that he was a working crew leader, that he filled in for missing line workers several times per week and that he continued to utilize the same impact and vibratory tools after becoming a crew leader, although not as often. The Arbitrator places greater weight on Petitioner's testimony regarding his actual job duties as a crew leader than on the testimony proffered by Mr. Malmassari.

The Arbitrator further notes that Petitioner credibly testified that he started to have bilateral symptoms in his hands in 2005, while working as a crew leader. Petitioner worked through those symptoms as a crew leader until he sustained a breakdown in his condition that caused him to seek medical attention on the manifestation date of 3/5/14. The Arbitrator is not dissuaded to find otherwise by Petitioner's position as a crew leader for the 22 years prior to the manifestation date. In so noting, the Arbitrator places greater weight on the testimony of Petitioner, the treating records of Dr. Rhode and on the opinion of Dr. Eilers over that of Dr. Cohen. Accordingly, based on the preponderance of credible evidence admitted at trial, the Arbitrator finds that Petitioner sustained repetitive and cumulative trauma resulting in bilateral carpal tunnel syndrome arising out of his over 34 year employment with Respondent and manifesting on 3/5/14.

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

Based on the Arbitrator's findings on the issues of accident, manifestation date and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with the care and treatment of his bilateral carpal tunnel syndrome, including his out of pocket expenses incurred, pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8 (j) of the Act. PX 1, ARB EX 1.

K. What temporary benefits are in dispute? (TTD)

Following Mr. Pence's carpal tunnel releases, he was taken off work by Dr. Rhode from 9/2/14 to 12/14/14, a period of 14 6/7 weeks. Based on the Arbitrator's findings on the foregoing issues, the Arbitrator further finds that Respondent shall pay Petitioner TTD for a period of 14-6/7 weeks commencing 9/2/14 through 12/14/14. Respondent shall receive credit for amounts paid, if any.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 1% of the right upper extremity, 1% of the left upper extremity, and 2% of the person as a whole as determined by Dr. Rhode, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Px. 4. The Arbitrator notes that this is a factor to be considered in making such a disability evaluation. Dr. Eilers noted that, although Petitioner had a good result from his bilateral carpal tunnel surgeries, he must still avoid returning to any tasks where he is hammering, operating impact hammers or other repetitive work activities that could re-aggravate and cause his carpal tunnel to progress once again. Px. 6. The Arbitrator gives equal weight to the opinion of Dr. Rhode.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an Assembly Crew Leader at the time of the accident and that he has returned to work for the Respondent in a full duty position. The Arbitrator notes that Petitioner has been able to return to work full-time for Respondent, albeit in a lighter job not doing heavy, repetitive tasks in the manner he previously performed. Px. 6. As a result, the Arbitrator therefore gives lesser weight to this factor in determining disability.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident. Because of Petitioner's advanced age and exclusively manual labor work history, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner has had no change in future earnings capacity. Because Petitioner was able to return to his employment in full with Respondent, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that other than a minor decrease in hand usage endurance, Petitioner's bilateral carpal tunnel surgery with release was a success and his symptoms have resolved. Px. 4. However, Petitioner must still avoid returning to any tasks where he is hammering, operating impact hammers or other repetitive work activities that could re-aggravate and cause his carpal tunnel to progress once again. Px. 6. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the right hand and 5% loss of use of the left hand under Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF **MADISON**)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDREA BROWN,

Petitioner,

vs.

NO: 14 WC 24638

17IWCC0545

STATE OF ILLINOIS,
CHOATE MENTAL HEALTH

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 notice, accident, causal connection, temporary total disable (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

After reviewing its records, the Commission has determined that the Petitioner has several prior workers' compensation settlements. Specifically, for claim 03 WC 10938, date of accident: September 22, 2002, Petitioner received an award of 27.50% loss of use of the left arm; the Commission takes judicial notice of this prior award *sua sponte*. The Commission, therefore, modifies the Arbitrator's award of 15% loss of use of the left arm and finds that Petitioner is entitled to 42.5% loss of use of the left arm. Respondent is entitled to a credit of 27.50% for the previous settlement in case 03 WC 10938. The net award to Petitioner is 15% loss of use of the left arm. All else is affirmed and adopted.

17IWCC0545

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 6, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURHTER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $586.85 per week for a period of 62-37 weeks, May 6, 2014 through July 6, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $132,148.10 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $528.17 per week for a period of 113.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the right hand (19 weeks), 10% loss of use of the left hand (19 weeks), 15% loss of use of the right arm (37.95 weeks), and 15% loss of use of the left arm (37.95 weeks) after accounting for Respondent's credit for the prior left arm award, as stated herein above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a 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.

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: SEP 7 - 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 7/25/17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROWN, ANDREA
Employee/Petitioner

Case# **14WC024638**

STATE OF ILLINOIS/CHOATE MENTAL HEALTH
Employer/Respondent

17IWCC0545

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:

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

SEP 6 - 2016

RONALD A.RASCIA, 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

ANDREA BROWN
Employee/Petitioner

v.

STATE OF ILLINOIS/CHOATE MENTAL HEALTH
Employer/Respondent

Case # 14 WC 24638

Consolidated cases: N/A

17IWCC0545

An *Application for Adjustment 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

On **May 5, 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 **$45,774.48**; the average weekly wage was **$880.28**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $132,148.10, as set forth in PX1, 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 temporary total disability benefits of $586.85/week for 62 3/7 weeks, commencing 5/6/14 through 7/6/15, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$528.17**/week for **113.9** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10 % loss of the right hand (19 weeks), 10 % loss of the left hand (19 weeks), 15 % loss of the right arm (37.95 weeks), and 15 % loss of the left arm (37.95 weeks).**

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

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

Signature of Arbitrator

8/16/16
Date

ICArbDec p. 2

SEP - 6 2016

17IWCC0545

FINDINGS OF FACT

At the time her injuries manifested, Petitioner was a Support Service Lead Worker for Respondent in its laundry department. (T.16, 17). She began her career with Respondent in 1982 as a Technician Trainee, training to be a Technician who gives direct care to recipients for activities of daily living such as bathing and feeding. (T.18). She transitioned into a Mental Health Technician I in 1984 and worked for Respondent until her departure in 1987. (T.18, 19). Petitioner returned in 1997, and resumed caring for recipients as a Mental Health Technician II. (T.19, 20). Petitioner testified that she worked as a hospital billing clerk, a bank teller, and a bookkeeper at a lumber yard during her 10-year hiatus. (T.19). Petitioner became a dietary Support Service Worker for Respondent in 2001, which required her to prepare food lines and lift pans of food, deliver food to units, and clean dishes. In 2003, Petitioner transferred to the housekeeping department as a Support Service Worker, and she became the lead worker in 2008. (PX10).

In 2012, Petitioner was transferred to the laundry as the lead worker and was responsible for loading and unloading commercial washers and dryers, pushing and pulling carts of clothing, lifting heavy bags of laundry, and sorting the laundry. (T.24, 57, 58). Petitioner estimated that approximately 2.5 hours is spent just lifting laundry in and out of commercial washers and dryers. (T.50). During the wash and/or drying cycles, Petitioner is taking inventory, delivering or gathering more laundry. (T.59). She testified that she uses her hands and arms for six hours out of her eight-hour work day. (T.59). Petitioner completed a Work History Timeline/Job Description detailing her job history and duties which was entered into evidence as Petitioner's Exhibit 10. (PX10).

Petitioner reviewed Respondent's Demands of the Job form and testified that it did not accurately represent the intensity and frequency of her lifting activities. (T.26, 27). Petitioner testified that the job required constant use of the upper extremities during the shift. She indicated they would be lifting items weighing up to 100 pounds, and pushing carts that weigh 200 pounds throughout the work day. She was required to use her hands for gross manipulation, fine manipulation, and perform wet work with her hands "constantly."

Respondent brought Chris Wells, who was responsible for completing and signing the Demands of the Job form, to the hearing. (T.26). He was called by Petitioner and testified in agreement with Petitioner that she uses her hands anywhere from four to six hours per day. (T.61).

Petitioner testified that she does not suffer from diabetes, gout or rheumatoid arthritis, and that her hypertension is controlled with medication. (T.30, 31).

Petitioner testified that during the course of these duties, she began experiencing pain in her elbows, arms and fingers. (T.24). On May 5, 2014, Petitioner was pulling heavy laundry weighing approximately 50 pounds out of a washer and transferring it into a dryer when her pain became so severe that she felt it from her fingers up to her shoulders with numbness and tingling in her fingers, causing her to drop the clothes in her hands. (T.25). Petitioner confirmed on cross-examination that her job required her to lift 50 pounds of wet laundry out of the commercial washer at one time. (T.45). Petitioner testified that, after the accident, she "could not do anything at that point in time" so she filled out an accident report which was entered into evidence as Petitioner's Exhibit 11. (T.25; PX11). Petitioner candidly testified she previously complained of symptoms in her arms and elbows caused by her work for which she sought evaluation, but prior to May 5, 2014, these did not keep her from working. (T.39). After May 5, 2014, however, her symptoms became so severe that she could no longer work. (T.39).

Petitioner was able to see her family physician, Dr. Cerny, almost immediately following the incident. (T.28; PX3, 5/5/14). Dr. Cerny noted that Petitioner was working in the laundry department and noted pain in both her arms and elbows. (PX3, 5/5/14). He noted that Petitioner had a history of chronic repetitive motion injuries, took Petitioner off work, and referred Petitioner for orthopedic evaluation. *Id.*

Petitioner saw Dr. Sonjay Fonn on May 7, 2014. (PX4, 5/7/14). Dr. Fonn noted that he had not seen Petitioner since he treated her in 2012 for her lumbar spine which was essentially normal. *Id.* Dr. Fonn noted that Petitioner worked "in a laundry mat [sic] doing a lot of heavy lifting, bending, stopping and repetitive motions for about two years and progressively getting worse." *Id.* He noted that an EMG study showed bilateral cubital tunnel syndrome, but also suspected possible cervical radiculopathy and ordered a cervical spine MRI. *Id.* He kept Petitioner off work and stated that if nothing was wrong with Petitioner's cervical spine, he would recommend proceeding with cubital tunnel releases if conservative modalities failed to improve Petitioner's condition. (PX4, 5/7/14, 6/10/14). The MRI performed on July 8, 2014, showed no protrusions or disc herniations and only mild degenerative changes. (PX3, 7/8/14). While Dr. Fonn recommended treatment for same, Petitioner stipulated at the hearing that she was making no claim for injuries to her cervical spine. (T.37).

Despite thorough cervical spine care, including multiple injections, Petitioner's arm symptoms persisted. (PX4; PX5). Petitioner sought evaluation with Dr. David Raskas on August 18, 2014. (PX6, 8/18/14). Dr. Raskas took the history of Petitioner's bilateral elbow symptoms with numbness and tingling in her hands as result of handling loads of clothing for Respondent and that it "came to the point where it was bad enough that she really could not tolerate it any longer in May of 2014. *Id.* He noted that Petitioner's neck pain did not radiate into her arms at all. *Id.* Dr. Raskas' physical examination was positive for compressive neuropathy bilaterally over the upper extremities. *Id.* He also noted that Petitioner's minimal cervical degeneration was "less than average for her age." *Id.* Based on the results of Petitioner's EMG, which clearly showed that Petitioner suffered from cubital tunnel syndrome, Dr. Raskas recommended that Petitioner be evaluated by Dr. Paletta. *Id.*

Respondent had Petitioner examined by Dr. Anthony Sudekum on August 26, 2014. (RX6). Dr. Sudekum noted Petitioner's prior positive nerve conduction studies showing bilateral cubital tunnel syndrome, and his own nerve conduction studies were also positive for bilateral cubital tunnel syndrome.[1] *Id.* Yet, Dr. Sudekum, a hand surgeon, indicated Petitioner's cervical spine and/or her left shoulder were the cause of her bilateral upper extremity complaints. *Id.* He did not feel that Petitioner's employment in any way caused, contributed or aggravated her condition. *Id.*

Petitioner saw Dr. George Paletta on September 29, 2014. (PX7, 9/29/14). Dr. Paletta noted that Petitioner's upper extremity complaints persisted despite cervical spine treatment, and that Dr. Raskas effectively ruled out Petitioner's neck as the source of her upper extremity complaints. *Id.* Dr. Paletta also noted that Petitioner had undergone two EMG nerve conduction studies which demonstrated peripheral compressive neuropathies at the elbows and wrists bilaterally. *Id.* Dr. Paletta's physical examination was also positive for cubital tunnel syndrome and carpal tunnel syndrome bilaterally. *Id.* Dr. Paletta believed that Petitioner suffered from symptomatic bilateral cubital tunnel syndrome as well as carpal tunnel syndrome. *Id.* Given the severity of

[1] Although Dr. Sudekum only diagnosed cubital tunnel syndrome from Dr. Sudekum's studies, the raw data from the studies later interpreted by Dr. Paletta showed bilateral carpal tunnel syndrome as well as bilateral cubital tunnel syndrome. (PX7; PX12, p.15).

Petitioner's condition, Dr. Paletta recommended bilateral ulnar nerve transpositions with carpal tunnel releases. *Id.*

Respondent had Petitioner examined by Dr. Richard Lehman on October 7, 2014. (RX8). Dr. Lehman's physical examination of Petitioner's shoulder was benign, and he stated that there were no complaints that would suggest a pathological process in either of her shoulders. *Id.* He testified by way deposition consistently with the opinion in his report, and testified that he had no opinions with regard to Petitioner's cervical spine or her hands and elbows. (RX9, p.13, 14).

On November 11, 2014, Respondent had Petitioner examined by Dr. Robert Bernardi. (RX10). Dr. Bernardi noted that Dr. Raskas, a spine specialist, did not believe that Petitioner's complaints were related to her cervical spine. *Id.* At the time of his examination, Petitioner was not suffering from any neck symptoms. *Id.* After reviewing Petitioner's records, performing his own physical examination and reviewing Petitioner's medical records, Dr. Bernardi concluded that Petitioner's "upper extremity symptoms are not related to a cervical spine injury," and that Petitioner's neck did not require any treatment. *Id.* Dr. Bernardi's deposition testimony was consistent with his report. (RX12). He testified by way of deposition that his physical examination findings were consistent with diagnoses of bilateral cubital tunnel syndrome and carpal tunnel syndrome rather than cervical pathology. *Id.* at 15.

On November 3, 2014, Dr. Paletta authored a report regarding causation and clarified that he believed that Petitioner's carpal and cubital tunnel syndromes were related to her employment. (PX7, 11/3/14). He noted that Petitioner's employment worsened her symptoms, and that pushing and pulling heavy laundry carts and the handling of wet heavy laundry required repetitive forceful grip and flexion extension of the elbows. *Id.* Thus, he concluded that Petitioner's work was at least a contributing factor to her conditions. *Id.* On November 4, 2014, Dr. Paletta performed left upper extremity carpal tunnel release and cubital tunnel release with ulnar nerve transposition. (PX8). The same procedure was performed on Petitioner's right side on February 12, 2015. *Id.*

Petitioner testified that she obtained relief from her surgeries, and that her numbness and tingling in her fingers improved dramatically. (T.31). Despite assertions that her symptoms were coming from her neck, Petitioner testified that she currently has no neck or shoulder pain radiating into her arms or hands, that she has no shoulder pain radiating from her neck into her shoulder, and she is making no sort of claim for her shoulder or neck. (T.34, 35).

Dr. Sudekum testified in his deposition that he was unaware that Dr. Raskas ruled out Petitioner's cervical spine as the source of her complaints. (RX7, p.36). Dr. Sudekum was also unaware that Dr. Bernardi authored a report indicating that he did not believe that any of Petitioner's upper extremity complaints were referable to Petitioner's neck. *Id.* at 50. He was completely unaware that Dr. Bernardi's examination was consistent with a diagnosis of bilateral carpal and cubital tunnel syndromes. *Id.* at 70. He did not receive Dr. Bernardi's report, nor did he receive Dr. Bernardi's deposition. *Id.* at 53, 54. Respondent also failed to provide Dr. Sudekum with the report of Dr. Lehman, who opined that Petitioner suffered from no condition referable to her shoulder. *Id.* at 59. He was unaware of Petitioner's improved post-surgical outcome, but testified that the fact that Petitioner improved following surgery would have no bearing on his causation opinion. *Id.* at 77.

Petitioner's upper extremity surgeon, Dr. Paletta, also testified by way of deposition. (PX12). Dr. Paletta testified that given the fact that Dr. Raskas had ruled out Petitioner's cervical spine and had referred her to him for evaluation of her upper extremities, the fact that Petitioner's symptoms were persistent and severe, and the fact that his physical examination and Petitioner's prior EMGs were positive for bilateral peripheral neuropathies, Dr. Paletta testified that Petitioner clearly suffered from severe bilateral cubital tunnel syndrome and carpal tunnel syndrome. (PX12, p.12-17). Given the severity of Petitioner's condition, which resulted in numbness, weakness of the hand, and significant abnormalities on electrophysiologic studies, Dr. Paletta recommended and performed surgery. *Id.* at 17, 18, 20.

With regard to causal connection, Dr. Paletta concluded that Petitioner's employment at Choate Mental Health caused, contributed to, and/or aggravated by her upper extremity condition. *Id.* at 17, 18. With regard to the motions engaged in and the stresses involved which were factors, he testified that Petitioner's handling of laundry required forceful gripping, pushing, pulling heavy, wet laundry, and pushing of carts. *Id.* at 18. He acknowledged that although Petitioner suffered from non-occupational risk factors for the development of peripheral compression neuropathies, he testified that it was impossible to exclude Petitioner's employment as a factor. *Id.* at 19. Dr. Paletta also reviewed the Demands of the Job form and testified that the usage detailed by Respondent thereon would contribute to or aggravate Petitioner's carpal and cubital tunnel syndromes. *Id.* at 26.

Petitioner testified credibly that despite her improvement from surgery, Petitioner continues to experience pain in her upper extremities with activities such as lifting. (T.32). She testified that her arms and wrists are sore at the end of her shift, and testified that her arms and wrists are weaker than they used to be. (T.33). Petitioner takes Tylenol for her symptoms. (T.33). Consistent with Petitioner's testimony, shortly before the time he released Petitioner to maximum medical improvement, Dr. Paletta noted that Petitioner continued to have some numbness and tingling in her fingers. (PX7, 6/3/15, 7/15/15). Dr. Paletta noted that this was to be expected given the severity of Petitioner's ulnar nerve changes and her fixed numbness preoperatively. *Id.*

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?

The purpose behind the Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work. *Durand v. Indus. Comm'n*, 224 Ill.2d 53, 862 N.E.2d 918, 926 (Ill. 2006) citing *Peoria Cnty. Belwood Nursing Home v. Indus. Comm'n*, 115 Ill. 2d 524, 505 N.E.2d 1026 (Ill. 1987). The Court expressly stated:

> Requiring complete collapse in a case like the instant one would not be beneficial to the employee or the employer because it might force employees needing the protection of the Act to push their bodies to a precise moment of collapse. Simply because an employee's work-related injury is gradual, rather than sudden and completely disabling, should not preclude protection and benefits....To deny an employee benefits for a work-related injury that is not the result of a sudden

> mishap…penalizes an employee who faithfully performs job duties despite bodily discomfort and damage. *Durand v. Indus. Comm'n*, 862 N.E.2d at 926.

In *Darling v. Indus. Comm'n*, the Court expressly stated that quantitative evidence of the exact nature of repetitive work duties is not required to establish repetitive trauma injury and that demanding such evidence was improper. *Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 195, 530 N.E.2d 1135, 1142 (1st Dist. 1988). The Appellate Court found that requiring specific quantitative evidence of amount, time, duration, exposure or "dosage" would expand the requirements for proving causal connection by demanding more specific proof requirements which the Appellate Court declined to do. *Darling,* N.E.2d at 1143. The Court further noted, "To demand proof of 'the effort required' or the 'exertion needed'…would be meaningless" in a case where such evidence is neither dispositive nor the basis of the claim of repetitive trauma." *Id.* at 1142. Additionally, the Court noted that such information "may" carry great weight "only where the work duty complained of is a common movement made by the general public." *Id.* at 1142. The Arbitrator notes that unloading and loading commercial size washers and dryers and handling hundreds of pounds of laundry represents and increased risk when compared to the standard loads handled by the general public from a qualitative stand point and doing so repeatedly throughout the day represents a quantitative increase in the risk as well.

Even when other non-occupational factors contribute to the condition of ill-being in a repetitive trauma case, "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist. 2000). Furthermore, as highlighted by the Appellate Court's decision in *Edward Hines Precision Components v. Indus. Comm'n* there is no standard threshold which a claimant must meet in order for his or her job to classify as sufficiently "repetitive" to establish causal connection. *Edward Hines*, 365 Ill.App.3d 186, 825 N.E.2d 773 (Ill.App.2d Dist. 2005); see also *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013) (citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (1991) (holding that a 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).

Even varied job duties can be repetitive if each of the various tasks requires intensive use of the upper extremities. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 388 Ill.App.3d 297, 901 N.E.2d 1066 (Ill.App. 4th Dist., 2009) (holding that claimant's duties, although "varied," were "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).

The Arbitrator finds that the evidence in the record establishes that Petitioner's job duties were intensive and repetitive. Petitioner testified credibly that she uses her hands and arms for six hours out of her eight-hour work day. (T.59). Petitioner completed a Work History Timeline/Job Description detailing her job history and duties which was entered as Petitioner's Exhibit 10. (PX10). Respondent's witness and Petitioner's supervisor who completed the Demands of the Job form, Chris Wells, testified in agreement with Petitioner that she uses her hands anywhere from four to six hours per day. (T.26, 61).

Dr. Paletta credibly explained that Petitioner's job duties were risk factors that required forceful gripping, pushing, pulling heavy, wet laundry, and pushing of carts, which caused or contributed to the development of Petitioner's bilateral carpal and cubital tunnel syndromes. (PX12, p.17-19, 26).

Dr. Sudekum, despite his own positive nerve tests, attributed Petitioner's conditions to her neck and shoulder, even though he is not a specialist in these areas. He was unaware that spine and shoulder specialists had ruled out those body parts as the cause of Petitioner's upper extremity symptoms. The Arbitrator finds the testimony and opinions of Dr. Paletta much more persuasive than those of Dr. Sudekum.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner met her burden of proof in establishing that she sustained bilateral carpal and cubital tunnel syndromes which arose out of and in the course of her employment with Respondent, and that her current condition of ill-being is causally related to same.

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

Repetitive-trauma injuries occupy an odd niche between accidental injury, compensable under the Act, and occupational disease, compensable under the Workers' Occupational Diseases Act. *A.C. & S. v. Indus. Comm'n*, 304 Ill. App. 3d 875, 879, 710 N.E.2d 837, 840 (Ill. App. 1st Dist., 1999). In choosing to cover such injuries as accidental injuries, as noted by the Appellate Court in *A.C. & S.*, the Supreme Court modified the standards for determining the date of injury for repetitive trauma cases in order provide protection for injured workers. *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 840-841 (Ill. App. 1st Dist., 1999). The method for determining the manifestation date for repetitive injuries is flexible and liberally construed depending upon the facts of the case. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: **(a)** the date the employee actually became aware of the physical condition and its relation to work through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

In *Oscar Mayer*, the claimant acknowledged that it was clear from the record that he knew of his injuries and their relationship to employment prior to his manifestation date. *Oscar Mayer v. Indus. Comm'n*, 176 Ill.App.3d 607, 609 (4th Dist. 1988). However, he argued that the date of "collapse" should still be considered a viable date for determining injury in repetitive trauma cases. *Id.* The Appellate Court agreed, noting that the appropriate date of injury can be "where the employee's existing physical structure gives way under the stress of his usual labor and he is suddenly disabled." *Id.* The Court wrote:

> By their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of

> limitation set by statute. Similarly, an employee is also clearly prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident. *Id.* at 611. (citations omitted, emphasis original).

In short, the Court embraced the "date of collapse" method of determination, setting the manifestation date on the date of surgery, or the date the employee could no longer work, allowing compensation to be awarded to a claimant despite his full knowledge that his condition was work-related well before he filed a claim because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Id.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

In this case Petitioner was aware of her condition prior to May 5, 2014, however Petitioner continued diligently working until her collapse on that date. On May 5, 2014, Petitioner was pulling heavy laundry weighing approximately 50 pounds out of a washer and transferring it into a dryer when her pain became so severe that she felt it from her fingers up to her shoulders with numbness and tingling in her fingers, causing her to drop the clothes in her hands. (T.25). Petitioner confirmed on cross-examination that she lifted 50 pounds of wet laundry out of the commercial washer at one time. (T.45). Petitioner testified that she "could not do anything at that point in time" so she filled out an accident report which was entered into evidence as Petitioner's Exhibit 11. (T.25; PX11). Petitioner candidly testified she previously complained of symptoms in her arms and elbows caused by her work for which she sought evaluation, but prior to May 5, 2014, these did not keep her from working. (T.39). After May 5, 2014, however, her symptoms became so severe that she could no longer work. (T.39). Petitioner completed a Notice of Injury and sought care on the same day. (RX1).

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that May 5, 2014, 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?

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n,* 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001). Respondent did not dispute the reasonableness and/or necessity of Petitioner's treatment, only liability for same based on its dispute of accident, causal connection and notice. (T.4). Petitioner testified that the surgery and post-operative therapy greatly improved her condition. (T.31).

Respondent shall pay reasonable and necessary medical services of $132,148.10, as set forth in PX1, 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 (K): What temporary benefits are in dispute? (TTD)

Respondent did not dispute the period of Petitioner's temporary total disability, only liability for benefits based on its dispute as to accident, causal connection and notice. Based upon the above findings of the Arbitrator finds Petitioner was temporary and total disabled for 62 3/7 weeks.

Respondent shall pay Petitioner temporary total disability benefits of $586.85/week for 62 3/7 weeks, commencing 5/6/14 through 7/6/15, as provided in Section 8(b) of the Act.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence with regard to Petitioner's carpal tunnel syndrome. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner continues to be employed as a Support Service Lead Worker for Respondent using her hands and arms. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of § 8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. She has diminished healing capacity as a result thereof, but she must live with her disability for a number of years. Thus, the Arbitrator gives *more* weight to this factor.

With regard to subsection (iv) of § 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that although there is no evidence of reduced earning power at this time; given the significance and nature of Petitioner's injuries, her significant surgical intervention, and her residual disability, it is reasonable to conclude that such repercussions will manifest in the future. The Arbitrator gives *little* 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 developed significant bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. (PX7). Petitioner ultimately required bilateral cubital tunnel releases with ulnar nerve transposition and bilateral carpal tunnel releases. (PX8). Petitioner continues to experience pain in her upper extremities with activities such as lifting. (T.32). She testified that her arms and wrists are sore at the end of her shift, and testified that her arms and wrists are weaker than they used to be. (T.33). Petitioner takes Tylenol for

her symptoms. (T.33). Consistent with Petitioner's testimony, shortly before the time he released Petitioner to maximum medical improvement, Dr. Paletta noted that Petitioner continued to have some numbness and tingling in her fingers. (PX7, 6/3/15, 7/15/15). Dr. Paletta noted that this was to be expected given the severity of Petitioner's ulnar nerve changes and her fixed numbness preoperatively. *Id.* The Arbitrator gives significant 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 10% loss of use of each hand and 15% loss of use of each arm pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Bell,

Petitioner,

vs. NO: 14 WC 28318

Illinois Department of Veterans Administration,

17IWCC0548

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both Petitioner and Respondent 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 below modifications to the temporary total disability (TTD) and maintenance awards.

1. The Commission finds that Petitioner was temporarily totally disabled from August 6, 2014, through September 14, 2015, or a period of 57 5/7 weeks.

   The arbitrator found that Petitioner's period of TTD began on June 26, 2014, the date that, according to her testimony, she received an oral instruction from Dr. Sampat to refrain from work. However, that instruction is reflected nowhere in Dr. Sampat's treatment notes. Petitioner bears the burden to prove her inability to work to establish a claim for TTD, and based on this record, the Commission finds that she did not carry her burden to prove that she was restricted from work as of June 26. The Commission instead finds that Petitioner's period of TTD began on August 6, 2014, the date Dr. Burra provided a written order declaring her unable to work.

2. The Commission finds that Petitioner is not entitled to maintenance.

   Section 8(a) of the Workers' Compensation Act requires employers to pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of an employee, including all maintenance costs and expenses incidental thereto. Petitioner's August 20, 2015, functional capacity evaluation

17IWCC0548

revealed her to be capable of work at a medium physical demand level. Petitioner's treating physician, Dr. Burra, noted that evaluation without dispute in finding that Petitioner had reached maximum medical improvement, and he wrote that Petitioner could return to work, albeit with a qualification that his return-to-work order would be reevaluated if the demand level of her prior job was misrepresented. Because both the functional capacity evaluation and Dr. Burra assert that Petitioner is capable of returning to medium-level work, and because that demand level encompasses her prior work and more, the Commission finds that that vocational rehabilitation and maintenance are not necessary or appropriate in this case.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 4/28/16 is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $319.00 per week for 57 5/7 weeks.

IT IS FURTHER ORDERED that Respondent shall not be required to pay maintenance benefits to Petitioner.

SEP 7 - 2017

DATED:
o:8/30/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BELL, CYNTHIA
Employee/Petitioner

Case# **14WC028318**

ILLINOIS DEPT OF VETERANS ADMINISTRATION
Employer/Respondent

17IWCC0548

On 4/28/2016, 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 0.40% 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:

0924 BLOCK KLUKAS MANZELLA & SHELL
MICHAEL BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
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

APR 28 2016

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

17IWCC0548

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CYNTHIA BELL
Employee/Petitioner

v.

ILLINOIS DEPT. OF VETERANS ADMINISTRATION
Employer/Respondent

Case # **14** WC **28318**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ROBERT FALCIONI**, Arbitrator of the Commission, in the city of **NEW LENOX**, on **04/07/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **05/10/2014**, 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 **$24,240.00**; the average weekly wage was **$466.15**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$16, 161.11** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$16,161.11**.

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

ORDER

Credits

Respondent shall be given a credit of **$16,161.11** for TTD, $ for TPD, and $ for maintenance benefits, for a total credit of **$16,161.11**.

Respondent shall be given a credit for allmedical 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.

Maintenance

Respondent shall pay Petitioner maintenance benefits of $319.00 (minimum, married plus 2 dependents)/per week for 24 1/7 weeks, commencing 10/22/15 through 04/07/2016, as provided in Section 8(a) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $11,934.00 to Hinsdale Orthopedics, $10,427.96 to Adventist Bolingbrook Hosp., and $21,029.00 to Athletico P/T and $111.00 to Central IL Radiological Assoc., as provided in Sections 8(a) and 8.2 of the Act.

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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $319.00/week for 63 5/7 weeks, commencing 06/26/2014 through 09/14/2015, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole (For injuries before 9/1/11)

The Respondent shall pay the Petitioner permanent partial disability benefits of $279.70/week for 86 weeks, as provided in Section 8(e) of the Act, because the physical injuries sustained caused the 40% loss of use of the left leg.

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

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

Robert E Dalton
Signature of Arbitrator

April 27, 2016
Date

APR 28 2016

17TWCC0548

BEFORE THE WORKERS' COMPENSATION COMMISSION

CYNTHIA BELL, Petitioner	)	
vs.	)	No.: 14 WC 28318
ILLINOIS DEPARTMENT OF VETERANS ADMINISTRATION Respondent.	)	

RIDER TO ARBITRATOR'S DECISION IN 14 WC 28318
(Denying vocational rehabilitation and ordering permanency)

Findings of Fact Common to all Issues in the Case:

Petitioner was a 53 year old Administrative Assistant for the Illinois Department Veteran's Affairs (Pet's. Ex. 6). She had an associate's degree in general studies, and had taken some college courses towards marketing, although she never got a degree. From 1980 when she would have been approximately age 20, until 1993, she worked for General Electric as a sales representative for electrical products. Her work entailed physicality, as she would do trade shows or go to customers facilities where part of the job was to demo and display various electrical components of various weights, setting up materials on the table and the like. She left her job with General Electric in 1993 until approximately 1995, to stay at home and raise her children. She then went to work for her husband's company, which was residential electrical contracting, doing mostly office work but the job had some physicality to it as well.

In 2008, with the national recession, she and her husband lost both their business and house, so they moved in with her parents and she took a three (3) month course in real estate, hoping the real estate market would break open, which it never did. She worked for Centry 21 and then Baird and Warner between 2009 and 2012, earning at most $9,000.00 in the final year. The job was commissions only. Due to cost, Petitioner had suspended her real estate license afterwards.

In 2012, her husband got a job doing electrical work in Ottawa. In 2013, she began working at the Kroger Store in Ottawa as a cashier, and her job entailed standing most of the day. Her knees were fine in performing her work. While working there she found a job with the Illinois Veterans' Administration, which was temporary with a chance to get full employment. She worked an initial three (3) months, and then was bumped when a different employee came back, and then a month later she was called back to work for an additional three (3) months.

The duties of the job included physical work. She worked two (2) wings, where she would put away supplies at the nurses' station and CNA stations, which included stocking shelves as high as she could reach, lifting 15 to 50 lbs. for 90 minutes. In addition, she lifted patient charts, which were large binders, 15 to 20 lbs. in weight, which took a great deal of time during the day. The binders had to be current. She also answered the phones, delivered messages and did general office work.

Before May 20, 2014, she never injured or had seen a doctor for her left knee, and she had been recently able to maintain employment as a cashier where she would be standing most of the day without difficulty.

On the day of the accident, which is not disputed, a stack of boxes was blocking her access to stock supplies, and after taking a couple of these boxes off the top, she attempted to move them with her left foot and experienced a sharp pain in the knee which she immediately reported. The same day, May 20, 2014 she went to OSF Prompt Care, also known as Ottawa Express Care, where they did X-rays and prescribed medication. She was told she had a sprain or strain, and to take it easy and return if there was more pain or no improvement in several weeks. She then continued working until job expired, which was May 31, 2014. She had difficulty going up and down the hallway, and experienced a sharp pain, especially if she was pivoting. At home she had difficulty with stairs.

The office record of the initial examining physician, Dr. Sampat, shows a complaint that she twisted at work at the VA Clinic the same date, had medial joint line tenderness, and the doctor diagnosed sprain/strain/contusion. He recommended ice, elevation, and Ibuprofen, to return if no improvement (Pet's. Ex. 1, pp. 8 – 9).

June 26, 2014, Petitioner returned to Dr. Sampat, with the same history, an aching pain which was described as mild and intermittent aggravated by movement, and that she had tried rest, non-steroidal, anti-inflammatory drugs, ice and elevation. Improvement was minimal, and the pain would worsen with pivot movement, consistent with Petitioner's testimony (Id @ 9). Dr. Sampat then noted that she should "continue ice (sp) and ibuprofen PRN severe pain. "Patient provided diagnoses and plan education" "Will refer to ortho." (Id @ p. 11).

Petitioner testified that the doctor restricted the use of her leg until she saw an orthopedist, and that he had referred her to Rezin Orthopedics, whose office was next door to Dr. Sampat's. Pursuant to an understanding with Dr. Sampat, she immediately that day walked over to Dr. Rezin's office. There she was advised by a nurse that they had called the workers' compensation person and was advised that workers' compensation would not approve the visit, so they would not see her.

Petitioner testified that she did not look for work between that date and August 6, 2014, because Dr. Sampat had advised her to stay off her leg except for necessary activities until she saw the orthopedist. She was starting to limp and her knee wouldn't support her after an hour.

On August 6, 2014, she saw Dr. Giridhar Burra at Hinsdale Orthopedics, who agreed to see her on credit. Her history to Dr. Burra was the same as she testified at hearing, advising that her work status was off work consistent with the oral instructions of Dr. Sampat, which were pending orthopedic evaluation. She also specifically described the attempt to make the appointment at Rezin Orthopedics which was unsuccessful (Pet's. Ex. 3, p. 10). After the initial visit, Dr. Burra took her off work unless she could do seated work only, which by her unrebutted testimony was unavailable from Respondent(Id. @ 13). It also appears that this is the date Respondent started paying temporary total disability. Dr. Burra then ordered an MRI, performed September 15, 2014, which found joint space narrowing, osteophyte formation, high grade condromalacia, joint infusion, a posterior medial meniscal tear, and questionable loose body, seen adjacently.

Dr. Burra continued the restrictions and on January 2, 2015, noted the catching sensation and feelings of giving out, and that the mechanism of her work related injury

was detailed August 6, 2014. Swelling would come and go, and she had patellofemoral condromalacia and an exacerbation of this with the work related injury. He had concern with potential loose body and/or medial meniscal tear, with the doctor's current work status being off work pending surgery January 8, 2015 (Id @ 24, 28). Dr. Burra's diagnosis was left knee medial meniscus tear, possible loose body, and exacerbation of tricompartmental osteoarthritis for which he prescribed surgery (Id @ 26).

In the interim, on October 20, 2014, Petitioner underwent a Section 12 Examination with Dr. Pietro Tonino, the Chief of Sports Medicine at Loyola University Medical Center (Pet's. Ex. 10). His impression agreed with Dr. Burra's of left knee condromalacia, and possible medial meniscal tear, casually related to the injury based on no prior history and being seen on the date of injury without resolution of symptoms to date. Dr. Tonino also recommended arthroscopic evaluation of the left knee and possible menesictomy and chondroplasty. He also found no evidence of symptom magnification (Pet's. Ex. 10, p.2). Petitioner testified that all treatment was pre-authorized after this exam.

January 8, 2015, Petitioner underwent surgery with Dr. Burra at Adventist Bolingbrook Hospital (Pet's. Ex. 4a). At surgery he found fairly extensive condromalacia, grade 4, in two compartments, and extensive medial meniscal tearing involving the middle 1/3rd of the posterior 1/3rd of the body. The doctor then performed an arthroscopy and partial medial menesictomy (Pet's. Ex. 4a pp. 1 – 2).

Petitioner than began physical therapy at Athletico, which was approved by the Respondent's TPA, Tri-Star (Pet's. Ex. 5, p.16). At the final discharge visit, the therapist noticed that after surgery Petitioner required three synvisc injections, and that she still had difficulty bearing all weight on the left lower extremity with the knee flexed (Pet's. Ex. 5, p. 149). It was noted that the Petitioner had functional limitations of being unable to occasionally lift 50 lb. boxes of medical supplies from floor to waste, floor to shoulder, and floor to overhead, as well as being unable to carry boxes of supplies weighing 50 lbs. a distance of 10 feet using both hands. She also had functional limitations of repetitive frequent squatting, ascending and descending a step stool, and prolonged sitting for one hour.

She also had difficulties sleeping at night (rolling), unable to kneel or squat, transferring in and out of a car, walking on uneven ground, walking one hour max, and going down stairs (Id.). Positive findings on her left knee on examination, included left quad and hamstring weakness, tenderness on palpation, increased soft tissue tension over the posterior knee, limited range of motion improvement in extensor leg on left straight leg raise, crepitus and decreased cadence, antalgic at times (Id. p. 150). The therapist noted continued problem with stair negotiation, squatting and kneeling and that she should avoid excessive knee flexation and extension due to worsening symptoms. "Patient has adapted a modified position to avoid pain" (Id @ 150-151).

One month later Petitioner had a Functional Capacity Evaluation, where she was found at the medium level. The examiner noted during the evaluation, which was valid, pain on the medial side of her patella with many of the activities performed. Activities that required squatting, deep knee bending, kneeling and crawling increased symptoms. She demonstrated compensatory body mechanics by leaning her body on her right leg. She terminated most activities due to pain and weakness on the medioinferior part of the patella. She demonstrated limitations in balance, squatting, crawling, kneeling and crouching, and that the physician should address further options. Petitioner testified that the lifting she did at the FCE to get to the medium level was done while balancing on her good leg, which is consistent with the examiner's report.

On September 14, 2015, Petitioner returned to Dr. Burra. Dr. Burra noted that Petitioner advised her that her job was truly not sedentary, and Dr. Burra felt that she was MMI baring further treatment. He released her without restrictions, to her job, noting: "on the other hand if this job is truly not sedentary and is beyond the functional abilities demonstrated on FCE, then these restrictions may need to be re-evaluated" (Pet's. Ex. 3, p. 69).

On October 22, 2015, Petitioner on referral saw Dr. Burra's partner, Dr. Kris Alden (Pet's Ex. 3, pp. 72 [1st page of visit], 70-71). Dr. Alden is a former clinical associate professor at the University of Chicago specializing in complex primary and revision hip and knee joint reconstruction, having an MD degree, as well as PhD degree from the Department of Physiology and Biophysics at the University of Illinois in

Chicago, and having completed a fellowship in lower extremity joint reconstruction at the Mayo Clinic. He is well published.

Dr. Alden at his exam noted patella femoral crepitus, patella femoral compression pain, and tenderness over the medial compartment. He felt that her symptoms had visibly progressed on X-ray in the last year, as he reviewed his X-rays with her at the date of the exam. He thought conceivably she could be treated with anti-inflammatories and an injection from time to time, noted that she tried Synvisc without good relief, and he believed she would do well with knee replacement in the future. "There unfortunately is no non-arthroscopy option which would give her good symptomatic relief" (Id @ 70-71).

The last medical record in evidence is the visit of December 17, 2015 to Dr. Alden (Pet's Ex. 3, pp. 73 – 75). He noticed the previous treatment recommendation of total knee arthroscopy. She attempted a new job, doing light janitorial and she was unable to do more than a day and a half. The knee thereafter was painful and swollen. Dr. Alden noted that at this point in time, she failed conservative treatment and would require future total knee arthroplasty. He limited her to weight bear as tolerated (Id @ 74). He restricted her to light or sedentary work, and was to limit prolonged standing or walking (Id @75).

Petitioner testified that on January 2, 2016, she began looking for work, as in addition to usual expenses she was helping with her son's college tuition payments. No records of this part of her job search were admitted into the record. January 6, 2016 her attorney formally requested vocational rehabilitation from the State.
Petitioner had gone in person to a couple of employers, who directed her to their website. She would use Indeed.com, Jobpost.com and Monster.com. Companies like Exelon and AT&T had their own web sites, and Petitioner testified she would also go there. She was doing her search about 3 hours a day looking for a job as a receptionist, or light secretarial, as there wasn't much out there. She would also walk to try and lose weight.

The only job she had since the time of her injury, other than working for Respondent to the end of May when injured, was the janitorial job at which she lasted

one and a half days. On March 9, 2016, she began keeping a record of her job searches when her attorney sent her a form (See Exhibit 13).

Petitioner testified that she does home exercises, the things her therapist taught. She is trying to lose weight and will walk around the block, do crunches and sit-ups. She cannot do running or any exercise which involves her knees. She always has a dull pain which will become painful, with difficulty going down stairs, having to do a step at a time. She feels pain, the knee feels unstable, and there is a cruncheyness, as well as pain in the center. She can't kneel even to bathe the dog. She had to quit Zumba classes. She does no gardening or cutting the grass. Her big thing is to go to Wal-Mart where after an hour she will need to go home. The bills were offered into evidence, with an objection only on a basis of liability, with Petitioner noting that she did have to do a pre-surgical exam before her knee surgery which is included in the bills.

She did try to retain her job with Respondent, as the director of nursing liked her, but she essentially was bumped. The doctor at Ottawa Prompt Care did tell her to restrict her use of the leg and to see an orthopedist. August 6th was the earliest she could get in to see an orthopedist after the State denied the visit to Rezin Orthopedics.

In Support of the Arbitrator's Decision regarding "F" (Causal Connection), the Arbitrator makes the following findings and conclusions:

Petitioner testified to no prior knee problems, which is borne out by the histories she gave all treating physicians. She was seen for a Section 12 Examination by Dr. Pietro Tonino, Chief of Sports Medicine at Loyola University Medical Center, who stated: "diagnosis is possible medial meniscus tear and condromalacia of the left knee, again, it is my opinion that this is related to her injury at work." (Pet's. Ex. 10, p. 2). The treating specialist agreed, with Dr. Burra describing the mechanism of injury in his records, and Dr. Alden noting that there was no prior history of knee problems as well. Accordingly, the Arbitrator finds that Petitioner's conditions of ill being in her left knee are causally related to the accident of May 20, 2014.

In Support of the Arbitrator's Decision regarding "L" (TTD and Maintenance), the Arbitrator makes the following findings and conclusions:

With respect to Temporary Total Disability, Petitioner was injured May 20, 2014, and continued working to May 31, 2014, when her job expired, as it was temporary in

nature with only a possibility for obtaining full time employment, which Petitioner was unable to do. The urgent care physician, Dr. Sampat, on the second visit of June 26, 2014, orally advised her to stay off her leg as her knee was not improving, although the medical record only refers to "education" of the patient. Petitioner testified the understanding was that she would immediately seek medical treatment upon his referral from Rezin Orthopedics, which was next door, which she did on the same day. However, Respondent would not approve treatment, so she had to find a doctor who would treat her on credit, and the earliest treatment she was able to obtain was August 6, 2014 when she saw Dr. Giridhar Burra, who was well qualified and trained under Dr. James Andrews (Pet's. Ex. 14). He immediately restricted her to sitting work only, on August 6th, which, as was true with Dr. Sampat's oral restrictions, were less than her job duties required of her. Petitioner was unable to see an orthopedic surgeon on June 26, 2014, due to the State's refusal to authorize treatment. The records evidence no major changes between the June 26th visit to Dr. Sampat, who was not an orthopedist, and the August 6th visit to Dr. Burra when he restricted her. From this date forward there are clear written records either keeping Petitioner off work or on light duty, which was not accommodated by Respondent, per the unrebuted testimony of Petitioner. Because of this condition she had surgery January 8, 2015. She was then off work or on light duty until determined to be at MMI per Dr. Burra on September 14, 2015. Accordingly, the Arbitrator finds the period of Temporary Total Disability from June 26, 2014 through September 14, 2015, a period of 63 5/7 weeks. The Arbitrator notes that Dr. Sampat did not issue a written off work or light duty note on June 26, 2014, but given the unrebutted testimony of Petitioner that he orally advised her to remain of the leg unless necessary, and the findings in the medical record of that date, the Arbitrator finds Petitioner's testimony credible on the issue of whether Dr. Sampat actually restricted her on that date, and accordingly includes the period June 26, 2014 thru August 6, 2014 in the award of TTD.

Regarding Maintenance, Petitioner testified that it was in October, shortly after the October 22, 2015 visit with Dr. Alden, that she found a light janitorial job, for which she trained for a week and for which she only lasted a day and a half at that time. The supervisor, who was observing her, advised she could not do the job due to her leg and

terminated her employment. Thus the period of maintenance should begin with the October 22, 2015 visit to Dr. Alden, when he gave her restrictions, with Petitioner having not only looked for work, but finding a job within a very short period of time. After unsuccessfully attempting this job, it was reasonable for Petitioner to return to Dr. Alden, which she did on December 17, 2015. Dr. Alden then restricted her to light or sedentary work only with limited prolonged standing and walking, consistent with the problems she had at work. Petitioner then testified that she did not begin looking for work again until January 2, 2016, but offered no written job logs to substantiate this testimony. It is noted in the record that Petitioner's attorney made a demand for vocational rehabilitation on January 6,, 2016, which was refused by Respondent. Exhibit 13 is the log of jobs that she has searched for since March 9, 2016, with the hearing being held April 7, 2016.

Although Petitioner requested vocational rehabilitation on January 6, 2016, there has been no compliance evidenced with Commission Rule 9110.10 (formerly 7110.10). "the Arbitrator notes the following cases in deciding this issue. In *Rapp v. State of Illinois Dept. of Transportation*, 10 I.W.C.C. 0015 where no vocational assessment was done by respondent, maintenance was charged to Respondent from the date of MMI.

In *Walker v. Village of Bolingbrook*, 12 I.W.C.C. 0533, Claimant was a maintenance worker who was injured and after completing work hardening, returned to work with Respondent. Respondent thereafter advised that they were unable to provide work for him within his restrictions and employment was terminated. Claimant performed a job search, which Respondent attempted to dispute as being inadequate. The Commission found that the Respondent may not criticize a job search when it refuses to provide any vocational assessment. The Commission held that because the Respondent should have provided vocational rehabilitation, it should also provide him with maintenance benefits under Section 8(a) of the Act.

Accordingly, the Arbitrator awards maintenance for Petitioner's self directed job search, which was initially successful until it was realized both by her and Dr. Alden that she could not perform at that level, continuing through the time of hearing. Maintenance is awarded from October 22, 2015 through April 7, 2016, being 24 1/7 weeks, less 9 (actually 8 1/2) days Petitioner worked, for a total of 22 6/7 weeks.

In Support of the Arbitrator's Decision regarding "J" (Medical Expenses), the Arbitrator makes the following findings and conclusions:

Petitioner treatment consisted of initial visits, two times, to an urgent care physician, then treatment by one orthopedic group, including the surgery which was prescribed by Respondent's Section 12 Examiner, follow up physical therapy, a Functional Capacity Evaluation, two additional visits to the same orthopedic group, to their knee reconstruction specialist, and nothing further. All appears to be standard treatment leading up to a surgery, and then follow up care. The periods of time for the treatment appear reasonable. Respondent pre-approved all treatment after its Section 12 Exam. The bills were admitted into evidence with objection only as to liability, and all doctors found causal connection, including Respondent's Section 12 doctor.

Accordingly, the bills, as appears in Arbitrator's Exhibit 2, being Petitioner's Exhibits 7, 8, 9, and 12 are awarded subject to the fee schedule or agreement, and specified as follows:

Hinsdale Orthopedics Associates, $11,934.00; Adventist Bolingbrook Hospital, $10,427.96; Athletico, $21,029.00 for which an insurance carrier paid that sum. If workers' compensation paid this bill, there is no award as to this bill as it is paid. If group insurance paid the bill, then the bill is awarded, and Respondent shall have an 8j credit of the aforesaid sum and shall hold the Petitioner harmless from any group reimbursement claims pursuant to the statute. To the same effect, Petitioner's Exhibit 12, the bill from Central Illinois Radiological Associates, is awarded, in the sum of $111.00, with Respondent to have an 8j credit for the payments made by group, and to hold Petitioner harmless with respect to group reimbursement claims pursuant to statute. Further, Petitioner's Exhibit 16, a bill from Hinsdale Anesthesia Associates which would have been from the surgery, is unavailable and reserved for later hearing if unpaid by Respondent. All bills are to be paid according to the medical fee schedule.

In Support of the Arbitrator's Decision regarding "O" (Vocational Rehabilitation Request) and "L" (Nature and Extent of the Injury), the Arbitrator makes the following findings and conclusions:

The Arbitrator, having considered the evidence and the National Tea Guidelines, denies Petitioner's request for maintenance and vocational rehabilitation. With respect to permanent disability, Petitioner had surgery for a partially torn medial meniscus, and subsequently had three synvisc injections for Grade 4 chondromalacia, which is the most severe level. Dr. Alden described Petitioner's arthritis as moderate and in two compartments, and that total knee arthroplasty was a current consideration and that she will definitely need it in the future. Petitioner testified she can no longer run or kneel, going down stairs is difficult, and anything that stresses her knee is difficult. She no longer does activities such as mowing the lawn or gardening, or even bathing the dog since that requires kneeling. The most she can do is walk for about an hour around Wal-Mart, or walk around the block to try and lose weight, which her doctor has prescribed. The records show her weight at 169 lbs.

Pursuant to Section 8.1b., the Arbitrator has considered the following factors:

1. AMA Impairment Ratings were waived by the parties as a prerequisite to a disability evaluation (Arb. Ex. 1), so the Arbitrator gives that element no weight either in favor of a higher or lower award;
2. The occupation of the injured employee was as an office assistant which required physical labor, regularly lifting 15 to 50 lbs. items to be stocked on shelves overhead for both the nurses' area and in a separate area for the CNA's.
3. The age of the employee is 53 at the time of the accident and 55 currently, evidencing that the employee has some years of employment remaining. Both elements are given some weight.
4. In respect to the fourth element, the employee's future earnings capacity, it appears that the highest job she was able to obtain was doing janitorial work, which unfortunately was a job that only lasted 1 ½ days after training. Her earning capacity with Respondent, which was a job she no longer is able to do, was $466.15/week. Prior to that she held an entry level job as a cashier at Kroger. She has been unable to find employment in a self-directed job search, evidencing that her earning capacity is impaired, and the Arbitrator places some greater weight on this.

5. In respect to element 5, evidence of disability corroborated by the treating medical records, Dr. Alden was the most qualified physician involved in the case, being a joint reconstruction specialist who formally had teaching credentials at the University of Chicago and is well published and trained in the field. He restricted Petitioner to light or sedentary work, and limited prolonged standing and walking. This would preclude her employment with Respondent, her employment with Kroger's as a cashier which she held immediately prior, her employment with General Electric where she would have to lift and carry various objects to set up displays for trade shows, and leaving the only employment in her work history in which she might succeed being that with her husband's residential contracting company, except for the fact it went defunct due to the economy in 2008. Her limited real estate experience was unsuccessfull. The Arbitrator affords great weight to this factor, the most of any, and finds Petitioner significantly disabled with respect to her ability to perform the limited types of employment she has been trained to do.

Based on the record as a whole, and considering in particular the above factors, the Arbitrator finds that Petitioner has sustained a loss of use of the left leg to the extent of 40% thereof, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF **KANE**)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL KURZROCK,

Petitioner,

vs. NO: 14 WC 38847

YRC FREIGHT,

17IWCC0546

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD), permanent partial disability (PPD), and penalties and attorneys' fees, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that the Petitioner established that he sustained a work-related accident arising out of and in the course of his employment on October 28, 2013.

The Commission further finds that Petitioner's current condition of ill-being was causally related to the October 28, 2013 accident, and as a result, Petitioner is entitled to reasonable, necessary, and related medical expenses totaling $14,044.73, TTD from October 29, 2013 through November 12, 2013, representing 2 and 1/7 weeks, and 25 weeks of PPD benefits as Petitioner sustained disability to the extent of five percent (5%) loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act.

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. On October 28, 2013, Petitioner was employed as a driver for Respondent; part of his duties included unloading and loading trucks. (T.6-7).

2. On October 28, 2013, Petitioner began his work shift at 2:00 AM. He started his shift unloading trailers, which also included lifting trailer doors and dock plates in and out of the trailers. (T.8). Petitioner was lifting boxes of books that weighed 60 to 70 pounds each. (T.9). He testified, "I was doing – I believe it was about a skid, skid and a half which on those skids we usually put nine boxes to a layer, three to four layers high so it could be 30 to 45 boxes a skid." (T.9). Petitioner testified that about 4:30-5:00 AM, he had noticed "a pressure sensation" in his stomach, but continued to work his shift. (T.8; T.10).

3. During Petitioner's lunch break at 9:00 AM, he noticed "a large baseball size lump in my stomach which was very hard and painful." (T.8). He did not have this bulge when he woke up that morning. (T.27). He notified his immediate supervisor, Tom Lincoln, and thereafter, they spoke to Petitioner's terminal manager, Bob Hessy. (T.9-10). "[H]e asked to see. So I raised my shirt and showed it to him. He saw the lump and they immediately sent me to their clinic." (T.10). Petitioner completed an accident report and went to the clinic. (T.10; T.18). Petitioner testified that he had indicated on the accident report that he was "not sure exactly when or how the injury occurred." (T.19; RX1). He also agreed that he had written on the report that his pain "wasn't sudden. The pain and tightness escalated over time." (T.19; RX1). Petitioner clarified on re-direct that the pain and tightness escalated from the time he noticed it around 4:30 AM-5:00 AM to 9:30 AM. (T.22). However, on re-cross examination, Petitioner testified that he believed his injury was due to lifting over and over again. (T.25).

4. Petitioner testified on cross-examination that he did not do any heavy lifting outside of work in the weeks prior to October 28, 2013. However, he did recently move into a house in mid-October 2013. Petitioner then stated that he did move items, possibly weighing 50 to 60 pounds. (T.20-21). On re-direct, Petitioner testified that between his move on October 16, 2013 and October 28, 2013, he did not have any unusual sensations in the area where his hernia was located. (T.23-24). He also stated that at times, he was required to lift up to 80 pounds at work. (T.7). When he was moving, he may have lifted up to 60 pounds. (T.24).

5. Petitioner visited Dreyer Medical Clinic on October 28, 2013. (T.10). He testified that he had previously treated with Dreyer. "We always go there for our two year DOT physicals. They've known about the hernia and how it's happened." (T.11; T.14; T.19). Petitioner explained that on February 8, 2005, he had been lifting freight when he noticed a pulling sensation in his stomach. (T.11; PX1). The February 8, 2005 medical record was consistent with Petitioner's testimony, and stated that no bulging was present and Petitioner had no history of hernia or other abdominal problems. (PX1). He followed-up the next day with

his primary care provider, Dr. Rakesh. (T.12). "He found a small hernia or hole in my muscle and he said it was about the size of your fingertip." (T.12). Dr. Rakesh had advised Petitioner that although surgery was not necessary at that time, Petitioner could experience problems such as "blowouts or bulge-out." (T.12-13; T.19-20). Petitioner did not return to see Dr. Rakesh after February 9, 2005. (T.12).

6. Between February 9, 2005 and October 27, 2013, Petitioner had no further treatment as it related to his 2005 hernia. "I did feel – I mean there are times when you did a lot of lifting and stuff where you could feel like maybe a dime size or maybe a little larger kind of little bulge which you could reduce on your own by pressure." (T.13; T.20). Petitioner would experience this bulge and push it in approximately twice a month. (T.13).

7. The October 28, 2013 medical record from Dreyer Medical Clinic was consistent with Petitioner's testimony as to his prior hernia treatment and his present complaints of pain and swelling "in the periumbilical area." Dr. William Johnston noted a scaphoid abdomen and tenderness in the periumbilical area. Dr. Johnston noted what appeared to be an incarcerated hernia, and attempts to manually reduce the hernia were unsuccessful. Petitioner was diagnosed with pre-existing periumbilical hernia and incarcerated periumbilical hernia. Dr. Johnston ordered Petitioner off work and recommended that he go to the hospital. (T.14; PX1).

8. Petitioner drove himself to Delnor Hospital's emergency room on October 28, 2013. (T.15). The emergency room physician noted "a golfball-sized incarcerated ventral hernia just superior to the umbilicus." The doctor also spent several minutes trying to reduce the hernia, but was unsuccessful. Petitioner underwent surgery to repair the hernia with Dr. David Hodgett. (T.15; PX2). His post-operative diagnosis was repair of strangulated ventral hernia with mesh. (PX2).

9. Petitioner was released to return to work with no restrictions on November 13, 2013. (T.15). When Petitioner returned to work for Respondent, he was required to undergo another DOT physical and he was subsequently allowed to return to work. (T.16). Petitioner has had no further issues in relation to his hernia since November 2013. (T.16).

10. As of the date of arbitration, Petitioner testified that he has a large scar, and noticed that the area where the surgery was performed was hard due to the mesh inside. (T.16).

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony, and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Indus. Comm'n*, 216 Ill. App. 3d 1048, 1054 (3rd Dist. 1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Dep't v. Indus. Comm'n*, 83 Ill. 2d 528, 533-34 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

In his Decision, the Arbitrator decided the issues of accident and causal connection together. The Arbitrator found Petitioner forthright and credible when he testified that he injured himself as a result of lifting boxes. However, the Arbitrator did not treat this claim as a specific injury claim, but instead denied accident and causal connection on the following basis: "Petitioner is claiming a repetitive trauma, but failed to offer a medical opinion that causally relates his current condition of abdominal ill-being with the work activities of October 28, 2013."

The Commission agrees that the record, primarily the medical evidence, does not support a finding of repetitive trauma, however, the Commission finds that Petitioner suffered a specific injury on October 28, 2013. The records from Dreyer Medical Clinic and Delnor Hospital indicate that Petitioner injured himself while lifting at work the morning of October 28, 2013. (PX1; PX2). No doctor opined that Petitioner's injury was the result of repetitive trauma and there is no other evidence, other than Petitioner's brief testimony and the accident report, to support such an alleged claim. Petitioner, however, clarified on re-direct that the pain and tightness escalated from the time he noticed it around 4:30 AM-5:00 AM to 9:30 AM. (T.22).

The Commission notes the timing of the first complaints of pain as they are consistent with a specific event. The Commission further notes the development of pain and symptoms thereafter, which rendered Petitioner incapable of work. He then went to Dreyer Clinic and Delnor Hospital.

For an injury to be compensable under the Act, "a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). From a specific injury perspective, the record supports a finding of accident. "The result of an accident, must be traceable to a definite time, place and cause." *Matthiessen & Hageler Zinc Co. v. Indus. Bd.*, 284 Ill. 378, 383 (1918).

Here, Petitioner testified that on October 28, 2013, he was assigned to lift and unload boxes of books from certain trailers. Each box weighed approximately 60 to 70 pounds. (T.8-9). He testified, "I was doing – I believe it was about a skid, skid and a half which on those skids we usually put nine boxes to a layer, three to four layers high so it could be 30 to 45 boxes a skid." (T.9). Petitioner was also required to lift trailer doors and dock plates in and out of the trailers. (T.8). He began unloading boxes at 2:00 AM, when he began his shift. (T.8). Petitioner testified that around 4:30-5:00 AM, he had noticed "a pressure sensation" in his stomach, but continued to work his shift. (T.8; T.10). When he went to take his lunch break at 9:00 AM, "I noticed a large baseball size lump in my stomach which was very hard and painful." (T.8). He did not have this bulge when he woke up that morning. (T.27).

There is specific evidence in the record that traces Petitioner's resulting hernia to a definite time period (4:30-9:00 AM), place (Respondent's facility), and cause (lifting 60 to 70 pound boxes). The Arbitrator, in fact, found Petitioner credible when he testified to this accident. The Commission likewise finds Petitioner to be credible. Therefore, the Commission finds that

Petitioner sustained a work-related accident arising out of and in the course of his employment on October 28, 2013.

The Commission further considered Petitioner's testimony regarding moving into a new house in mid-October 2013, which required him to lift items weighing 50 to 60 pounds. (T.20-21). On re-direct, Petitioner testified that between his move on October 16, 2013 and October 28, 2013, he did not have any unusual sensations in the area where his hernia was located. (T.23-24). Therefore, the Commission does not find that Petitioner suffered an intervening injury, and his testimony does not change the Commission's conclusion, as it was not until October 28, 2013, after Petitioner had lifted 60 to 70 pound boxes at work, that he suffered his hernia condition.

As to causal connection, the Commission finds that Petitioner's current condition of ill-being, namely the incarcerated ventral hernia condition, was causally related to the October 28, 2013 accident. The Commission notes that Petitioner did have a prior history of treatment for a hernia condition that occurred on February 8, 2005 – eight years before the October 28, 2013 injury. In that instance, Petitioner suffered a small hernia while lifting freight. (T.11-12; PX1). Petitioner had no additional history of hernia or other abdominal problems up until this point. (PX1).

Our Supreme Court in *Sisbro, Inc. v. Indus. Comm'n* stated, "employers take their employees as they find them." 207 Ill. 2d 193, 205 (2003). It also stated:

> Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was a causative factor . . . Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Id.*

Additionally, causal connection between an accident and an employee's condition may be found in instances where a chain of events demonstrate "a previous condition of good health, an accident, and a subsequent injury resulting in disability." *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Between February 9, 2005 and October 27, 2013, Petitioner in this claim had no further treatment as it related to his hernia. He did testify that, "I did feel – I mean there are times when you did a lot of lifting and stuff where you could feel like maybe a dime size or maybe a little larger kind of little bulge which you could reduce on your own by pressure." (T.13; T.20). Petitioner would experience this bulge and push it in approximately twice a month. (T.13). However, in this time period, Petitioner did not require medical treatment nor was there any recommendation for surgery. There was also no evidence in the record that Petitioner was unable to perform his duties for Respondent as a result of any hernia condition.

Following Petitioner's accident at work on October 28, 2013, Petitioner required medical attention, wherein two physicians attempted to manually reduce the hernia but were unsuccessful. (T.14-15; PX1; PX2). Petitioner underwent surgery to repair the hernia, and his post-operative diagnosis was repair of strangulated ventral hernia with mesh. (T.15; PX2). Petitioner was also ordered to remain off work following the accident and surgery. (T.14-15; PX1).

The chain of events in this claim demonstrates Petitioner was capable of managing his prior symptoms, working without restriction, up until the October 28, 2013 accident, at which time he suffered at a minimum, an aggravation to his pre-existing periumbilical hernia. His injury necessitated surgical repair and time off work while Petitioner recovered. Thus, the Commission finds that Petitioner's employment was a causative factor in the resulting condition of ill-being.

Consequently, Petitioner is entitled to reasonable, necessary, and related medical expenses totaling $14,044.73, as well as TTD from October 29, 2013 through November 12, 2013, representing 2 and 1/7 weeks. The Commission also finds Petitioner sustained disability to the extent of five percent (5%) loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act. In consideration of the five factors listed under Section 8.1(b) of the Act:

(i) Impairment Rating: No weight was given to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: Following Petitioner's discharge from treatment, he returned to work for Respondent with no restrictions.

(iii) Petitioner's Age: Petitioner was 36 years old on the accident date. At this age, Petitioner will have to deal with his disability for an extended period of time.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, no weight was given to this factor.

(v) Evidence of Disability: Evidence of disability was corroborated by the treating medical records. As a result of the work injury, Petitioner suffered a strangulated ventral hernia in the periumbilical area that required surgery with the insertion of mesh. (PX1; PX2). Less than three weeks after the accident date, Petitioner was released to work with no restrictions. (T.15). Petitioner has had no further issues in relation to his hernia since November 2013. (T.16). As of the date of arbitration, Petitioner testified that he has a large scar, and noticed that the area where the surgery was performed was hard due to the mesh inside. (T.16).

Based on the totality of the evidence, the Commission finds Petitioner to be permanently partially disabled to the extent of 5% loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act.

17IWCC0546

Lastly, the Arbitrator did not award penalties and attorney's fees. As actual questions existed in terms of accident and causal connection in this claim, and there was no evidence that Respondent was unreasonable or vexatious in denying benefits to Petitioner, the Commission hereby denies any award for penalties and attorney's fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on July 25, 2016, is hereby reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $875.33 per week for a period of 2 1/7 weeks (October 29, 2013 through November 12, 2013), that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 25 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 5% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses totaling $14,044.73 pursuant to Sections 8(a) and 8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all 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 $34,100.00. 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.

Michael J. Brennan

Thomas J. Tyrrell

17IWCC0546

Dissent

I respectfully dissent from the decision of the majority. Arbitrator Cronin's decision was thorough, well reasoned, and grounded in the evidence adduced at hearing. I would affirm and adopt it in its entirety.

Kevin W. Lamborn

DATED: SEP 7 - 2017

MJB/pm
O: 7-11-17
052

NOTICE OF ARBITRATOR DECISION

KURZROCK, MICHAEL
Employee/Petitioner

Case# **14WC038847**

YRC FREIGHT
Employer/Respondent

17IWCC0546

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:

0312 BOUDREAU & NISIVACO
NINA MARIANO
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JASON KOLECKE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Kurzrock
Employee/Petitioner

v.

YRC Freight
Employer/Respondent

Case # 14 WC 38847

Consolidated cases: ___

17IWCC0546

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Geneva**, on **10/15/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

17IWCC0546

On **10/28/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$68,276.00**; the average weekly wage was **$1,313.00**.

On the date of accident, Petitioner was **36** years of age, *married* with **2** dependent children.

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

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

ORDER

Compensation is hereby denied, based on the Arbitrator's denial of accident and causation.

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

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

Signature of Arbitrator

7-23-2016
Date

JUL 25 2016

Michael Kurzrock v. YRC Freight
Case No.: 14 WC 38847
Arbitrator: Honorable Brian Cronin
Trial Date: 10/15/15

17IWCC0546

STATEMENT OF FACTS

Petitioner is a union member and has been a driver/dock worker for YRC Freight since 1999. As part of his job duties he must lift up to 80 pounds. On a daily basis, in the early morning hours, he unloads and reloads a truck.

On February 8, 2005, Petitioner sustained a small hernia after lifting freight at work. He felt pressure in his abdomen. He reported the injury and filled out an accident report. He went to Dr. Daleesh the next day, who told him that surgery was not necessary, but that he might have problems down the road. Petitioner testified that the hernia was about the size of a fingertip. He was able to continue working full duty and would self-reduce the hernia on occasion. It was not painful and he did not return to the doctor for it. He had a DOT physical every two years.

Petitioner testified that his hernia condition remained asymptomatic until October 28, 2013. He testified that he began his work shift around 2 a.m. and before work he was sleeping. His job duties that morning included lifting the trailer doors and dock plate, as well as lifting boxes of books that weighed 60-70 pounds each. He testified that he piled up the boxes three to four layers high on a skid. At around 4:30 or 5 a.m., while he was lifting the boxes of books, he felt pressure in his abdomen like someone was constantly pressing a thumb in Petitioner's stomach. The sensation did not go away but increased in intensity. He continued to work until his 9 a.m. lunchtime. At about 9:30 a.m., Petitioner noticed that the bulge was now hard and painful and the size of a baseball. Petitioner indicated that a bulge that size was not there earlier.

Petitioner reported the incident to Tom Lincoln, his supervisor, and proceeded to the Dreyer Occupational Clinic where he was evaluated and referred to Delnor Hospital for emergency surgery. Petitioner underwent a repair of a strangulated ventral hernia with mesh and had an uneventful recovery. He was released to return to work on November 13, 2013. Petitioner testified that he notices a hardness/tightness in the area of the hernia, but has otherwise recovered.

On cross-examination, Petitioner testified that he cannot pinpoint the exact moment on October 28, 2013 that the hernia occurred. He had no sudden pain, but experienced pressure in his abdomen.

Respondent showed Petitioner Rx.1, which is the YRC Employee Notice of Injury. Petitioner agreed that he completed and signed this document. Petitioner wrote, *inter alia*, that the injury occurred on October 28, 2013 at 5:30 a.m., and that he "was not

sure exactly when or how injury occurred, it wasn't sudden the pain and tightness escalated over time." (Rx.1) Petitioner testified that he wrote these words in the document because he did not feel a stabbing pain at that time.

Respondent presented evidence that Petitioner moved houses on October 16, 2013, which was less than two weeks prior to the incident. Petitioner testified that he did do some lifting during his move and could have been lifting boxes that weighed 50-60 pounds. He may have self-reduced the bulge in his abdomen after the move, but it was a smaller bulge. Petitioner testified that he did not notice anything different with his abdomen from the date of his move, October 16, 2013, to the start of his workday on October 28, 2013.

On October 28, 2013, Petitioner testified, he was unable to self-reduce, that is, he was unable to push the hernia back in. Petitioner testified that he believed that such hernia occurred on October 28, 2013 from the repetitive lifting of the boxes that he undertook that day.

CONCLUSIONS OF LAW

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

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

Petitioner began performing his job duties, which included lifting boxes, at 2 a.m. on October 28, 2013. At around 5 a.m. that morning, he felt an abnormal sensation in his abdomen, but continued working. When he went to eat lunch, he noticed pain and a baseball-sized bulge in his abdomen and sought medical attention.

Petitioner's job duties include loading and unloading heavy product.

As Petitioner performs frequent lifting of 60-70 pound boxes at work, the Arbitrator makes the reasonable inference this is a risk peculiar to his employment to which the general public is not exposed. The fact that he moved houses twelve days before this incident at which time he lifted boxes of up to 60 pounds does not change this fact.

In 2005, Petitioner sustained a small hernia at work while he was lifting. This small hernia did not require surgical repair. He was able to work without any problem until October 28, 2013.

The Arbitrator finds that the Petitioner was forthright and credible. He testified that he believed this injury occurred as a result of lifting boxes.

In Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203,797 N.E.2d 665, 671 (2003), the Court held that "[a] claimant may be entitled to benefits under the Act even though he suffers from a preexisting condition of ill-being." Id. at 205, 797 N.E.2d at 672-73. "[I]n preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." Id. at 204-05, 797 N.E.2d at 672.

"Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." (Emphasis in original.) Id. at 205, 797 N.E.2d at 673.

Nevertheless, on October 28, 2013, William Johnston, M.D., of Dreyer Occupational Clinic wrote:

> "This is the initial Occupational Health visit for a previously healthy 36-year-old male who states that he has noticed some pain and swelling in the periumbilical area. He reports that this began just a couple of hours ago, and has noticed a firm swelling in the region. He reports that he did have a pre-existing minor periumbilical hernia that had not been giving him any trouble in the past. He states that he did not sustain any sudden increase in pain. He did not notice any increase in pain or tearing when he was lifting but noticed that over the course of the past few hours, the pain and swelling in the area has increased. He denies any GI symptomatology such as nausea or vomiting ***
>
> He is discharged for this condition which should be considered a non work-related condition. The periumbilical hernia pre-existed. The incarceration of that hernia is a medical complication and is not related to any specific injury event." (Px.1)

Petitioner is claiming a repetitive trauma, but failed to offer a medical opinion that causally relates his current condition of abdominal ill-being with the work activities of October 28, 2013.

In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and the claimant's disability. Williams v. Industrial Comm'n, 614 N.E.2d 177, 180, 185 Ill. Dec. 43 (1993)

The Arbitrator recognizes that Dr. Johnston is associated with Dreyer Occupational Clinic, which is the clinic to which Respondent sent Petitioner. However, Dr. Johnston puts forth the only medical opinion in this case.

Based on the foregoing, the Arbitrator concludes that Petitioner failed to prove the issues of accident and causation.

Signature of Arbitrator

7-23-2012
Date

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

Floyd Blazier,
Petitioner,

vs. NO: 14 WC 40256

Erickson Auto Parts & Services,
Respondent.

17IWCC0534

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses 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 15, 2016 is hereby affirmed and adopted.

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

DATED: SEP 5 - 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-08/30/17
jdl/wj
68

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

Floyd Blazier
Employee/Petitioner

v.

Erickson Auto Parts & Service
Employer/Respondent

Case # 14 WC 40256

17IWCC0534

An *Application for Adjustment 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 **Rockford**, on **June 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

17IWCC0534

FINDINGS

On **July 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.

Timely notice of this alleged accident ***was not*** given to Respondent.

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

In the year preceding the injury alleged, Petitioner earned **$32,705.72**; the average weekly wage was **$628.96**.

On the date of alleged accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

ORDER

The Petitioner failed to prove that an accident occurred which arose out of and in the course of his employment with the Respondent and failed to prove a causal relationship between the alleged accident and any condition of ill-being. The Petitioner's claim for compensation is, therefore, denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

July 11, 2016
Date

FACTS:

On July 23, 2014 the Petitioner was employed by the Respondent as a truck driver. The Petitioner testified that, on that date, while he was getting out of his truck, he stepped on something and twisted and immediately experienced pain in his back. The Petitioner testified that he did not report the incident that day and instead went home. The Petitioner testified that he then sought medical treatment at Beloit Hospital but he did not report that he hurt himself at work. The Petitioner testified that he returned to work the next day and reported that he got hurt getting out of his truck.

The Petitioner testified that his back pain continued and he sought treatment first at Lanoway Chiropractic and then at Reich Chiropractic. The Petitioner testified that he ultimately came under the care of Dr. Kenneth Gold and began a course of treatment which included an MRI and physical therapy, and then referral to a pain clinic where he underwent two spinal cord stimulator implantation attempts. The Petitioner testified that he continues to experience pain in his low back which radiates down into his left leg and foot.

The records of Beloit Memeorial Hospital demonstrate that the Petitioner was seen there on July 23, 2014 with a chief complaint of left hip pain radiating down his leg. The Petitioner described an onset of symptoms "2 days ago" with gradual worsening and current pain and burning from his lower left back and hip radiating down his left leg. It is noted that the Petitioner denied any trauma or event that precipitated the onset of his pain. The Petitioner was diagnosed with left hip pain and low back pain and was prescribed medications and discharged home.

The records of Lanoway Chiropractic demonstrate that the Petitioner was seen there on July 25, 2014 with complaints of pain in his left hip and down into his left leg. The Petitioner denied any "minor back wrenches, strains, falls, minor auto accidents" in the past 10 years, and reported that his pain started "Sunday night/Monday". In response to the question "How did it happen?" the Petitioner reported; "Fell asleep on floor w/grandson".

The records of Reich Chiropractic demonstrate that the Petitioner was seen there on July 30, 2014 with complaints of left low back pain and left hip, buttock, thigh, and calf pain. The history noted was "7/22/14 stepped out of truck slipped on rock left foot and twisted to keep balance . . . felt pain in left hip down outside of left leg into calf". The Petitioner continued treatment at Reich Chiropractic through September 26, 2014.

Dr. Gold's records demonstrate that the saw the Petitioner for complaints of back, left hip, and left leg pain on February 2, 2015. The emergency room visit of July 23, 2014 is noted but no history of injury is indicated. Dr. Gold's assessment included "Low back pain, presumed secondary to degenerative joint disease involving lumbar spine with radicular symptoms. Dr. Gold prescribed the Petitioner off work for 12 weeks. On February 27, 2014, Dr. Gold prescribed a lumbar MRI for the Petitioner which reportedly revealed "mild posterior bulging". In June of 2015 Dr. Gold prescribed an epidural steroid injection for the Petitioner.

The records of Dr. Ann Prune of Riverwind Theraputic LLC demonstrate that the Petitioner underwent a course of Occupational Therapy from April 27, 2015 through July 27, 2015.

Wayne Erickson, the Respondent's owner testified that the Petitioner did report twisting has back. Mr. Erickson testified that did not remember the date on which that occurred but he testified that the Petitioner did not report a work injury. Specifically, Mr. Erickson testified that the Petitioner reported that he twisted his back but did not know hoe he did it. Mr. Erickson testified that he first learned of the Petitioner's claimed work injury three or four months later when he learned of the Petitioner's claim from his insurance adjuster.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here.

In so finding, the Arbitrator notes the history contained in the Beloit Memorial Hospital Emergency Room records does not corroborate the Petitioner's testimony with regard to the mechanism of injury and date of the injury claimed. The history documented on July 23, 2014 indicates that the Petitioner described the onset of his symptoms "2 days ago" and denied "any trauma or event that precipitated the onset of his pain." The Petitioner acknowledged that he did not give a history of a work injury when he was seen at Beloit Hospital. The Arbitrator finds it difficult to believe that had the injury occurred as described by the Petitioner he would not have reported it when he sought treatment at the emergency room on the day it occurred, The Arbitrator also finds it difficult to believe that had the injury occurred that day, the Petitioner would have reported an onset of symptoms "2 days ago".

The Arbitrator also notes that the Lanoway Chiropractic record dated July 25, 2014, demonstrates that the Petitioner reported that his condition happened when he "fell asleep on floor with grandson". There is no mention of any accident or the Petitioner's job in the history documented at Lanoway Chiropractic. While the Petitioner testified that he did not give this history to Lanoway Chiropractic, the Arbitrator finds that testimony difficult to believe. Additionally, the Arbitrator finds it difficult to believe that a work injury would not have been noted had the Petitioner reported one.

Additionally, the Arbitrator notes the history of stepping out of his truck on July 22, 2014 the Petitioner gave to Reich Chiropractic on July 30, 2014 is the third version of the alleged accident noted in the Petitioner's medical records. While the Petitioner's testimony was consistent with the mechanism of injury described in this note, the date of the alleged injury indicated is not consistent with the Petitioner's testimony.

Based upon the inconsistent histories contained in the medical records, the Arbitrator questions the credibility and reliability of the Petitioner's testimony regarding the alleged accident. The Arbitrator also notes that, while the temporal sequence of events might suggest a causal relationship between the Petitioner's complaints and his alleged injury, the Petitioner's testimony is not sufficiently credible or reliable to support such a conclusion. Additionally, there is no medical opinion in the record which causally relates the Petitioner's condition to his alleged work injury.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove that a causal relation exists between the Petitioner's alleged work injury and any condition of ill-being.

As the Arbitrator has found that the Petitioner failed to meet his burden with regard to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm 14 WC 41388	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with correction	☐ Rate Adjustment Fund (§8(g))
☒ Reverse 14 WC 41387	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph DiLeonardi,

Petitioner,

vs.

NO: 14 WC 41387
14 WC 41388

City of Chicago,

17IWCC0570

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) for 14 WC 41387 having been filed by the Petitioner and notice provided to all parties, the Commission after considering the issues of accident, causal relationship, temporary total disability benefits, medical expenses, prospective medical care, credit and choice of medical providers, and being advised in the facts and the law reverses the Decision of the Arbitrator. Timely Petition for Review under §19(b) for 14 WC 41388 having been filed by the Petitioner and notice provided to all parties, the Commission after considering the issues of causal relationship, temporary total disability benefits, medical expenses and prospective medical care and being advised in the facts and the law, affirms the Decision of the Arbitrator.

Finding of Facts

At the August 22, 2016 arbitrator hearing, Petitioner testified on November 16, 2010 he was employed with Respondent in the Water Management Department in the position of assistant cleaning foreman and was a member of the Plumbers Union Local 130 at that time. T. 11-12. He has been employed with Respondent since approximately 1996. T. 12. From 1996 through 2001, Petitioner was employed as a union laborer and became a union plumber in 2001 *Id.* He worked in the sewer department, which is part of water management. T. 13.

Petitioner testified he is responsible for approximately five to six different crews that travel and assist repair crews in the construction, cleaning and maintenance of the sewers in the City of Chicago. T. 13. His area is as far north as Howard and as far south as Division and from the lakefront to as far west as Cumberland. *Id.* Petitioner's office is located at 4900 W. Sunnyside in Chicago. *Id.* His regular workdays are Monday through Friday, and he works regular work hours. T. 14. He reports to work first at his office. *Id.*

Petitioner testified he became an assistant foreman around 2001. T. 14. His duties have remained the same generally speaking from 2001 to the present. *Id.* During an average work day, Petitioner spends approximately two hours at his office at the Sunnyside location. *Id.* His workday consists of six more hours during which he is in the field. T. 14-15. While in the field, he checks jobs and repair crews or equipment. T. 15. Those jobs include flooding in streets and alleys, flooding under viaducts and clogged sewers. *Id.* In addition to supervising jobs, he has responsibility for equipment. T. 15-16.

Petitioner testified for the six hours in the field, he travels to each job site driving a pick-up truck provided by Respondent. T. 19. However, in 2010, Respondent did not provide his vehicle as he received the same approximately three or four years prior. *Id.* Previously and specifically on November 16, 2010, Petitioner drove his own vehicle while out in the field, a Nissan Murano, and was reimbursed for mileage by Respondent. T. 20.

Petitioner testified in 2010, during an average work day he would visit at minimum three job sites and at maximum approximately 15 job sites. T. 20. The average per day would be approximately eight job sites visited. T. 21. At each of those locations, Petitioner would get out of his car and then get back into his car at the completion of his visit. *Id.* During an average week, he would visit approximately 40 job sites. *Id.*

Petitioner testified prior to November 16, 2010 he received no treatment for his low back. T. 22. He did not believe he lost any time from work for any back related issue and did not recall losing any time from work due to his back. *Id.* To the best of his recollection, he did seek treatment with MercyWorks in 1997, but he could not recall what part of his body was treated at that time. *Id.*

Petitioner testified on November 16, 2010 he was working in the field. T. 23-24. At approximately 1:00 p.m., he went to a job near Lunt Avenue in Chicago to check a catch bin. *Id.* Petitioner recalled parking his vehicle on a City street near 1830 W. Lunt Avenue. T. 24. Petitioner testified, "I opened the door, grabbed my gloves, opened the door, I thought I was stepping on the curb." T. 25. "Q. Which foot did you use to step onto the curb? A. My left foot, and I missed the curb. I thought I was stepping on the curb, and when I missed the curb my foot slipped on mud and leaves that were in the curb lane and I twisted my back and wound up falling down." *Id.* "Q. After you missed the curb, and you say you slipped, what if anything

happened to your low back? A. I twisted it when I fell and there was immediate pain." T. 26. Petitioner testified he experienced immediate pain in his low back just above the pant line; the pain was dead center middle; he felt a sharp pain in his low back as well as a little tingling sensation in his right leg to his foot. T. 26-27.

Petitioner testified following the November 16, 2010 accident, he reported the accident to his supervisor Robert Mroflza. On November 18, 2010, Mr. Mroflza completed an accident report. Petitioner was shown PX1 and identified it as the accident report Mr. Mroflza completed. T. 29. Mr. Mroflza's handwriting is in the area under No. 21 which is the detailed description of the injury he sustained on November 16, 2010. *Id.* Petitioner acknowledged his signature on PX1 right above No. 35. *Id.*

Petitioner testified he began a course of medical care on November 17, 2010 with his primary care physician, Dr. Sadowsky, who recommended Petitioner see a chiropractor for treatment. T. 30. On November 18, 2010, Petitioner reported to MercyWorks, Respondent's company clinic as his boss referred him there, and he began a course of care which continued through April 28, 2011. *Id.* While under the care of the physicians at MercyWorks, it was recommended he undergo a lumbar MRI, which he undertook on December 1, 2010 at Resurrection Medical Center. T. 31. MercyWorks also recommended he undergo physical therapy for his lower back and referred him to Dr. Wehner. *Id.* Dr. Wehner provided treatment to him from December 29, 2010 through March 9, 2011. *Id.* Dr. Wehner prescribed medications and reviewed the results of the lumbar MRI study. T. 31-32.

Petitioner testified as it relates to the November 16, 2010 accident, he was off work from November 18, 2010 through January 14, 2011 and received workers' compensation benefits. T. 32. On January 15, 2011, Petitioner returned to his job duties at the Water Department Sewer Department as an assistant foreman. T. 33.

Petitioner testified he began treatment with chiropractor Dr. Cunningham on March 31, 2011. T. 34-35. Petitioner initially testified he was referred to Dr. Cunningham by a friend but then stated he was referred by his primary care physician, Dr. Sadowsky. T. 33. The Commission notes there were no records from Dr. Sadowsky submitted into evidence by either party. Petitioner began a course of care with Dr. Cunningham at Advanced Chiropractic Care on March 31, 2011 and continued through July 15, 2014, receiving chiropractic care regularly during that period. T. 35. As part of this facility, Dr. Cunningham referred Petitioner to other doctors including Dr. Ring, a pain management doctor. T. 36. While under the care of Dr. Ring from March 31, 2011 through July 8, 2013, Petitioner received treatment including 4 trigger point injections to his lower back on April 8 and 14, 2011, December 24, 2012 and May 13, 2013. *Id.* When Dr. Ring was not available, Petitioner saw his associate Dr. Olowe at the Advanced Pain and Rehabilitation facility. T. 37. Dr. Olowe administered trigger point injections on March 4, May 27 and June 17, 2014. *Id.* Some of the medical records from Advanced Chiropractic also list the name in Spanish, Avanzado Chiropractic, and Petitioner

stated this is the same facility located around 4500 W. Fullerton. T. 38. Dr. Ring also recommended Petitioner undergo an EMG, which was performed on April 2, 2013. T. 38-39. The medical bills from chiropractor Dr. Cunningham and the pain treatment physicians were submitted for payment through group health insurance, which paid the bills. T. 39. Petitioner treated with Advanced Chiropractor group, Dr. Cunningham, Dr. Ring and Dr. Olowe through July 2014 without much improvement. *Id.*

Petitioner testified he sought treatment from a different facility, Wellness in Motion Chiropractic Center, from August 2, 2014 through August 8, 2014. T. 40. The chiropractor from that facility referred him to Dr. Padron with whom he treated until November 6, 2014. T. 40. Dr. Padron recommended a lumbar MRI, which Petitioner underwent at Edgebrook Radiology on August 11, 2014. T. 41.

Petitioner testified from the time he returned to work on January 15, 2011 up until the day before the second accident on December 3, 2014, he noticed pain on a daily basis which was tolerable with taking the medications, Norco and Oxycodone. T. 42.

Petitioner testified on December 3, 2014 he reported to a job at 644 W. Kemper in Chicago for a problem with a sewer. T. 43-44. He was driving a pick-up truck issued by the City. T. 44. After he parked the vehicle near the job site, he stepped out of the vehicle with his vest and gloves in his hands. *Id.* Petitioner testified he, "Stepped out, grabbed my vest, gloves, walked over to the crew, was assisting them, slipped on the ice, twisted." T. 44-45. He stopped himself mid fall as one of the other guys stopped him from falling. T. 45. Petitioner twisted his low back and felt pain instantaneously, very sharp stabbing pain in the same area right around the belt-line with a pain level of 8-9/10. *Id.*

Petitioner testified following the December 3, 2014 accident, he reported to MercyWorks at the request of his supervisor. T. 46. He treated at MercyWorks from December 3, 2014 through December 10, 2014. *Id.* Petitioner resumed medical care with Dr. Padron from December 4, 2014 through June 28, 2016. *Id.* He was off work from December 4, 2014 through May 18, 2015, and he received workers' compensation benefits during that period of time. T. 47. He also sought medical treatment from orthopedic surgeon Dr. Gireesan and treated with him from December 18, 2014 through June 6, 2016. *Id.* Dr. Gireesan recommended a lumbar x-ray study, which was undertaken at Northwestern on February 5, 2015. T. 48. Dr. Gireesan also recommended a lumbar MRI on March 2, 2015. *Id.* He underwent another EMG on October 30, 2015. *Id.* Dr. Gireesan recommended physical therapy and Petitioner attended this at ATI from December 19, 2014 through February 5, 2015. *Id.* He continued to receive pain medications prescribed by Dr. Padron, and Dr. Gireesan was aware of the same. T. 48-49. Dr. Padron recommended Petitioner undergo the lab pro-screening test to determine if he was compliant with the medication. T. 49. Dr. Padron prescribed Norco and Oxycodone, the same medications he had been taking previously. *Id.* Dr. Gireesan recommended a two-level lumbar fusion. T. 50. Petitioner has not undergone this surgery as Respondent has not approved payment for the

surgery. *Id.* Petitioner testified he wished to proceed with the surgery and requested the arbitrator award payment for the same. *Id.*

Petitioner testified he returned to work as a foreman for Respondent on May 19, 2015 and has continued to work in this capacity. T. 51. Petitioner has noticed since returning to work his performance of his job duties is altered as jobs he was previously able to perform now require assistance from others or take a longer period to perform. T. 51-52. Petitioner testified he has developed a limp. T. 52.

On cross-examination, Petitioner testified as to his prior back injuries. Petitioner recalled injuring his low back while breaking up debris with a pry bar on or about January 21, 1997. T. 56. He did not recall receiving treatment at Ravenswood emergency room but recalled being diagnosed with a strain. *Id.* Petitioner testified he did not recall injuring his back on or about November 9, 1998 when he was lifting a sewer lid and did not recall receiving treatment for the same. T. 57. Petitioner did not recall injuring his low back on August 23, 1999 while changing a cracked lid on a catch basin and manhole. *Id.* Petitioner did not have any other injuries to his low back before 2010 outside of work. *Id.*

Regarding the November 16, 2010 incident, Petitioner acknowledged on direct examination he testified he was getting out of his car, and he did not step on the curb; "I thought I was stepping on the curb and I slipped in the gutter line." T. 58. As for the accident report, Petitioner testified as to the certification of correctness explaining the report was completed by another individual prior to him signing the same. *Id.* Petitioner acknowledged that the accident report memorializes he slipped on the curb and not the gutter line, and he made no request to change the description. T. 59.

As to the history of accident provided to Dr. Gireesan, Petitioner acknowledged the discrepancy between stepping on a curb versus missing a step, and such history was provided when the circumstances were no long fresh in his mind. T. 60.

Petitioner testified following the incident of November 16, 2010, he initially sought treatment with his primary care physician. T. 62. When Dr. Ring was not available, Petitioner sought treatment with Dr. Olowe who performed a set of 3 injection. *Id.* He then sought treatment from a second chiropractor on a referral from a friend. *Id.* After he returned to work on November 15, 2011, he remained in treatment. T. 63. With respect to his second injury on December 3, 2014, he sought treatment from Dr. Gireesan on a referral from a friend. *Id.* Petitioner recalled telling Dr. Gireesan he visited a water park with his children in January 2015. He did not remember the name of the water park, and he believed he was there overnight. T. 63-64. Petitioner testified unequivocally that he did not ride the water slide at the water park. T. 64. At Respondent's request, Petitioner was evaluated by Dr. Singh, who recommended he enter a work-conditioning program; Petitioner did not attend work hardening but returned to work. *Id.*

Dr. Singh did not recommend surgery. *Id.* Currently Petitioner is working his usual and customary position with Respondent. *Id.*

On re-direct examination Petitioner clarified the particulars of his fall on November 16, 2010 explaining he slipped on the gutter line, the bottom part of the curb where the top and the bottom meet; the concrete where the top of the gutter goes down, and it is the concrete onto the street level. T. 66. The gutter line was part of the curb. *Id.* With respect to the treatment provided at Ravenswood emergency room in 1997, Petitioner did not recall having any follow-up treatment for his low back. *Id.* With regards to 1998 and 1999, Petitioner did not recall any follow-up treatment, other than those one-time visits at MercyWorks; he had no recollection regarding the actual treatment undertaken at that time; to the best of his recollection, he did not lose any time from work. T. 66-67. From the year 2000 up until the November 16, 2010 accident, Petitioner did not recall having any treatment for his low back; he did not remember taking any medication for his low back during that time. T. 67. Relative to the trip to the water park, Petitioner testified it was a family excursion in the winter after the December 3, 2014 accident; his children were five and two years old at that time. T. 68. At the water park, Petitioner stated he mainly sat while his wife was with their children. *Id.* Petitioner saw Dr. Gireesan on January 7, 2016 and told him he was at a water park with his children and that trip would have been some time in December 2015. T. 69.

A "City of Chicago Report of Occupational Injury or Illness" dated November 18, 2010 was admitted into evidence as PX1. This report was signed by Petitioner and supervisor Robert Mroflza. The report noted the date and time of injury as November 16, 2010 at 1:00 p.m. The date this was reported to the supervisor is noted as November 17, 2010 at 2:00 p.m. The location of incident is noted as 1830 W. Lunt. The injury is described as the following: "While employee was getting out of his car to check C.B. (catch basin) he slipped of curb falling to ground and hurt his lower back."

The medical records evidence on November 18, 2010 Petitioner sought treatment with Dr. Pithadia of MercyWorks. The following is noted in the employee's description of injury: "This patient is a 34-year old male who while at work on the 16th was getting out of his car at a job site and slipped on a curb and fell to the ground. After that the patient did get up and did go back to work for the next couple of days. Up until yesterday which was November 17th the patient continued to have low back pain with radiation to his right buttock, right knee and right ankle which gave him a severe pain." Dr. Pithadia noted Petitioner sought treatment from his primary care physician who prescribed a Medrol Dosepak. Petitioner reported his pain level at 8/10 with pain extending into the right buttock, to the right knee and down the leg; shooting in quality and electric-like. Lumbar x-rays were taken which evidenced no acute abnormalities, no spondylolisthesis and no shortening of the space in the disc. Dr. Pithadia diagnosed lumbar strain and sciatica; continued the Medrol Dosepak; and prescribed medications- Toradol, Voltaren, and Flexeril. Dr. Pithadia issued restrictions of no prolonged standing or sitting, no

repeated bending, stooping, squatting, pushing, jerking or twisting, minimum walking and climbing including stairs, and no lifting over 10 pounds. PX2; RX2.

Thereafter on November 26, 2010 Dr. Pithadia re-evaluated Petitioner who reported continued pain of 7/10 with radiation to his right leg even with taking prescribed medications. On examination Dr. Pithadia found lumbosacral positive to palpation at L5-S1 region right paraspinal and positive straight leg raises. Dr. Pithadia diagnosed lumbar strain and sciatica. Dr. Pithadia added Vicodin for pain relief and ordered a lumbar MRI. Petitioner was to continue limited duty work with the same restrictions. PX2; RX2. On December 1, 2010 Petitioner underwent a lumbar MRI without contrast at Resurrection Hospital which evidenced no significant paravertebral soft tissue abnormalities. The radiologist's impression was moderate degenerative changes at the level of L4-L5 and L5-S1 with left paracentral posterior disc osteophyte complexes causing mild to moderate left neural foraminal narrowing. PX3.

On December 10, 2010 Dr. Pithadia re-evaluated Petitioner and noted the lumbar MRI evidenced osteophyte/degenerative joint disease and positive disc herniation. Petitioner reported that same pain level. On examination Dr. Pithadia found tenderness to palpation L5-S1 right paraspinal and positive straight leg raises on the right. Dr. Pithadia diagnosed low back pain and lumbar strain. Dr. Pithadia prescribed 12 sessions of physical therapy and continued the same work restrictions. Dr. Pithadia opined Petitioner had reached maximum medical improvement. PX2; RX2.

The medical records of Accelerated Rehabilitation evidence Petitioner was evaluated initially on December 14, 2010. The physical therapist notes Petitioner reported on November 16, 2010, "He stepped out of his car and step off a curb with LLE, which caused some mild discomfort in the lumbar spine. He notes that evening he had significant increase in symptoms and upon waking in the next day, had severe pain radiating to the RLE with difficulty weight bearing." Petitioner reported occasional radiculopathy into his right lower extremity and difficulty with standing, walking and prolonged sitting. It was noted Petitioner had been off work since the date of injury. Therapy was recommended three times a week for four weeks. PX4.

On December 29, 2010 Dr. Pithadia re-evaluated Petitioner who complained of increased pain with radiation to his right foot with sporadic coldness. Petitioner attended eight sessions of physical therapy with no relief. His examination was the same. Dr. Pithadia again reviewed the lumbar MRI and noted small paracentral disc osteophyte complexes causing no central canal strain and no significant disc herniation. Dr. Pithadia diagnosed lumbar strain and radiculopathy and referred Petitioner to orthopedic back specialist, Dr. Wehner. He was to take Vicodin/Flexeril as directed and continue limited duty work restrictions. PX2; RX2.

The medical records evidence on December 29, 2010 Dr. Wehner evaluated Petitioner, and she noted the following history: "He is reporting a date of injury of 11/16/10 when he got

out of his truck on the curb and caught himself partially from falling. He states the next day he had onset of low back pain." Dr. Wehner noted Petitioner's treatment to date. Petitioner reported he had a great deal of difficulty sleeping, occasional stingers in his right leg, pain in his low back, both heels and radiation down the back of his right leg. He also reported an icy problem. Petitioner denied any previous history of back problems. On examination Dr. Wehner found gait and heel-toe pattern were normal, Petitioner could bend to mid tibia level with his fingertips, extension was 20 degrees, hip range of motion was without pain, straight leg raises were mildly positive on the right at 90 degrees, knee and ankle reflexes were 2+, motor strength was 5/5 and there was no atrophy and no edema. Dr. Wehner reviewed the lumbar MRI scan with Petitioner and noted it evidenced some Schmorl nodes at L4-L5 and L5-S1, and at L4-L5 there was a moderate sized left paracentral disc osteophyte complex, but this did not cause any central canal narrowing; at L5-S1 there was also a small to moderate left paracentral posterior disc osteophyte; there was no significant compression of the nerve root or displacement of the thecal sac. Dr. Wehner diagnosed low back pain and encouraged Petitioner to finish his present physical therapy program. Dr. Wehner recommended Ibuprofen and Flexeril at nighttime and expect Petitioner to improve with conservative treatment. Dr. Wehner noted Petitioner was off work. PX5.

On December 29, 2010, the therapist at Accelerated Rehabilitation noted Petitioner presented with minimal subjective improvements with low back pain. He continued to have difficulty while changing positions and performing most the exercises. Petitioner continued to walk with an antalgic gait pattern and subjectively had complaints of pain with most activities performed. The therapist noted Petitioner would defer to the doctor's recommendation for further treatment. PX4. On December 31, 2010 Dr. Pithadia continued physical therapy for three times for one week. PX2; RX2.

On January 7, 2011 Dr. Wehner re-evaluated Petitioner and noted Petitioner's compliance with physical therapy without significant improvement. Petitioner reported he felt like there was a knuckle in his back and no leg pain. On examination Dr. Wehner found gait and heel-toe pattern were normal, range of motion was without pain, straight leg raises were negative, knee and ankle reflexes were 2+ and motor strength was 5/5. Dr. Wehner again reviewed the lumbar MRI findings that evidenced some small degenerative changes. Dr. Wehner opined surgical intervention did not appear necessary. Dr. Wehner noted a lack of radicular pain complaints as such injection treatment would not be beneficial. Dr. Wehner encouraged Petitioner to continue his home exercise program and continue taking Ibuprofen. Dr. Wehner noted, "At this point he could be transitioned back to regular work." PX5.

On January 12, 2011 Dr. Pithadia re-evaluated Petitioner who reported seeing Dr. Wehner who cleared him to return to work. He reported his pain was still at 3/10. On examination, there was no tenderness and straight leg raises were negative. Dr. Pithadia reviewed the physical therapy records and noted Petitioner showed no progress. Dr. Pithadia

diagnosed lumbar strain/radiculopathy; released Petitioner to return to work at full duty; and discharged him from care. PX2; RX2.

On January 21, 2011 Dr. Wehner re-evaluated Petitioner who reported it felt good to be back at work. He was performing his full duty work and taking Ibuprofen. Overall, he felt the same with low back pain, but no leg pain. Petitioner expressed concern as to why his back pain was not improving. Dr. Wehner noted, "I again went over his MRI and showed him that these findings are degenerative and were pre-existing. He does not have any nerve root compression or spinal cord compression that would be worrisome. The pain is mostly mechanical low back pain and should be treated mostly with exercises." Petitioner was to continue working full duty. Dr. Wehner informed Petitioner that with time most of his symptoms should improve dramatically to the point where they are at baseline. He was to follow-up in four weeks. PX5.

On March 9, 2011 Dr. Wehner again evaluated Petitioner who reported working but complained of daily back pain. Dr. Wehner again reviewed the lumbar MRI with Petitioner and encouraged him to pursue the exercise option of strengthening his back. Dr. Wehner ordered physical therapy, lumbar rehabilitation, twice a week for three weeks. PX5.

On March 10, 2011 Dr. Pithadia re-evaluated Petitioner who reported his pain level was 4/10. It was noted that Dr. Wehner recommended additional physical therapy, and Petitioner was to see her in four weeks. Dr. Pithadia diagnosed lumbar strain. Petitioner was to continue full duty work without restrictions with a follow-up on April 7, 2011. PX2; RX2.

The medical records evidence Petitioner sought treatment with Dr. Cunningham of Advanced Chiropractic Care on March 31, 2010. Dr. Cunningham noted Petitioner complained of pain, stiffness, spasm, ache and radiating pain, constant and worse with activity with a reported pain level of 6-7/10. Dr. Cunningham diagnosed lumbago, sciatica and lumbar radiculopathy and recommended chiropractic spinal manipulation, electrical muscle stimulation, myofascial trigger point release technique and ultrasound therapy two to three times a week. PX10.

The medical records evidence also on March 31, 2010 Petitioner sought treatment from Dr. Ring of Advanced Pain Care and provided a history of injury at work when he fell off a curb. Petitioner complained of pain which was constant but varied in intensity, generally 5/10, with his highest level of pain 9/10 and lowest 3/10. Dr. Ring's assessment was low back pain and left leg radiculopathy and recommended administer trigger point injections as well as medications. PX6.

On April 8, 2011 Dr. Ring administered a lumbar epidural injection and trigger point injections. On April 14, 2011 Dr. Ring administered trigger point injections in Petitioner's left lower back. PX6, PX7.

On April 28, 2011 Dr. Pithadia evaluated Petitioner who reported treatment at Advanced Chiropractic Care which he felt was helping him. Dr. Pithadia noted Petitioner underwent an epidural steroid injection with a pain level of 2/10. On examination Dr. Pithadia found positive range of motion, flexion and extension and diagnosed a lumbar strain with recommendation to continue with chiropractor care and full duty work. Petitioner was asked to follow-up on May 19, 2011. PX2; RX2.

The medical records of Advanced Chiropractic Care evidence Petitioner received chiropractic treatments from April 27, 2011 through June 9, 2011 and the following dates in 2011: July 11, July 18, November 11, November 18, December 5 and May 24, 2012. PX10.

The medical records of Avanzado Quiropractico evidence Petitioner received chiropractic treatments on the following dates: July 11, 2011, November 14, 2011, December 12, 2011, January 9, 2012, March 8, 2012 and then once a month through July 2014. It was noted Petitioner was treating for chronic low back pain L4/5 and L5/S1. PX11.

Petitioner continued treatment with Dr. Ring once a month from May 9, 2011 through July 11, 2011 and then from November 14, 2011 through July 8, 2013. Dr. Ring administered trigger point injections on December 24, 2012 and May 13, 2013. Petitioner reported overall relief of 30% on June 9, 2011, 60% on November 14, 2011 and 70% from January 9, 2012 through July 8, 2013. PX6; PX7.

On April 2, 2013 Dr. Olowe of Advanced Pain and Rehabilitation evaluated Petitioner on a referral from Dr. Ring. Dr. Olowe noted Petitioner reported his pain level was 7/10 with sharp, achy and burning in nature and exacerbation with bending and relief with medication. Petitioner reported his symptoms started in November 2011. Dr. Olowe noted treatment of physical therapy, medications and injections to date. Dr. Olowe reviewed the December 1, 2010 lumbar MRI and noted it evidenced moderate degenerative changes at the L4-L5 and L5-S1 level with left paracentral posterior disc osteophyte complexes causing mild-to-moderate left neural foraminal narrowing. On examination Dr. Olowe found positive bilateral lumbar facet loading and trigger points in the back bilaterally. Dr. Olowe's assessment was low back pain, lumbar radiculopathy, lumbar disc syndrome and multiple areas of trigger point pain. Dr. Olowe performed an EMG/NCV and recommended continue physical therapy. PX8. In the EMG/NCV report, Dr. Olowe concluded the electro-diagnostic study changes were consistent with a left S1 radiculopathy. PX12.

Thereafter Petitioner commenced treatment with Dr. Olowe through July 15, 2014. Throughout his course of treatment, Petitioner complained of pain with levels varying from 6/10 to 9/10 with some relief from the medication regime prescribed by Dr. Olowe. During the treatment, Dr. Olowe prescribed varying medications as well as administered trigger point injections on several occasions. PX8.

The medical records evidence on August 2, 2014 Petitioner sought treatment from Dr. Cisternino of Wellness in Motion Chiropractic Center. Petitioner complained of pain localized in left lower back that was constant, sharp, achy, shooting and stiff. Petitioner reported his symptoms were static, and his average pain level was 8/10. Petitioner reported a history of back problems of an approximate three-year duration associated to a fall. Dr. Cisternino performed chiropractic adjustment and massage. On August 8, 2014, Dr. Cisternino re-evaluated Petitioner who reported no change in his symptoms. On examination Dr. Cisternino found palpable moderate tender taut fibers over the lumbar musculature. Chiropractic adjustment and massage were performed. Dr. Cisternino diagnosed herniation or displacement of lumbar disc without myelopathy, lumbar region subluxation segmental dysfunction. Dr. Cisternino recommended further chiropractic treatments. PX13.

The medical records evidence on August 6, 2014 Dr. Padron of Park Ridge Pain evaluated Petitioner who provided the following history: "This is a 38-year-old male reinjured himself three years ago at work. Patient was coming out of his truck took a misstep on the curb lost his balance and fell on his back. Was being managed by another pain physician who performed 30 to 40 trigger point injections last two years with minimal benefit. Underwent an epidural two years ago with no benefit. Just started chiropractic therapy one week ago." Dr. Padron examined Petitioner and recommended a repeat lumbar MRI. Dr. Padron's assessment was low back pain/lumbago and lumbar radiculitis, and he prescribed hydrocodone and Ibuprofen. PX14. On August 11, 2014 Petitioner underwent a lumbar MRI which evidenced: 1) at the L4-L5 and L5-S1 levels, subligamentous posterior disc herniations measuring approximately 3-4 mm and 4-5 mm respectively were noted to indent the ventral surfaces of the thecal sac without significant spinal stenosis. There was mild bilateral neuroforaminal narrowing seen at the L4-L5 level and mild bilateral neuroforaminal narrowing, greater on the left, at the L5-S1 level, exacerbated by mild ligamentum flavum hypertrophy and some facet arthrosis; 2) the rest of the lumbar spine appeared unremarkable. PX15.

On August 13, 2014, Dr. Padron reviewed the recent lumbar MRI and diagnosed Petitioner with sacroilitis by physical examination. Dr. Padron recommended caudal epidural steroid injection and bilateral sacroiliac joint injections. Dr. Padron's assessment was low back pain/lumbago, lumbar radiculitis and inflamed sacroiliac joint. PX14. On August 21, 2014, Dr. Padron administered a caudal epidural steroid injection and a sacroiliac joint steroid injection. On September 5, 2014 Petitioner reported no benefit from the injections. Dr. Padron recommended repeating the injections. If those were of no benefit, he would refer Petitioner to a neurosurgeon for evaluation and recommendation. On September 25, 2014, Dr. Padron administered a caudal epidural steroid injection and a sacroiliac joint steroid injection. Medications were refilled. On October 9, 2014 Dr. Padron noted resolution of radiculopathy complaints but continued sacroiliac joint complaints as such he would repeat the sacroiliac joint injections. On November 6, 2014, Dr. Padron administered a sacroiliac joint steroid injection. PX14. On November 21, 2014 Petitioner reported minimal benefit from the sacroiliac joint steroid injection. Dr. Padron noted Petitioner was still extremely symptomatic, and he would

refer him to neurosurgery for evaluation and recommendations. Medications were refilled. PX14.

A "City of Chicago Report of Occupational Injury or Illness" dated December 3, 2014 was admitted into evidence as PX19. This report was signed by Petitioner and supervisor Paul Hansen. The report noted the date and time of injury as December 3, 2014 at 9:45 a.m. The date this was reported to the supervisor is noted as December 3, 2014 at 12:15 p.m. The injury is described as the following: "While assisting and working with Vactor W5-052r I slipped on ice and caught myself and Joe Gagliano also helped to grab me. After that felt immediate pain, waited a few hours to see if it would feel better and it did not. Came back to District to inform Mike Dwyer what happened and need to see the doctor." In a Witness Statement by Joe Gagliano dated December 4, 2014, a date of accident of December 3, 2014 is noted. Vehicle number W5-052R is noted. Mr. Gagliano noted, "Mr. Joe DiLeonardi was working with us on job. Sewer was not taking water and street was loaded with ice. Mr. Joe DiLeonardi slipped on ice and I caught him before his head hit the street."

The medical records evidence on December 3, 2014 Petitioner sought treatment from Dr. Podgorska at MercyWorks for complaints of back pain. The following history was noted: "This is a new problem. The current episode started today. The problem occurs constantly. The problem is unchanged. The pain is present in the lumbar spine. The pain is at a severity of 9/10. The pain is severe. The pain is the same all the time. The symptoms are aggravated by standing, twisting position and bending. Stiffness is present all day." "Pt slipped and fell today on ice injuring back, attempted to break fall, yet still fell. Denies further complaints." On examination Dr. Podgorska found the lumbar area tender and spastic left paraspinal muscles, range of motion was full and straight leg raises negative. Dr. Podgorska noted Petitioner currently takes Vicodin and medicated himself at 10 a.m. that morning. Dr. Podgorska assessed a lumbar strain; provided a Toradol injection 60 mg; and released Petitioner to return to work with restrictions of no repeated bending, stooping, twisting, pushing or pulling and no lifting over ten pounds. On December 10, 2014, Petitioner informed Dr. Podgorska he was treating elsewhere. PX20; RX2.

In the interim on December 4, 2014, Dr. Padron re-evaluated Petitioner and noted the following: "Patient symptoms have become exacerbated. Patient was at work slipped on ice, did not hit the ground but in trying to maintain his balance his body jerked and symptoms and pain increased." On examination Dr. Padron found normal gait, no limp, right hip and left hip tenderness of the PSIS and the SI joint, lateral flexion to the left minimal degrees and right minimal degrees, rotation to the left and right minimal degrees, flexion 20 degrees, extension 0 degrees, pain with all motion and maneuvers and limited range of motion compared to previous examinations. Dr. Padron's assessment was the same as the previous month. PX14. On December 8, 2014 Dr. Padron noted Petitioner was still symptomatic with chronic low back pain. A neurosurgical evaluation was still pending. Dr. Padron switched medication to extended release. PX14.

The medical records evidence on December 18, 2014 Dr. Gireesan, a neurosurgeon evaluated Petitioner. The following history was noted: "Josef was injured at work on 11/22/2010. He works for the water management. He got out of his car at work and missed his step and jolted his back and the pain took him down. He could not work. He went to Mercy Works. He was given a month of PT. He was off work for months. He saw a doctor and went back to work in January of 2011. He started PT two months later on his own for his back. He has been working full duty since that time until 12/3/2014. He slipped on ice at work at job location 647 West Kemper. He started having pain immediately following that. He is not at work at this time." Petitioner reported low back pain rated at 9/10. Petitioner was taking Oxycontin 30mg twice a day for pain and also Dialudid for pain the past few months. Dr. Gireesan reviewed the August 11, 2014 lumbar MRI and noted the sagittal T2 sequence revealed decreased signal at L4-L5 and L5-S1 levels with collapse of the disc; the axial images did not reveal any evidence of a herniated disc. Dr. Gireesan assessed discogenic low back pain, L4-L5 and L5-S1 levels aggravated as a result of a work-related injury. Dr. Gireesan explained to Petitioner his pain was coming from L4-L5, L5-S1 level. Dr. Gireesan discussed with Petitioner and his wife the lumbar MRI findings and recommended a structured physical therapy program three times a week for four weeks. PX22. ATI records evidence Petitioner attended physical therapy from December 19, 2014 through February 5, 2015. PX27.

On January 5, 2015 Dr. Gireesan re-evaluated Petitioner who reported attending seven physical therapy sessions with no improvement. He also had three lumbar epidural steroid injections which had not helped. Petitioner reported his pain was constant and bothered him. He had not been able to sleep even with the medications Ambien and Trazodone. Dr. Gireesan increased dosage of Trazodone to 100mg and refilled Ambien. Petitioner was to remain off work and continue physical therapy. Petitioner was not taking Oxycontin and was managing his pain with Vicoprofen. On January 19, 2015 Dr. Gireesan noted Petitioner attended 13 sessions of physical therapy without any significant improvement from the initial evaluation. Petitioner reported he attempted to perform all exercises to the best of his ability. He managed pain with Oxycontin 30mg twice a day. Dr. Gireesan continued physical therapy and increased the dosage of medication. He was to remain off work. PX22.

At Dr. Gireesan's direction, Petitioner underwent lumbar x-rays on February 5, 2015. The radiologist found the vertebral bodies and disc spaces were preserved, and there was no fracture or subluxation noted. There was mild facet joint arthritis. The study was otherwise unremarkable. PX23. That same day, Dr. Gireesan re-evaluated Petitioner who reported low back pain with radiation of pain, numbness and tingling into his left leg. Dr. Gireesan noted Petitioner's lack of improvement with conservative treatment. He reviewed the plain lumbar x-rays taken that day and informed Petitioner based on the x-rays and lumbar MRI findings, he had deterioration of the disc at L5-S1 and L4-L5 levels. Dr. Gireesan recommended a two-level anterior interbody fusion at L4-L5 and L5-S1 to mitigate pain which Petitioner wished to pursue. Dr. Gireesan ordered a repeat lumbar MRI to be performed at Northwestern in a closed machine. He discontinued physical therapy and continued to authorize Petitioner off work. PX22. Dr.

Padron also evaluated Petitioner the same day increased OxyContin 40 mg and prescribed Norco for breakthrough pain. PX14.

On March 9, 2015 Dr. Gireesan re-evaluated Petitioner and reviewed the March 2, 2015 MRI (PX24) and noted the sagittal T2 sequences reveal decreased signal to the L4-L5 and L5-S1 level. The axial images did not reveal any herniated disc into the canal. He reviewed the February 5, 2015 lumbar x-rays and noted the lateral x-ray revealed decreased disc height at L5-S1 as well as L4-L5 level. Petitioner reported he was to be seen by Dr. Kern Singh at the request of Respondent. Dr. Gireesan requested Petitioner provided Dr. Singh with a copy of the recent MRI. PX22.

Dr. Gireesan authored a report on April 28, 2015 at the request of Petitioner's attorney. Dr. Gireesan noted accident dates of November 17, 2010 and December 3, 2014 and recited his office notes through the date of his report. Dr. Gireesan noted Petitioner's past medical treatment and opined, "It is obvious from review of the records of Dr. Wehner MD, Dr. Barry Ring MD that Joe was in constant pain with no improvement over the past four years since his first injury in 2010 despite the epidural steroid injections, facet injections, physical therapy and pain management with OxyContin and Norco. Joe has been working full duty during the entire time with OxyContin, Nucynta and Norco and getting PT on his own." Dr. Gireesan opined Petitioner could 1) continue to manage pain with medication and lifting restrictions of 10 to 15 pounds occasionally, or 2) undergo a two-level interbody fusion at L4-L5 and L5-S1 level. He noted Petitioner wished to undergo this procedure. Dr. Gireesan opined following surgery, Petitioner would be prescribed post-operative physical therapy, then work conditioning and functional capacity evaluation. Dr. Gireesan opined Petitioner was temporarily totally disabled. PX26.

Petitioner continued to treat monthly with Dr. Gireesan and Dr. Padron. Throughout the treatment, Petitioner reported low back pain ranging from 6/10 to 9/10 with continued use of narcotic medication. Petitioner reported he continued to work in his supervisory capacity which required driving which caused increased pain. Dr. Gireesan continued to recommend surgery. PX22. On October 30, 2015, an EMG/NCV was performed by Dr. Schichtl, whose impression was electro-diagnostic evidence most consistent with an L5 radiculopathy on the left. Needle EMG examination did not reveal any active denervation. PX25.

On January 7, 2016 Dr. Gireesan noted Petitioner reported, "He was at the water park with his kids and could not do much with them because of the pain." Dr. Gireesan noted Petitioner was working and taking his prescribed medications. Petitioner described his low back pain as sharp. Driving was particularly hard for him. He also had difficulty sitting for long periods of time. Dr. Gireesan opined Petitioner was a candidate for the two-level fusion, and he would request approval for same. PX22.

On February 8, 2016 Dr. Gireesan evaluated Petitioner who complained of low back pain with radiation to the left leg with his leg and foot falling asleep. Petitioner reported difficulty with getting in and out of a car and walking with a limp, dragging his left leg. Dr. Gireesan's assessment was the same. Dr. Gireesan refilled prescribed medications and noted he was awaiting Dr. Singh's report. Petitioner was to continue to work. PX22. Dr. Gireesan noted Petitioner was the same on March 25, 2016. Dr. Gireesan opined he believed Petitioner's complaints of pain were legitimate based on the radiological findings. Petitioner was working in full capacity taking painkillers. Dr. Gireesan opined, "I believe his back pain is real." Dr. Gireesan opined the MRI and plain x-rays revealed the structural basis for the pain. Dr. Gireesan opined, "I do not believe there is any symptom magnification since he is working full duty even with the Narcotic pain medications." Dr. Gireesan opined Petitioner would benefit from a two-level lumbar fusion. Dr. Gireesan did not agree with Dr. Singh's report and the suggestion that Petitioner had no structural or anatomical basis for his complaints of low back pain. Dr. Gireesan advised Petitioner to continue to work in his present capacity and to manage the pain with medications until the time of surgery. PX22. On May 2, 2016, Dr. Gireesan noted he would contact the attorney and insurer as to status of the approval for the proposed surgery. PX22.

On June 15, 2016 Dr. Gireesan authored an additional report in response to Petitioner's attorney's May 11, 2016 letter, which requested opinions regarding the November 17, 2010 and December 3, 2014 accidents and Petitioner's current condition of low back pain. Dr. Gireesan noted Petitioner was injured at work on November 17, 2010 when he stepped out of his car at work, lost his footing and fell to the ground on his buttocks. Dr. Gireesan noted, "He started having severe pain in his low back area since that incident." Dr. Gireesan opined, "Based on the history that Mr. DiLeonardi provided to me I have to conclude that the injury that he suffered on 11/17/2010 aggravated preexisting degenerative condition in the low back area causing him to have severe pain in the low back to this day. I believe the second injury also contributed to his complaints of severe low back pain." PX26.

On March 30, 2015 Dr. Singh evaluated Petitioner pursuant to §12 of the Act at Respondent's request. Dr. Singh noted Petitioner's employment with Respondent. The following history was noted: "He states that on December 3, 2014, he was working on a sheet of ice, and he slipped and caught himself. He did not fall to the ground. His coworker helped prevent him from falling. He does report that this has been ongoing since 2010 with his low back pain." Dr. Singh reviewed the medical records and noted Petitioner's treatment since December 3, 2014. Petitioner reported low back pain at 8/10 with radiation into his entire left leg. His symptoms have been unchanged. He had not worked since December 3, 2014. On examination Dr. Singh found Petitioner was 5'5" and weighed 170 pounds. He had self-limiting range of motion of flexion at 5 degrees, extension at 5 degrees, axial rotation at 5 degrees, the lower extremities were symmetric and equal without sensory loss, strength was 5/5 and reflexes were equal. Waddell findings of positive pain with percussion, simulated axial loading, simulated axial rotation, positive distracted straight leg raising and positive symptom

magnification. Dr. Singh reviewed the March 2, 2015 lumbar MRI films, which revealed decreased signal intensity at L4-5 and L5-S1 with minimal evidence of central or foraminal stenosis and there did appear to be left and right-sided foraminal narrowing at L5-S1 with no significant spinal canal narrowing. Dr. Singh diagnosed degenerative disc disease at L4-5 and L5-S1 and lumbar muscular strain. RX1.

Dr. Singh opined, "I do not believe the patient's current symptoms are causally related to a work-related injury." His prognosis was guarded. Dr. Singh felt Petitioner's work capacity was light duty with less than 10 pounds of lifting, pushing and pulling and minimal bending, kneeling, stooping and squatting. Dr. Singh opined, "Clearly the patient's symptoms are preexisting in nature, as he reports pain from 2010 onward." Dr. Singh wished to review the August 2014 lumbar MRI films and compare them to the most recent MRI films. Dr. Singh opined the medical documentation did not support a causal relationship between the December 3, 2014 accident and injury. Dr. Singh opined no further treatment, including additional diagnostic testing, was necessary and recommended work conditioning for two to four weeks to determine Petitioner's level of effort given and recommended a third-party independent site with validity of effort testing. Dr. Singh opined if Petitioner gave an invalid effort, he should be released from care and placed at maximum medical improvement. Dr. Singh opined the work restrictions were temporary in nature until Petitioner completed the work conditioning program. Maximum medical improvement would occur upon completion of the work conditioning program. Dr. Singh opined, "I do not believe surgical intervention would be beneficial in this individual who has nonanatomic pain complaints with minimal evidence of central and foraminal stenosis." RX1.

On December 7, 2015 Dr. Singh authored an addendum report wherein he noted his review of additional medical records from Dr. Wehner, Dr. Ring and Dr. Gireesan as well as lumbar MRI films from December 1, 2010 and August 11, 2014 and the April 2, 2013 EMG/NCV. Dr. Singh noted Petitioner's diagnosis was preexisting disc degeneration at L4-5 and L5-S1. Dr. Singh opined Petitioner's current condition and diagnosis was not related to the work accident of December 3, 2014, and his L4-5 and L5-S1 disc degeneration predated the injury in question. Dr. Singh opined Petitioner's current treatment was not medically necessary nor related to the work accident, and no further treatment was recommended. Dr. Singh opined, "The patient's symptoms clearly predate the injury in question, present from 2010 persistently through the date of injury (12-3-14)." Dr. Singh opined Petitioner can work full duty without restrictions. Dr. Singh reviewed Petitioner's job description and opined he can perform his regular job duties and was at maximum medical improvement. RX1.

On January 25, 2016 Dr. Singh performed an additional evaluation pursuant §12 of the Act at the request of Respondent regarding the November 2010 accident. Dr. Singh reviewed medical records of Dr. Padron and Dr. Gireesan. Petitioner reported his current symptoms were worsening in nature and his entire left leg was painful. He rated his pain at 8/10. He was taking Norco and Oxycontin. On examination Dr. Singh found self-limiting range of motion of flexion,

extension and axial rotation to 5 degrees and no sensory loss. Waddell signs were positive, same as at the last examination. Dr. Singh diagnosed degenerative disc disease at L4-5 and L5-S1. Dr. Singh opined, "I do not believe the patient's current symptoms are causally related to his 11/2010 work-related injury, as the patient's pain complaints are nonanatomic in nature and do not correlate with diskogenic pain at L4-5 and L5-S1." Dr. Singh opined Petitioner's work capacity was full duty without restrictions, and he could perform the duties of his usual occupation. Dr. Singh opined the medical documentation did not support a causal relationship between the November 2010 accident and injury and opined further treatment was not necessary placing Petitioner at maximum medical improvement. Dr. Singh opined, "Anterior lumbar fusion in this individual at L4-5 and L5-S1 will not help his pain, as his pain complaints do not correlate to the diskogenic pathology at L4-5 and L5-S1. His leg complaints are nonanatomic in nature. He is on extreme amounts of narcotics for which I ran the Illinois Prescription Monitoring Program, receiving oxycodone as well as hydrocodone every 2 weeks." RX1.

The following medical bills were admitted into evidence as PX29 as it relates to a Section 8(j) credit of the Act: Advanced Pain Care dates of service 3-31-11 through 7-8-13, total charges of $21,544.32. Advanzado Quiropractico dates of service 7-11-11 through 7-15-14, charges of $14,400.27. Cari Medical Office, Dr. Ring dates of service 2-6-12 through 6-10-13, charges of $6,280.03.

At the August 22, 2016 arbitration hearing, the Application for Adjustment of Claim for 14 WC 41387 was amended to reflect a date of accident of November 16, 2010. T. 6-7; ArbEX3. This change was also reflected on the Request for Hearing form. ArbEX1. The parties stipulated Petitioner sustained accidental injuries arising out of and in the course of his employment on December 3, 2014. Request for Hearing, ArbEX2. The parties also stipulated that the issue of medical expenses would be raised at a future date (T. 9-10), and PX29 is an itemization relative to medical benefits paid by Respondent through its group health insurance carrier for which an 8(j) credit would be allowed with the final amount to be determined at a later date by stipulation of the parties. T. 94.

The Commission makes the following more specific factual findings:

*Petitioner established he was a traveling employee while working for Respondent on November 16, 2010 and December 3, 2014.

*Petitioner sustained an accident on November 16, 2010 when he stepped out of his vehicle at a job site, lost his footing and fell to the ground on his buttocks injuring his low back.

*Petitioner sustained an accident on December 3, 2014 while working at a job site when he slipped on ice and twisted injuring his low back.

*Petitioner suffered a lumbar strain as a result of each accident as well as an aggravation of his degenerative disc disease at the L4-L5 and L5-S1 levels due to the accident of November 16, 2010.

*Petitioner is in need of ongoing medical care as recommended by his treating physician, Dr. Gireesan.

Conclusions of Law

A. Accident

A "traveling employee" is an employee who must travel away from his or her employer's premises in order to perform his or her job. *Jensen v. Industrial Commission,* 305 Ill. App. 3d 274, 278, 711 N.E.2d 1129 (1999). The Commission finds Petitioner established he was a traveling employee. In his job as an assistant foreman, Petitioner was required to work in the field six hours per day checking 1) jobs, 2) repair crews and/or 3) equipment. T. 15. He drove between locations during the day, visiting between three and fifteen job sites and on average eight job sites per day. T. 20. When he drove his own vehicle, he was reimbursed for mileage. T. 20. Otherwise he drove a pick-up truck provided by Respondent. T. 19.

In *Johnson v. Industrial Commission,* 278 Ill. App. 3d 59, 64, 662 N.E.2d 156 (1996), the Appellate Court stated, "Under the standard pronounced in *Ace Pest Control, Inc. v. Industrial Comm'n* (1965), *32 Ill. 2d 386, 205 N.E.2d 453*, the test for determining whether an injury to a traveling employee arose out of and in the course of her employment is the reasonableness of the conduct in which the employee was engaged at the time of the injury and whether it might normally be anticipated or foreseen by the employer; the key factors of this test are 'reasonableness' and 'foreseeability.' *Wright v. Industrial Comm'n* (1975), *62 Ill.2d 65, 69-70.*" On November 16, 2010 Petitioner was injured as he was exiting his vehicle parked on a city street at a job site. Thusly he was in the course of his employment. Further Petitioner either missed the curb and stepped on mud and leaves and slipped and fell (T. 25) or slipped off the curb and fell. PX1; PX2. In either scenario, the Commission finds the conduct Petitioner was engaged in at the time of his injury, exiting his vehicle that was parked on the street, was reasonable and foreseeable by Respondent.

Furthermore, the case of *Nee v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 132609WC, is directly on point and dispositive. In *Nee*, the claimant was a plumbing inspector employed by the City of Chicago. His duties required him to travel throughout the City by car to inspect the plumbing in both residential and commercial buildings. The claimant testified he reported to work each day at the filtration plant and receive the day's inspection assignments. He inspected approximately five to seven sites each day, driving from location to location. The claimant contended and the City admitted that he was a traveling employee. The

claimant testified on July 27, 2009, after finishing an inspection at 2007 North Sedgwick, he tripped on a curb and fell as he was walking back to his car to go to his next assignment. When he tripped, he twisted his knee and felt immediate pain. The claimant gave a history to the medical providers which was consistent with his testimony. The arbitrator found claimant sustained a compensable injury. On review, the Commission reversed finding claimant failed to prove he sustained accidental injuries arising out of and in the course of his employment. The claimant sought judicial review of the Commission's decision, and the Appellate Court reversed, holding the Commission's finding that claimant failed to prove he sustained accidental injuries arising out of and in the course of his employment was against the manifest weight of the evidence.

In *Nee*, the Appellate Court noted that 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 Commission*, 129 Ill. 2d 52, 57 (1989). Therefore, the issue in the case was 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." *Id.* at 58.

> The Appellate Court further explained:
> The risk of tripping on a curb is a risk to which the general public is exposed daily. Under the 'street risk' doctrine, however, when, as in this case, the claimant's job requires him to travel the streets, the risks of the street become one of the risks of the employment. *Potenzo*, 378 Ill. App. 3d at 118 (citing *C.A. Dunham Co. v. Industrial Comm'n*, 16 Ill. 2d 102, 111 (1959)); see also *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014-1015. As our supreme court held in *C.A. Dunham Co.*, 16 Ill. 2d at 111, 'where the street becomes the milieu of the employee's work, he is exposed to all street hazards to a greater degree than the general public.' No doubt curbs, and the risk attendant to traversing them, confront all members of the public. *Caterpillar Tractor Co.*, 129 Ill. 2d at 62. However, when a traveling employee, such as the claimant in this case, is exposed to the risk while working, he is presumed to have been exposed to a greater degree than the general public. *City of Chicago v. Industrial Comm'n*, 389 Ill. 592, 601 (1945); see also *C.A. Dunham Co.*, 16 Ill. 2d at 111; *Mlynarczyk v. Illinois Workers' Compensation Comm'n*, 2013 IL App (3d) 120411WC; *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014-1015. *Nee v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 132609WC, ¶¶ 26, 27.

As such, the Commission finds Petitioner's accident also arose out of his employment.

Based on the above, the Commission finds Petitioner proved he was a traveling employee on November 16, 2010 and sustained an accident arising out of and in the course of his employment. Petitioner testified he was required to travel away from his office to perform his job as supervising foreman. T. 15. Petitioner testified on November 6, 2010 he was performing

his job duties in the field (checking a catch basin), when he slipped on a curb. T. 24-25. A minor discrepancy exists as to whether Petitioner slipped on the curb itself or the gutter line, but such discrepancy is irrelevant. The act of traversing the curb presents an increased risk as stated by the Court in *Nee v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 132609WC. The Court has spoken, and the Commission is bound accordingly. Whether this Commission agrees with the standards of "reasonable and foreseeable" and the "street risk doctrine" is immaterial. It lies with the legislative branch to make such changes in the controlling standards. The Commission further finds Petitioner proved he sustained an accident arising out of and in the course of his employment on December 3, 2014 based on the parties' stipulation.

B. Causal Relationship

The Commission finds Petitioner proved the existence of a causal relationship between the injuries he sustained on November 16, 2010 and his current condition of ill-being. However, the Commission affirms the Arbitrator's finding that Petitioner failed to prove a causal connection to the December 3, 2014 accident and his current condition of ill-being.

Petitioner sought medical treatment immediately following his accident of November 16, 2010 and provided a consistent history of accident. PX2. Thereafter Petitioner continued to seek medical treatment with numerous providers with consistent complaints of pain in his low back extending into his leg. PX6; PX12; PX15. Certainly, Petitioner's pain levels waxed and waned throughout his treatment as did his radiating pain, but such complaints never resolved. Additionally, the diagnostic tests, MRIs and EMGs, verified herniated discs at L4-L5 and L5-S1 as well as S1 radiculopathy. PX24; PX25.

Dr. Padron evaluated Petitioner on November 21, 2014 (approximately two weeks prior to the December 3, 2014 accident) and noted Petitioner to be extremely symptomatic despite injections and medications; as such recommending a referral to a neurosurgeon for further evaluation and treatment. PX14. Dr. Padron evaluated Petitioner on December 4, 2014 (the day following the December 3, 2014 accident) and noted chronic back pain with continued recommendation for a neurosurgical consultation. PX14.

Dr. Gireesen, a neurosurgeon, initially evaluated Petitioner on December 18, 2014 and recommended conservative treatment with physical therapy and medications. After physical therapy was attempted without success, Dr. Gireesen recommended surgical intervention. PX22. Dr. Giressen opined: "Based on the history that Mr. DiLeonardi provided to me I have to conclude that the injury that he suffered on 11/17/2010 aggravated preexisting degenerative condition in the low back area causing him to have severe pain in the low back to this day. I believe the second injury also contributed to his complaints of severe low back pain." PX26.

Dr. Singh holds a contrary opinion ultimately finding no causal relationship between the injuries and Petitioner's current condition of ill-being as it is his belief Petitioner's pain complaints are non-anatomic and do not correlate to Petitioner's pathology. RX1. This opinion, though, contradicts Dr. Singh's initial opinions rendered on March 30, 2015 and December 7, 2015 wherein he finds Petitioner's pain complaints pre-existing in nature beginning in 2010-2010 being the onset of pain due to the first accident. RX1.

The Commission finds Petitioner's current condition of ill-being and need for treatment is due to the accident of November 16, 2010. The Commission finds the opinions of Dr. Gireesan more persuasive than those of Dr. Singh and affords greater weight to Dr. Gireesan's opinions accordingly.

C. Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner testified he was off work from November 18, 2010 through January 14, 2011 and he returned to work on January 15, 2011. He was paid temporary total disability benefits during this period. T. 32-33. Petitioner further testified he was off work from December 4, 2014 through May 18, 2015 and he returned to work on May 19, 2015. He was paid temporary total disability benefits during this period. T. 47. The Commission awards these periods of temporary total disability and grants Respondent credit for payment of temporary total disability benefits during those periods. The periods of TTD are 8-2/7 weeks and 23-5/7 weeks respectively.

D. Choice of Physicians

Petitioner testified he sought treatment from his primary care physician, Dr. Sadowsky on November 17, 2010, who recommended he see a chiropractor. T. 30. Petitioner eventually sought treatment from Dr. Cunningham, a chiropractor. T. 33. The Commission notes there were no records for Dr. Sadowsky submitted into evidence. Petitioner's testimony is unrebutted and therefore, the Commission finds Dr. Sadowsky referred Petitioner to Dr. Cunningham. Petitioner's treatment at MercyWorks and Dr. Wehner is not considered his choice as he was directed to these providers by Respondent. Therefore, the Commission finds Petitioner's first choice of physician and referrals therefrom consist of Dr. Sadowsky, Dr. Cunningham, Dr. Ring, and Dr. Olowe.

Petitioner testified he sought treatment from a chiropractor at Wellness in Motion who referred him to Dr. Padron. T. 40. Neither the records from Wellness in Motion nor Dr. Padron's records indicate the presence of a referral. Petitioner's testimony, though, is unrebutted, and therefore, the Commission finds Dr. Cisternino, the chiropractor from Wellness in Motion, referred Petitioner to Dr. Padron. Petitioner also testified a friend referred him to Dr.

Gireesan. T. 63. Dr. Padron noted on November 21, 2014 he would refer Petitioner to neurosurgery for evaluation and recommendations. PX14. Petitioner began treating with Dr. Gireesan on December 18, 2014. "[W]e note that the genesis of the referral has no bearing on the issue so long as the claimant's treating doctor ultimately made the referral." *Absolute Cleaning v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 463, 469, 949 N.E.2d 1158 (2011). Therefore, the Commission finds Petitioner's second choice of physician and referrals therefrom consist of Dr. Cisternino, Dr. Padron, and Dr. Gireesan.

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 pursuant to the parties' stipulation, the issue of medical bills will be addressed at a later date. T. 9-10.

F. Prospective Medical Care

Dr. Gireesan opined based on the x-rays and lumbar MRI findings, Petitioner had deterioration of the disc at the L5-S1 and L4-L5 levels. Dr. Gireesan opined that Petitioner would need a two-level anterior interbody fusion at L4-L5 and L5-S1 to mitigate his pain. PX22. The x-rays and lumbar MRIs evidenced a structural basis for his pain. PX26. Dr. Singh opined, "I do not believe surgical intervention would be beneficial in this individual who has nonanatomic pain complaints with minimal evidence of central and foraminal stenosis." RX1. The Commission finds the opinions of Dr. Gireesan more persuasive than those of Dr. Singh. Therefore, the Commission finds that Petitioner has not reached maximum medical improvement and is entitled to prospective medical care consisting of the surgery and any attendant care recommended by Dr. Gireesan and awards the same.

G. Credit

On the Request for Hearing form for14 WC 41387 the parties stipulated Respondent paid $9,971.28 in TTD benefits. On the Request for Hearing form for case 14 WC 41388 the parties stipulated Respondent paid $29,975.23 in TTD benefits. The total of TTD benefits paid equals $39,946.51 for which Respondent is entitled a credit. Further, the parties stipulated PX29 itemized amounts paid by Respondent pursuant to its group health insurance, but the exact amount of the credit pursuant to Section 8(j) of the Act would be determined at a future date. T. 94.

17IWCC0570

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 21, 2016 decision in 14 WC 41387 is reversed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's October 21, 2016 decision in 14 WC 41388 is affirmed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,203.36 per week for a period of 8-2/7 weeks, and the sum of $1,287.22 per week for a period of 23-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act.

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 surgery and attendant care prescribed by Dr. Gireesan.

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 Respondent paid $39,946.51 in TTD benefits.

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

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

17IWCC0570

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 22 2017
LEC/maw
o07/26/17
43

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

DiLEONARDI, JOSEPH
Employee/Petitioner

Case# **14WC041387**

14WC041388

CITY OF CHICAGO
Employer/Respondent

17IWCC0570

On 10/21/2016, 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 0.47% 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:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

17 I W C C 0 5 7 0

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joseph DiLeonardi
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **41387**

Consolidated cases: **14 WC 41388**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **8/22/16**. 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 _____

17IWCC0570

FINDINGS

On the date of accident, **11/16/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was* 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 **$93,862.84**; the average weekly wage was **$1,805.05**.

On the date of accident, Petitioner was **34** 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 **$9,971.28** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,971.28**.

Respondent is entitled to a credit of **$15,698.81** under Section 8(j) of the Act.

ORDER

Petitioner did not establish that he suffered injuries that arose out of and in the course of his employment with respondent on the aforementioned date of injury. As a result he is not entitled to benefits under the Act. The respondent is entitled to a credit for TTD benefits paid to petitioner.

This Arbitrator notes that the petitioner exceeded his choice of doctors under the Act when he chose to treat with Wellness in Motion Chiropractic Center.

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

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

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

#001 *Arb. George J. Andros*
Signature of Arbitrator

10/21/16
Date

ICArbDec19(b)

OCT 21 2016

Joseph DiLeonardi v City of Chicago
14 WC 41387 & 14 WC 41388

17IWCC0570

Statement of Facts:

The petitioner testified he had been employed with the respondent since approximately 1996 as a laborer. He works in the Water Department. In his current position he is responsible of approximately 5 crews that assist repair crews with the cleaning and maintenance of the sewers in the City of Chicago. His office is located at 4900 Sunnyside in Chicago. He works Monday through Friday. He is in the office for "about two hours" and six hours in the field. When he is in the field he is checking on jobs and the crews or equipment. He testified to various equipment that is used on the job.

The petitioner testified that he uses a City issued pick-up truck to drive between job sites when he is working in the field. At the time of the 2010 incident he did not have the City issued vehicle and drove his own vehicle. He believed that he was driving a Nissan Murano.

The petitioner sought treatment at Mercy Works in 1997 although he initially testified that he did not recall for what. He subsequently testified that he recalled injuring his low back while breaking up debris with a pry bar in 1997.

The respondent disputes that he suffered an injury that arouse out of and in the course of his employment on 11/16/10. The petitioner testified that he went to check a job near Lunt Avenue that morning. He went to look into a catch basin. He was driving his personal vehicle and recalled parking it on a City street near 1830 West Lunt Avenue. He did not provide an exact location. He testified that he opened the car door and grabbed his gloves. He was using his left foot to step onto what he thought was the curb when his left foot missed the curb. His foot slipped on mud and leaves that were in the "curb lane" and "twisted my back" and "fell down". He felt immediate pain in the center of his low back with a "sensation" in his right leg.

Following the aforementioned incident an Accident Report was completed. The petitioner verified that while his "boss" completed the form, he signed it. He agreed that the Accident Report did not indicate that he slipped on the gutter line, or mud or leaves as he testified. It reads that he slipped on a curb, nothing more. It did not indicate that he fell or that he twisted. There were no witnesses to the incident.

Subsequently, on re-direction examination the petitioner testified that when he testified that he slipped on the gutter line he was referring to the bottom part of the curb where the top and bottom meet.

Following the incident he reported to his PCP, Dr. Sadowsky who sent him to a chiropractor. He also reported to Mercy Works. This provider referred him to Dr. Wehner. Physical therapy ensued. Concern over his credibility is raised by (later) therapy and treatment far away east of Hanson Park Stadium in the central, west side of Chicago based upon the clinic address in the records.

On December 1, 2010 he underwent a MRI which revealed moderate degenerative changes at L4-5 and L5-S1 with left paracentral posterior disc osteophytes causing left neural foraminal narrowing.

With respect to this incident the petitioner returned to work on 1/15/11, returning to his usual and customary position with the respondent.

Several months after his return to work he started to see chiropractor Cunningham on 3/31/11. The petitioner testified that he was referred to him by a friend. He later changed his testimony indicating that he was referred to the chiropractor by his PCP. He treated with the chiropractor through 7/15/14.

The petitioner testified that he also treated at Advanced Pain and Rehabilitation facility with both Drs. Ring and Olowe. He received trigger point injections at this facility. Dr. Ring also referred him for an EMG which he underwent on 4/2/13. It revealed changes consistent with left S1 radiculopathy.

The petitioner testified that the medical bills from Dr. Cunningham, the chiropractor and for his pain treatment were submitted for payment through his group insurance. The parties agreed to table the issue of unpaid bills until the end of the case.

He testified that as of July 2014 he noticed "not much improvement to his low back" so he chose to seek treatment at a different facility. He reported to the Wellness in Motion Chiropractic Center On August 2, 2014 and treated there through August 8, 2014. He was referred here by a friend. He was referred by this chiropractor to Dr. Pardon where he treated until 11/6/14. Dr. Pardon sent him for an MRI which he had on 8/11/14. It revealed post disc herniations at L4-5 and L5-S1indenting the ventral surfaces of the thecal sac without significant spinal stenosis. Mild bilateral neuroformaminal narrowing was seen at L4-5 as was mild bilateral neuroforaminal narrowing greater on the left at L5-S1.

The petitioner testified that prior to the second incident he was back to work and performing his job with pain. He noted that it was tolerable with medication. He noted that he was taking Norco and Oxycodone. This drug therapy raised a red flag given the diagnostics and the petitioner goes to work every day. He testified that he was "driving", and did not take the medications during the course of his workday.

On 12/3/14 the petitioner re-injured his low back. The respondent agreed that he sustained an injury that arouse out of and in the course of his employment on this date. The petitioner testified that at the time he re-injured his low back and that the pain was "instantaneous". He noticed a very sharp stabbing pain that was in his lower back near the belt line.

The petitioner again reported to Mercy Works. He also continued to treat with Dr. Pardon.

Eventually he sought treatment with Dr. Gireesan. He was referred to him by a friend. The petitioner told this physical that when he was injured in 2010 when he missed a step getting out of his car.

Dr. Gireesan recommended an MRI, another EMG and physical therapy. A MRI dated 3/2/15 revealed multilevel degenerative changes. At L3-4 there was a disc bulge. At L4-5 there was a bulge with an annular fissure at the posterior central disc margin. At L5-S1 there was a bulge that was more prominent to the left with no spinal stenosis. An EMG dated 10/30/15 was consistent with L5 radiculopathy. The petitioner enrolled in physical therapy at ATI.

Eventually Dr. Gireesan recommended the petitioner undergo a two level fusion. The respondent has not authorized the surgery. The petitioner testified that he wants to proceed with the surgery. The petitioner continues to work as a foreman through the day of the hearing.

The petitioner testified while performing his job duties for the respondent he requires assistance or that it just takes him longer. He testified that he noticed that the developed a limp. This Arbitrator acknowledges that he did not observe the petitioner walking. The petitioner testified that his sleeping has changed noting he sleeps about three hours He testified that his pain level has increased since the second accident. It has affected his personality and well-being. Although he did not provide examples.

The petitioner told Dr. Gireesan that he was at a water park with his children in January. The petitioner testified that he recalled that. He thought it was in Wisconsin and that they were there overnight. He testified that he did not perform activities at the water park but sat at a table while his wife was with the kids.

He was examined at the employer's request by Dr. Singh a professor at Rush Medical University. The doctor issued two reports. In opined that the petitioner's complaints are nonorganic in nature and do not correlate with discogenic pain at L4-5 and L5-S1. The petitioner reported to him that his pain had been ongoing since 2010. On examination all five Waddells were positive. He indicated that the petitioner was able to work full duty and that there was no casual relationship between either accident and the injury. He further opined that a lumbar fusion would not help the petitioner's pain complaints and noted that he was on "extreme amounts of narcotics". Lastly, the doctor recommended a work conditioning program which he had not participated in as of the date of the trial.

Conclusions of Law:

14WC 41387

The petitioner testified that he slipped on the gutter line of a curb. His signed Accident Report indicated that he slipped on a curb. There is a difference between the two. He initially treated at Mercy Works. The records from this provider indicate that he slipped on a curb. There was no mention of a gutter line or leaves.

Clearly the petitioner embellished his testimony to include the fact that he slipped on mud and leaves. That did not happen. His memory is faulty and cannot be relied upon. There is nothing in the evidence submitted that supports an increased risk to him at the time of injury.

Both the Accident Report and the initial medical records are far more reliable than testimony at hearing many years later. Neither the Accident Report nor the petitioner's testimony indicates that there was any risk or hazard associated with the curb (for example that it might have been chipped or damaged). The petitioner testified that he stepped and missed the curb. This action has nothing to do with an increased risk or his employment.

It was on a street open to the general public. The petitioner testified that he drove his own vehicle. It follows that he parked it and therefore decided how close to park to the curb. There is no increased risk in any of his actions up to and including the moment that he stepped to get out of his vehicle. This is an unexplained incident.

Several months after a full duty release to work he began treating with a chiropractor and then at Advanced Pain and Rehabilitation. He sought treatment at a second chiropractor at Wellness in Motion Chiropractic Center in July of 2014. This provider is outside of his choice of two physicians and as such the respondent is not responsible for any bills generated by this provider or any providers within this chain of referral for treatment up until the 12/3/14 date of injury. This includes treatment with Dr. Pardon.

The petitioner did not establish that 11/16/10 incident arouse out of and in the course of his employment with the respondent. His request for benefits under the Act is therefore, denied.

The respondent is entitled to a credit for all TTD benefits paid to the petitioner.

14 WC 41388

The parties stipulate to the second accident date but dispute causation and the need for the surgery that the petitioner requests.

The petitioner's testimony about his pain level is questionable. He admitted attending a water park in Wisconsin. He admitted being there for the weekend with his children. This Arbitrator presumes that the petitioner drove to Wisconsin.

He testified that he needs assistance at work but neglected to go into detail. The assistance he alleges could be minor or significant. Because he neglected to advise this court, what, if anything he requires is unknown. The petitioner also testified that his pain level has affected his personality and well-being. Again he failed to provide any examples. This is unconvincing, however, because he did accompany his family to a weekend trip to a water park. This is not the action of someone whose personality has changed. That is the action of a man who enjoys being with his family and having fun.

The petitioner's credibility is questionable given his is working yet taking controlled substances "off duty".

The petitioner advised Dr. Singh that his back has hurt since 2010. The findings in his MRIs did not change radically. While he testified to increased pain complaints after the second incident he also testified to pain all along and continued to treat after his return to work, which is suggestive that his need for treatment relates o the 2010 incident.

Noteworthy is that Dr. Singh found that all five Waddell Signs were positive. He also opined that the petitioner's complaints were nonorganic in nature and noted that the fusion that was recommended would not help his pain complaints

Because the pain complaints appear related to the 2010 incident, that his Waddles were positive, and taking Dr. Singh's opinion into account, this Arbitrator denies the petitioner's request for surgery.

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

17IWCC0570

DiLEONARDI, JOSEPH
Employee/Petitioner

Case# **14WC041388**

14WC041387

CITY OF CHICAGO
Employer/Respondent

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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:

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CHICAGO, IL 60603

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

17IWCC0570

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joseph DiLeonardi
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **41388**

Consolidated cases: **14 WC 41387**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **8/22/16**. 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. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. XXIs Petitioner entitled to any prospective medical care?

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

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

N. Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **12/3/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$100,403.02**; the average weekly wage was **$1,930.83.**

On the date of accident, Petitioner was **38** 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 **$29,975.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $29,975.23.

Respondent is entitled to a credit of **$15,698.81** under Section 8(j) of the Act.

ORDER

Petitioner did not establish that his need for surgery is related to the aforementioned date of injury. His request for surgery 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.

#001 Arb. George J. Andros
Signature of Arbitrator

10/21/16
Date

ICArbDec19(b)

OCT 21 2016

Joseph DiLeonardi v City of Chicago
14 WC 41387 & 14 WC 41388

17IWCC0570

Statement of Facts:

The petitioner testified he had been employed with the respondent since approximately 1996 as a laborer. He works in the Water Department. In his current position he is responsible of approximately 5 crews that assist repair crews with the cleaning and maintenance of the sewers in the City of Chicago. His office is located at 4900 Sunnyside in Chicago. He works Monday through Friday. He is in the office for "about two hours" and six hours in the field. When he is in the field he is checking on jobs and the crews or equipment. He testified to various equipment that is used on the job.

The petitioner testified that he uses a City issued pick-up truck to drive between job sites when he is working in the field. At the time of the 2010 incident he did not have the City issued vehicle and drove his own vehicle. He believed that he was driving a Nissan Murano.

The petitioner sought treatment at Mercy Works in 1997 although he initially testified that he did not recall for what. He subsequently testified that he recalled injuring his low back while breaking up debris with a pry bar in 1997.

The respondent disputes that he suffered an injury that arouse out of and in the course of his employment on 11/16/10. The petitioner testified that he went to check a job near Lunt Avenue that morning. He went to look into a catch basin. He was driving his personal vehicle and recalled parking it on a City street near 1830 West Lunt Avenue. He did not provide an exact location. He testified that he opened the car door and grabbed his gloves. He was using his left foot to step onto what he thought was the curb when his left foot missed the curb. His foot slipped on mud and leaves that were in the "curb lane" and "twisted my back" and "fell down". He felt immediate pain in the center of his low back with a "sensation" in his right leg.

Following the aforementioned incident an Accident Report was completed. The petitioner verified that while his "boss" completed the form, he signed it. He agreed that the Accident Report did not indicate that he slipped on the gutter line, or mud or leaves as he testified. It reads that he slipped on a curb, nothing more. It did not indicate that he fell or that he twisted. There were no witnesses to the incident.

Subsequently, on re-direction examination the petitioner testified that when he testified that he slipped on the gutter line he was referring to the bottom part of the curb where the top and bottom meet.

Following the incident he reported to his PCP, Dr. Sadowsky who sent him to a chiropractor. He also reported to Mercy Works. This provider referred him to Dr. Wehner. Physical therapy ensued. Concern over his credibility is raised by (later) therapy and treatment far away east of Hanson Park Stadium in the central, west side of Chicago based upon the clinic address in the records.

On December 1, 2010 he underwent a MRI which revealed moderate degenerative changes at L4-5 and L5-S1 with left paracentral posterior disc osteophytes causing left neural foraminal narrowing.

With respect to this incident the petitioner returned to work on 1/15/11, returning to his usual and customary position with the respondent.

Several months after his return to work he started to see chiropractor Cunningham on 3/31/11. The petitioner testified that he was referred to him by a friend. He later changed his testimony indicating that he was referred to the chiropractor by his PCP. He treated with the chiropractor through 7/15/14.

The petitioner testified that he also treated at Advanced Pain and Rehabilitation facility with both Drs. Ring and Olowe. He received trigger point injections at this facility. Dr. Ring also referred him for an EMG which he underwent on 4/2/13. It revealed changes consistent with left S1 radiculopathy.

The petitioner testified that the medical bills from Dr. Cunningham, the chiropractor and for his pain treatment were submitted for payment through his group insurance. The parties agreed to table the issue of unpaid bills until the end of the case.

He testified that as of July 2014 he noticed "not much improvement to his low back" so he chose to seek treatment at a different facility. He reported to the Wellness in Motion Chiropractic Center On August 2, 2014 and treated there through August 8, 2014. He was referred here by a friend. He was referred by this chiropractor to Dr. Pardon where he treated until 11/6/14. Dr. Pardon sent him for an MRI which he had on 8/11/14. It revealed post disc herniations at L4-5 and L5-S1indenting the ventral surfaces of the thecal sac without significant spinal stenosis. Mild bilateral neuroformaminal narrowing was seen at L4-5 as was mild bilateral neuroforaminal narrowing greater on the left at L5-S1.

The petitioner testified that prior to the second incident he was back to work and performing his job with pain. He noted that it was tolerable with medication. He noted that he was taking Norco and Oxycodone. This drug therapy raised a red flag given the diagnostics and the petitioner goes to work every day. He testified that he was "driving", and did not take the medications during the course of his workday.

On 12/3/14 the petitioner re-injured his low back. The respondent agreed that he sustained an injury that arouse out of and in the course of his employment on this date. The petitioner testified that at the time he re-injured his low back and that the pain was "instantaneous". He noticed a very sharp stabbing pain that was in his lower back near the belt line.

The petitioner again reported to Mercy Works. He also continued to treat with Dr. Pardon.

Eventually he sought treatment with Dr. Gircesan. He was referred to him by a friend. The petitioner told this physical that when he was injured in 2010 when he missed a step getting out of his car.

Dr. Gireesan recommended an MRI, another EMG and physical therapy. A MRI dated 3/2/15 revealed multilevel degenerative changes. At L3-4 there was a disc bulge. At L4-5 there was a bulge with an annular fissure at the posterior central disc margin. At L5-S1 there was a bulge that was more prominent to the left with no spinal stenosis. An EMG dated 10/30/15 was consistent with L5 radiculopathy. The petitioner enrolled in physical therapy at ATI.

Eventually Dr. Gireesan recommended the petitioner undergo a two level fusion. The respondent has not authorized the surgery. The petitioner testified that he wants to proceed with the surgery. The petitioner continues to work as a foreman through the day of the hearing.

The petitioner testified while performing his job duties for the respondent he requires assistance or that it just takes him longer. He testified that he noticed that the developed a limp. This Arbitrator acknowledges that he did not observe the petitioner walking. The petitioner testified that his sleeping has changed noting he sleeps about three hours He testified that his pain level has increased since the second accident. It has affected his personality and well-being. Although he did not provide examples.

The petitioner told Dr. Gireesan that he was at a water park with his children in January. The petitioner testified that he recalled that. He thought it was in Wisconsin and that they were there overnight. He testified that he did not perform activities at the water park but sat at a table while his wife was with the kids.

He was examined at the employer's request by Dr. Singh a professor at Rush Medical University. The doctor issued two reports. In opined that the petitioner's complaints are nonorganic in nature and do not correlate with discogenic pain at L4-5 and L5-S1. The petitioner reported to him that his pain had been ongoing since 2010. On examination all five Waddells were positive. He indicated that the petitioner was able to work full duty and that there was no casual relationship between either accident and the injury. He further opined that a lumbar fusion would not help the petitioner's pain complaints and noted that he was on "extreme amounts of narcotics". Lastly, the doctor recommended a work conditioning program which he had not participated in as of the date of the trial.

Conclusions of Law:

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The petitioner testified that he slipped on the gutter line of a curb. His signed Accident Report indicated that he slipped on a curb. There is a difference between the two. He initially treated at Mercy Works. The records from this provider indicate that he slipped on a curb. There was no mention of a gutter line or leaves.

Clearly the petitioner embellished his testimony to include the fact that he slipped on mud and leaves. That did not happen. His memory is faulty and cannot be relied upon. There is nothing in the evidence submitted that supports an increased risk to him at the time of injury.

Both the Accident Report and the initial medical records are far more reliable than testimony at hearing many years later. Neither the Accident Report nor the petitioner's testimony indicates that there was any risk or hazard associated with the curb (for example that it might have been chipped or damaged). The petitioner testified that he stepped and missed the curb. This action has nothing to do with an increased risk or his employment.

It was on a street open to the general public. The petitioner testified that he drove his own vehicle. It follows that he parked it and therefore decided how close to park to the curb. There is no increased risk in any of his actions up to and including the moment that he stepped to get out of his vehicle. This is an unexplained incident.

Several months after a full duty release to work he began treating with a chiropractor and then at Advanced Pain and Rehabilitation. He sought treatment at a second chiropractor at Wellness in Motion Chiropractic Center in July of 2014. This provider is outside of his choice of two physicians and as such the respondent is not responsible for any bills generated by this provider or any providers within this chain of referral for treatment up until the 12/3/14 date of injury. This includes treatment with Dr. Pardon.

The petitioner did not establish that 11/16/10 incident arouse out of and in the course of his employment with the respondent. His request for benefits under the Act is therefore, denied.

The respondent is entitled to a credit for all TTD benefits paid to the petitioner.

14 WC 41388

The parties stipulate to the second accident date but dispute causation and the need for the surgery that the petitioner requests.

The petitioner's testimony about his pain level is questionable. He admitted attending a water park in Wisconsin. He admitted being there for the weekend with his children. This Arbitrator presumes that the petitioner drove to Wisconsin.

He testified that he needs assistance at work but neglected to go into detail. The assistance he alleges could be minor or significant. Because he neglected to advise this court, what, if anything he requires is unknown. The petitioner also testified that his pain level has affected his personality and well-being. Again he failed to provide any examples. This is unconvincing, however, because he did accompany his family to a weekend trip to a water park. This is not the action of someone whose personality has changed. That is the action of a man who enjoys being with his family and having fun.

The petitioner's credibility is questionable given his is working yet taking controlled substances "off duty".

The petitioner advised Dr. Singh that his back has hurt since 2010. The findings in his MRIs did not change radically. While he testified to increased pain complaints after the second incident he also testified to pain all along and continued to treat after his return to work, which is suggestive that his need for treatment relates o the 2010 incident.

Noteworthy is that Dr. Singh found that all five Waddell Signs were positive. He also opined that the petitioner's complaints were nonorganic in nature and noted that the fusion that was recommended would not help his pain complaints

Because the pain complaints appear related to the 2010 incident, that his Waddles were positive, and taking Dr. Singh's opinion into account, this Arbitrator denies the petitioner's request for surgery.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN MALLIE,

Petitioner,

vs.

No. 15 WC 18152
17 IWCC 497

EAGLE MATERIALS INC./ILLINOIS CEMENT,

Respondent.

ORDER

This matter comes before the Commission on Respondent's Motion to Recall Commission Decision pursuant to Section 19(f). On consideration of the decision at issue, the Commission finds there is no clerical error. Therefore, Respondent's Petition is denied

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Recall Commission Decision is hereby denied.

DATED: SEP 8 - 2017

Deborah L. Simpson

DLS/dw
46

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

Todd R. Reilson,
Petitioner,

vs. NO: 15 WC 00468

State of Illinois/ Department of Transportation,
Respondent,

17IWCC0573

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 August 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.

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

DATED: SEP 25 2017
o090717
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REILSON, TODD R
Employee/Petitioner

Case# **15WC000468**

ST OF IL/IL DEPT OF TRANSPORTATION
Employer/Respondent

17IWCC0573

On 8/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2937 LESKERA LAW FIRM
JOHN H LESKERA
120 E CHRUCH ST
COLLINSVILLE, IL 62234

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

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

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

AUG 22 2016

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

17IWCC0573

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

TODD R. REILSON
Employee/Petitioner

v.

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # **15** WC **00468**

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 **May 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. ☐ 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 9, 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 **$79,976.00**; the average weekly wage was **$1,538.00**.

On the date of accident, Petitioner was **49** 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 **$N/A** for TTD, **$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 **$ANY** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on September 9, 2014. All benefits are denied. The Arbitrator makes no findings regarding the remaining issues.

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

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

Signature of Arbitrator

August 18, 2016
Date

AUG 22 2016

STATE OF ILLINOIS)
) ss
COUNTY OF MADISON)

17IWCC0573

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TODD R. REILSON
Employee/Petitioner

v.

Case #: 15 WC 000468

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On September 9, 2014, Petitioner was 49 years old, married, and had one dependent child. He was employed by Illinois Department of Transportation ("IDOT") as a lead worker on the bridge crew at Highland Yard, and had been employed by IDOT for about 28 years. He has since retired and is working elsewhere.

Petitioner testified that on September 9, 2014, he was hooking up an arrow board to a pickup truck and when he was pulling it to the truck hitch to latch it he felt a twinge and pop in his lower left side in his groin area. The arrow board was a big sign, almost like a trailer, and was used to direct traffic on the roadway. It weighed 800 to 900 pounds. Petitioner testified that in pulling and lifting the arrow board to the back of the truck, he estimated the weight and force to be about 100 to 150 pounds. There was no one else working around him at that time and he did not report it right away, as he thought it was a muscle strain that would go away. He testified he pulled muscles all the time and he would typically just take some aspirin and carry on.

Petitioner testified that the next day he saw his family physician, Dr. Oscar Florendo, for unrelated stomach issues. He had been experiencing diarrhea, gas, and bloating for about two weeks and had an appointment to get that checked out. He testified those complaints had nothing to do with the discomfort in his left lower groin and he did not mention the groin pain to Dr. Florendo at the appointment on September 10, 2014, as he thought it was "no big deal". He was sent by Dr. Florendo for a CT scan that same day, in response to his complaints. He testified the CT scan showed a hernia, and when he was told of the hernia he immediately believed it had occurred while hooking up the arrow board.

Petitioner testified he first reported the accident to Respondent on October 6, 2014, and saw Dr. Florendo two days later, on October 8. Dr. Florendo referred him to Dr. Striegel, who diagnosed a hernia and ultimately performed surgery to repair it. Petitioner testified he did well

after the surgery and did not have any complications. He has a scar about six inches long, and he still frequently feels a pulling sensation where the scar is, about every couple of days. It does not interfere with his daily activities.

Petitioner was questioned about an appointment with Dr. Florendo in March 2014, about six months prior to this incident. He testified he was seen for bronchitis and a productive cough, and that after that time and until the incident on September 9, 2014, he did not have any pulling or tugging sensation in his groin. At no other time did have any such complaint, and he testified he did not have any kind of lifting at home or work that may have caused the hernia, other than the reported incident.

On cross-examination, Petitioner was questioned regarding any prior accidents or injuries while working for IDOT, and he recalled hurting his neck and back in 1999. He was questioned about 17 separate injuries to various body parts that he reported between June 14, 1995, and March 22, 2013. He recalled only two or three, and was either not sure or did not believe the others occurred. He testified that he possibly could have filled out incident only reports for those dates, but that he never missed time due to the injury. He explained that an incident report is completed if something happens, such as a scratch or scrape, and it's possible he filled out incident reports and nothing ever came of the individual incidents.

Petitioner was questioned why he did not fill out an incident report for the accident in question, when he felt a pop and twinge and immediate pain. He testified he thought it might go away with some aspirin, like a muscle strain, but that it did not. Petitioner reviewed the incident report he eventually completed on October 6, 2014, and was questioned about his response to one particular section. The report contained a section that stated, "If not reported on date of incident, explain." Petitioner wrote, "I could tell that I pulled something in my lower stomach area, but it went away." (RX1). He testified that the pain did not go away completely and that it would come and go. Petitioner was asked several times why he didn't complete an incident report or otherwise report the accident to his employer, and he testified he thought it would go away, and that the pain would come and go. He testified that when the incident occurred he felt a pulling and a bad muscle strain in his groin, that it was a pain he had not had before, but acknowledged he did not report it to his doctor the very next day, when he was there. He testified he did not bring it up to his doctor because he as there for diarrhea, gas, and bloating. He conceded he had previously reported other injuries to his doctor, but testified he did not tell him about this, the day after the incident, because he thought it would go away. Petitioner acknowledged that following the incident he continued to work his full duty job without problem, and continued to do so until the date of his surgery.

Petitioner testified that he had the CT scan on September 10, 2014, and that he was called by Dr. Florendo's office on September 11 and told he had a hernia. He conceded that he did not complete the incident report for another three weeks after that, on October 6. Petitioner was asked if he had an explanation as to why there was no mention of a work accident in any medical records until Dr. Striegel's note of October 27, 2014, and he conceded he did not. He believed he had mentioned the accident to Dr. Florendo, but did not know why it was not in the records.

Petitioner testified his retirement from IDOT had nothing to do with his physical condition or the hernia. He is currently working elsewhere as a salesman.

With regard to the arrow board, Petitioner conceded he did not actually lift or pull the full 800 or 900 pounds, as it is on a single axle with two wheels. He pulled it a foot or so to get it to the truck, in order to attach it. The truck was too low and the jack was taller than the hitch, so he had to pull the hook and kick the jack out, which is when he hurt himself.

On re-direct, Petitioner testified that he had no memory of all of the incident reports mentioned by Respondent's counsel, except the one when he hurt his lower back from a bad truck seat and the one when he hurt his neck opening a garage door. He remembered those two because they were fairly significant injuries. He did not recall if he filed a worker's compensation claim for the neck injury, but did so with the back injury. He testified he ran jackhammers and heavy equipment, and there was no way to report every little muscle pull that occurred. He would not report anything until it was necessary to get medical attention. In this case, medical attention was not necessary until October, three or four weeks after the incident.

Petitioner conceded on re-cross that IDOT's policy was to fill out an incident report anytime you had an injury, "so there is a record of it". On the day of his incident, he was the lead worker. He conceded that as a lead worker he did not have discretion to not fill out an incident report, even if he thought the injury was not severe enough. However, he did not believe he violated any IDOT policy by not filling it out, and testified it was common practice to not fill it out.

On September 10, 2014, Petitioner presented to Dr. Oscar Florendo at Osbec Medical with complaints of abdominal pain for two weeks. He reported pain at 8/10 in the left upper quadrant and lower left abdomen. He also had back pain, bloating, and diarrhea. Dr. Florendo ordered a CT of the abdomen and pelvis, which was done that day at St. Joseph's Hospital. The CT revealed mild sigmoid diverticuli without diverticulitis, as well as a small left inguinal hernia. The appendix was normal and there was no bowel obstruction. PX1, RX2.

On October 6, 2014, Petitioner completed an Employee's Notice of Injury, listing the date of injury as September 9, 2014. He wrote that he was hooking up to an arrow board, the pickup truck hitch was too low, and that he had to pick up the arrow board hitch and put it on the truck. As to why he did not report the incident the day it occurred, Petitioner wrote, "I could tell that I pulled something in my lower stomach area, but it went away." On October 6, 2014, an Employer's First Report of Injury was completed, reflecting the information as reported by Petitioner. On October 7, 2014, a Supervisor's Report of Injury was completed by Tim Krumm, Operations Bridge Maintenance Engineer. He indicated he received notice of the accident on October 6, and his report reflects the information as reported by Petitioner. RX1.

Petitioner returned to Dr. Florendo on October 8, 2014. It was noted he presented for a hernia, which was incapacitating. Examination revealed no abdominal tenderness. Assessment was left inguinal hernia, and Dr. Florendo referred Petitioner to surgeon Dr. Striegel. PX1, RX2.

On October 27, 2014, Petitioner presented to Dr. Stephen Striegel of Lincoln Surgical Associates. The history noted was, "Was pushing/pulling at work, felt a twinge". With regard to onset of symptoms, it was noted as "(?) vague discomfort left groin". On October 28, 2014, Dr. Striegel reported to Dr. Florendo that Petitioner had a left inguinal hernia by CT scan, but that he could not really feel it. He noted Petitioner had some groin discomfort and that he had recommended a left inguinal hernia repair, but had cautioned Petitioner that he may just have a groin strain. PX3, RX3.

The next record of treatment was February 8, 2015, when Petitioner presented to Dr. Striegel for a pre-operative history and physical. It was noted he had been seen in October 2014 and had some discomfort in his left groin that was "somewhat vague". He had been doing some pulling at work and felt a twinge and a pop. It was noted Petitioner had previously had a cholecystectomy. On examination, his abdomen was soft and nontender. There was no obvious hernia on either side. On February 9, 2015, Petitioner underwent a left inguinal hernia repair with mesh. He was taken off work and allowed to return to full duty work with no restrictions on February 18, 2015. PX3, PX4, RX3.

On February 23, 2015, Petitioner presented to Dr. Florendo for unrelated left elbow pain which he rated as 10/10. He reported it was a sharp pain that occurred intermittently and was worsening. Examination was negative for crepitus, edema, decreased mobility, tenderness, instability, numbness, or tingling. Assessment was left elbow pain and Dr. Florendo ordered x-rays, prescribed pain medications, and referred Petitioner to physical therapy. Left elbow x-rays taken that day showed moderate left elbow osteoarthritis. PX1, PX3, RX2.

On March 2, 2015, Petitioner followed up with Dr. Striegel, who noted he had healed up very nicely and was having no complaints. He was to return if there were problems. PX3, RX3.

On March 4, 2015, Petitioner presented to Phoenix Physical Therapy for an evaluation of his unrelated left elbow pain. He reported he had been having pain off and on for years, and that it was worse in the last few months. It was noted the x-ray showed "jagged edges on bone". Petitioner reported he could not straighten either elbow well and that he had run a jackhammer for 29 years. His pain was on the backside of the elbow and not 100% associated with activity. He had decreased elbow extension and was tenderness to palpation at the lateral epicondyle. The next therapy note is April 15, 2015, at which time Petitioner reported his left elbow was doing much better and that he was working out at the gym with no difficulty. He still had some decreased elbow extension and mild tenderness, but was discharged from therapy. RX2.

Petitioner's prior medical records dating back to 2011 from Dr. Florendo were admitted at trial, which revealed various health issues, including sore throat, cough, hyperlipidemia, low potassium, right elbow pain, and right hand contusion. In addition, and of relevance, on April 30, 2011, Petitioner presented to the emergency room at St. Joseph's Hospital with abdominal cramps which had started the day before. He underwent a CT scan of the abdomen and pelvis, which revealed collapsed sigmoid colon and descending colon. The Arbitrator notes the findings did not include a hernia, and Petitioner was diagnosed with mild colitis. On May 10, 2011, he followed up with Dr. Florendo and reported abdominal pain for two weeks. Diagnosis was abdominal pain and diarrhea, and lab work was ordered. On April 5, 2013, Petitioner presented

with complaints of pain and pressure in the epigastric area. An abdominal ultrasound of the right upper quadrant was performed on April 8, 2013, which was normal. On May 7, 2013, Petitioner again presented with complaint of abdominal pain in his right upper quadrant. A hepatobiliary scan was ordered, but the Arbitrator notes the results are not included in the records. On May 29, 2013, Petitioner presented to Dr. Scott Wong upon referral by Dr. Florendo. His assessment was abdominal pain, GERD, hypertension, and hyperlipidemia. On July 2, 2013, Petitioner returned to Dr. Florendo, for what was noted as "status post gall bladder surgery". PX1, RX2.

Dr. Striegel testified by way of deposition on April 4, 2016. He is a general and vascular surgeon, treats hernia conditions, and has been in practice 26 years. He testified consistent with his treating records. Petitioner was first seen on October 27, 2014, and complained of relatively vague discomfort in his left groin region. Petition said he had been doing some lifting, Dr. Striegel believed at work, and developed relatively vague discomfort in his left groin. Examination showed discomfort but no specific bulge. Based on the CT scan, Dr. Striegel felt he had a hernia. Surgery was performed to repair an indirect left inguinal hernia, and Petitioner did very well post-operatively. Dr. Striegel testified that the work lifting accident reported by Petitioner "could very well have been" a causal factor in the development of his hernia. PX1.

Dr. Striegel testified he reviewed Dr. Florendo's medical records, which included visits from March 3, 2014, and September 10, 2014. During the September 10 visit, Petitioner complained of abdominal pain, including bloating and diarrhea. Dr. Striegel testified neither of these records provided any causal factor with respect to Petitioner's hernia. The diarrhea and bloating sounded like diverticulitis, a gastrointestinal issue, which is what Dr. Florendo noted as well. During the March visit, Petitioner complained of a cough. Dr. Striegel testified coughing can cause a hernia, but usually not. It may aggravate a hernia more so than cause one. Activities such as heavy lifting can also aggravate or, in some cases, cause a hernia. Dr. Striegel testified Petitioner's hernia was causally related to the work lifting incident, which he understood to be a pushing/pulling incident which caused a twinge. PX1.

On cross-examination, Dr. Striegel acknowledged he and Petitioner's counsel had discussed the prior treating records immediately preceding the deposition, and he had reviewed them at that time. He testified he reviewed the CT scan from March 2011 and the scan from 2014, and noted something had changed radiographically. PX1.

Dr. Striegel conceded he was not aware of what Petitioner was pushing and pulling when he felt the twinge in his groin, nor was he aware of how heavy it was, or whether it was large and awkward. He testified, however, that he was reasonably certain that the activity had something to do with Petitioner's abdominal condition, as that was the only time Petitioner had felt that "twinge". He acknowledged that he based his causation opinion 100% on Petitioner's subjective complaints about what occurred on September 9, 2014. Dr. Striegel was asked if he found it odd that Petitioner saw Dr. Florendo on September 10, 2014, the day after the alleged work accident, and did not mention the accident, but rather said he had been having this issue for two weeks. He responded, "It's somewhat odd." He testified that it appeared Petitioner had two things going on at the same time, the twinge, and the gastrointestinal issues of bloating and diarrhea, likely due to a bug or virus. Dr. Striegel conceded again that it was odd that Petitioner did not say anything to Dr. Florendo about the twinge that he claimed to have felt the day before, but

testified that patients don't always give all of the consistent history all at once, and perhaps Petitioner was more concerned about the bloating and diarrhea at that point in time. PX1.

Dr. Striegel testified Petitioner's hernia was indirect, rather than direct. He explained that with an indirect hernia there is a congenital area where there is a definite weakness, and while Petitioner was born with the weakness, he was not born with the hernia. Although the CT scan showed a hernia, Dr. Striegel could not feel it the day of the initial exam. With a negative exam, he would not normally have surgically explored the groin, but the CT scan was positive. Without the CT scan, it is possible Petitioner would not have known he had a hernia, but also possible the hernia would have gotten bigger. He testified that lifting, in general, could have aggravated the hernia. PX1.

Dr. Striegel testified that post-operatively Petitioner healed up nicely and had no complaints. He was not aware of AMA ratings, but agreed Petitioner would have zero disability as result of his condition. PX1.

On re-direct, Dr. Striegel testified Petitioner had no restrictions and could participate in normal activities. He declined to say that Petitioner had weakness in the area of the surgery, but conceded that patients can have a recurrence, but it is generally not in the original area where the hernia comes back. PX1.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an accident occurred which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Worker's Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011). In order to satisfy the "arising out of" requirement of the Act, the Petitioner must show the injury was in some way incidental to his employment, creating a causal connection between his employment and the injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment. In so concluding, the Arbitrator finds the following three facts to be compelling. First, Petitioner did not report the accident to his employer for four weeks. Second, he did not mention the accident to any medical provider until October 27, 2014, seven weeks after it purportedly occurred. Third, Dr. Striegel's causation opinion was based on vague and incomplete facts.

Lack of reporting to his employer

It is undisputed that Petitioner did not report any incident to his employer until October 6, 2014, four weeks after it allegedly occurred. Petitioner's testimony regarding the lack of reporting contained several inconsistencies, which the Arbitrator finds significant. He testified he was hooking up an arrow board and felt "a twinge and a pop in my lower left side in my groin area…and I felt discomfort right away". He further testified he did not report the accident or fill out an incident report immediately because he thought it would go away. Yet, when confronted on cross-examination with 17 incident reports he had completed through the years, he testified that, "You have to report something, if something happened to you, and I don't care if it's a scratch or scrape or anything, they want you to say this is what happened here…." He acknowledged that an incident report was supposed to be filled out any time there was an injury, regardless of whether there was medical treatment. Despite having this knowledge, Petitioner did not report the incident immediately, and gave no clear explanation for not doing so.

The day immediately after the alleged accident, Petitioner's timekeeping records (RX1) show he took three and a half hours of sick time, and he testified he went to Dr. Florendo that day. Dr. Florendo's record from September 10, 2014, does not contain any reference to Petitioner experiencing a twinge or a pop, any work injury, or any work incident such as pulling, pushing, or lifting. Rather, his record from that day states, "History of Present Illness: Abdominal pain. Onset: 2 weeks…The location is hypogastric, left upper quadrant and lower left abdomen." The Arbitrator finds the lack of any history of a work accident to be compelling, especially in light of the fact that the appointment was the very next day after the alleged accident. Petitioner had a CT scan that same day, and testified that Dr. Florendo's office notified him the following day (September 11) that he had a hernia. He further testified that when he was told about the hernia what came into his mind was, "I knew when it happened…It happened when I was hooking up to that arrow board."

The day after the alleged accident, Petitioner reported lower left abdominal pain to his family doctor. Two days after the alleged accident he was told he had a hernia, which he related to lifting the arrow board. Yet, he still did not report the incident to his employer for another four weeks because, according to his testimony, he thought it would get better. He had pain, he had a diagnosis, he had a connection in his mind to a work incident, but he did not report the accident. The Arbitrator finds this to be not only illogical, but also lacking in veracity.

Lack of reporting to his medical providers

As indicated above, Petitioner presented to his family physician the day after this alleged accident, reported lower left abdominal pain, and did not mention any incident at work the previous day. Nor did he inform Dr. Florendo of an incident at work when he found out he had a hernia and he connected it in his mind to the alleged incident. He saw Dr. Florendo again on October 8, 2014, and still made no mention of this incident. It was not until he saw Dr. Striegel on October 28, 2014, seven weeks later, that he mentioned hurting himself while pushing/pulling at work. Even then, he made no mention of the very specific incident with the arrow board.

Basis for Dr. Striegel's causation opinion

A claimant must produce competent evidence of objective conditions or symptoms to show that her job duties caused her present disability....While medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only, expert testimony is necessary to show that the claimant's work activities caused the complained of condition. *Nunn v. Industrial Comm'n*, 157 Ill.App.3d 470, 477-478 (4th Dist. 1987).

The Arbitrator notes that Dr. Striegel, despite giving a causation opinion connecting Petitioner's work accident to his hernia, had almost no knowledge about Petitioner's alleged accident. While stating generally that Petitioner was "pushing/pulling at work", Dr. Striegel was unaware of what Petitioner was allegedly pushing/pulling, how heavy the item allegedly was, or whether the item was large or awkward. It is clear that Dr. Striegel, Petitioner's treating surgeon, did not have sufficient knowledge of Petitioner's alleged work accident to be able to provide a meaningful expert medical opinion regarding causation. As such, the Arbitrator is not persuaded by his testimony.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment. All other issues are rendered moot and the Arbitrator makes no findings regarding same.

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

FERNANDO VILLAREAL,

Petitioner,

17IWCC0533

vs.

NO: 15 WC 775

JOHNSON CONTROLS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, benefit rates, medical, causal connection, prospective medical and penalties pursuant to §19(k) & §19(l) and attorneys' fees pursuant to §16 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 Arbitrator intermittently used the spelling Roderigo for Rodrigo and Musquiz for Muzquiz. The Commission finds the spelling variations, and combinations thereof, refer to the same witness, Rodrigo Muzquiz.

The Arbitrator admitted Respondent's exhibit number eleven, Safety Alert 24-Hour Notice of Incident report (Rx11), authored by Fernando Ortiz, as a business record exception to the hearsay rule. The Commission finds that Fernando Ortiz would testify consistent with the report he authored. The Commission also finds Rx11 is evidence that Fernando Ortiz would testify consistent with Respondent's witnesses' testimony concerning the bar, Respondent's exhibit number one.

17IWCC0533

Rx11 provides a Description of Incident that states in pertinent part: "While attempting to make the adjustment with a pry bar, the operator alleged that it became stuck between the sprocket & the guide rail (as shown in the pictures below.)" Under the Description of Incident are two pictures. The writing to the left of the left-sided picture includes an arrow pointing to the "Location of the sprocket on non-operator's side of Flight chain." The second picture appears to be a close-up of the subject bar and sprocket and the written description on the right side of the picture on the right states: "Investigation does not validate that the pry-bar fits into suspect location." The Commission declines to draw inferences against the Respondent for failing to bring Fernando Ortiz to testify when the plain reading of his report conforms with the testimony of Mark Lyttle, Rodrigo Muzquiz and Larry Boswell concerning the bar, Respondent's exhibit number one. The Commission therefore strikes the last sentence in the first full paragraph on page 15 of the Arbitrator's Decision.

The Commission finds Rx11 obviates the need for Respondent to produce Fernando Ortiz as a rebuttal witness. Accordingly, the Commission also strikes the final sentence in the second paragraph on page ten of the Arbitrator's Decision. The Commission further strikes the second and last sentences in paragraph two on page 16 of the Arbitrator's Decision.

Therefore, the Commission vacates the Arbitrator's award of penalties pursuant to §19(k) and attorneys' fees pursuant to §16 and finds Petitioner is entitled solely to §19(l) penalties for non-payment of benefits pursuant to §8(a) and §8(b) of the Act in the amount of $10,000.00, the maximum allowed.

The Commission also finds the Arbitrator erroneously calculated the periods of temporary partial disability and temporary total disability. The temporary partial disability period from August 24, 2015 through March 6, 2016 is 28 weeks. The temporary total disability period from December 10, 2014 through December 15, 2014 is six days. The temporary total disability period from January 19, 2015 through August 23, 2015 is 31 weeks. The temporary total disability period from March 7, 2016 through April 18, 2016 is 6-1/7 weeks. In total the Commission awards 38 weeks temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 31, 2016, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $229.93 per week for a period of 28 weeks, for the period from August 24, 2015 through March 6, 2016, that being the period of temporary partial incapacity for work pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $394.93 per week for a period of 38 weeks, for the periods from December 10, 2014 through December 15, 2014, January 19, 2015 through August 23, 2015 and March 7, 2016 through April 18, 2016 that being the periods of temporary total incapacity for work pursuant to §8(b) of the Act.

17IWCC0533

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $24,863.18 for medical expenses pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that penalties pursuant to §19(k) and attorneys' fees pursuant to §16 are vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,000.00 for penalties pursuant to §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest pursuant to §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 $56,206.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 - 2017
KWL/bsd
08/23/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0533

VILLAREAL, FERNANDO
Employee/Petitioner

Case# **15WC000775**

JOHNSON CONTROLS
Employer/Respondent

On 8/31/2016, 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 0.45% 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:

0009 ANESI OZMON RODIN NOVAK ET AL
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

05507 RUSIN & MACIOROWSKI LTD
DANIEL ARKIN
10 S RUVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0533

FERNANDO VILLAREAL
Employee/Petitioner

v.

JOHNSON CONTROLS
Employer/Respondent

Case # 15 WC 775

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **12/7/15 and 4/18/16**. 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 _____

17IWCC0533

FINDINGS

On the date of accident, **12/4/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,804.80**; the average weekly wage was **$592.40.**

On the date of accident, Petitioner was **36** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $24,863.18, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $229.93/week for 27 6/7 weeks, commencing 8/24/15 through 3/6/16, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $394.93/week for 37 4/7 weeks, commencing 12/10/14 - 12/15/14, 1/19/15 - 8/23/15, and 3/7/16 - 4/18/16, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $0 for temporary total disability benefits that have been paid.

Respondent shall pay to Petitioner penalties of **$13,831.94**, as provided in Section 16 of the Act; **$23,053.23**, as provided in Section 19(k) of the Act; and **$10,000**, as provided in Section 19(l) of the Act.

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

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

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

Jason C. Mgntz

Signature of Arbitrator

8/29/16
Date

ICArbDec19(b)

AUG 31 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FERNANDO VILLAREAL, Petitioner, vs. JOHNSON CONTROLS, Defendant.	)))))))	17IWCC0533 No.: 15 WC 775

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Petitioner's Testimony & Medical Records

Petitioner was employed by Respondent for approximately four months as a machine operator before the accident date. (R.15) His job involved putting 25 to 35 pound cells used for car batteries into a machine for cleaning. (R.16) He was on his feet most of the time and the maximum amount he lifted at work was 75 pounds. (Id.)

According to his testimony, Petitioner was working the third shift at Respondent's plant on December 4, 2014 when a problem arose with his machine in which the chain came off the rail it was attached to. (R. 17-18) The chain runs the length of the machine and each end has a gear. (R.19) Petitioner testified that the chain came off the gear and Petitioner had to use a bar to put the chain back on the gear. (R.20) In the midst of this endeavor, the bar got stuck between the metal wall of the machine and the gear. (Id.) He was successful in getting the chain on the gear, but the bar remained stuck. (Id.) Petitioner used a hammer to strike the bar a few times to no avail. (Id.) He then moved the bar back and forth a few times with his hands the bar loosened a bit. (Id.) Petitioner then pulled on the bar vigorously and felt a pop in his left shoulder accompanied by pain. (R.20–21)

Petitioner's supervisor, Fernando Ortiz, was then called to the machine via walkie-talkie radio. (R.22) Fernando Ortiz asked a few questions while both men were situated near the machine. Supervisor Ortiz then grabbed a paper, filled out a report which he then had Petitioner sign. (Id.) Petitioner was then taken to the nurse's office where he waited four hours before eventually obtaining medical care. (R.23)

After two hours in the nurse's office, Fernando's supervisor, Mark Lyttle showed up. (R. 24) Petitioner testified that Mark Lyttle took him to the machine and told Petitioner to explain how the accident happened while Mark took notes. (R.25) Petitioner described how the accident happened to Mark but did not demonstrate due to his arm pain. (Id.) Petitioner testified that Mark Lyttle then brought two other operators to the machine to "re-create" the accident. (R.26) Petitioner testified that Mark Lyttle used the same bar (used by Petitioner when he was injured) to re-create the accident, and the bar got stuck in the machine. (R.27–28) After Mark Lyttle got the bar stuck, he asked the other operators if this was the correct procedure. (R.28) Mark Lyttle then took Petitioner back to the nurse's office. (R.30) Petitioner asked Mark if he was going to take him to the hospital, and Mark replied that the accident could have a big impact on the company, if Mark saw that Petitioner's arm had fallen off he would take him to the hospital but that he looked fine. (R.32) Petitioner testified he stayed two more hours in the nurse's office before eventually getting medical care.

Petitioner testified he told Mark Lyttle he would call the police because he was there against his will. (R.33) Mark Lyttle then made a few calls and took Petitioner to the hospital in a cab. (Id.)

Records from Delnor Community Hospital Emergency Room reflect that Petitioner arrived at 4:41 a.m., escorted by a co-worker. Delnor records further note the following history:

> *A 36-year-old male without past history, presents to the ER with complaints of left shoulder pain. The patient was at work tonight and working on a machine. He states his tool he was using got stuck. He pulled back on it very forcefully and developed immediate pain to the posterior shoulder. The patient states he was given ibuprofen at work, which has helped his pain, but has given him an upset stomach. He states the pain is not bad at rest at this point, but it is very painful to move. He does not want to move the shoulder at all. He notes it is tender in the posterior aspect.* (PX1).

On exam, "exquisite tenderness to posterior and lateral deltoid" as well as limited range of motion due to pain was noted. (Id.).

Left shoulder x-rays noted:

> *There is no evidence for dislocation. The humeral head and glenoid fosse appear normal. Only visualized on the Y view there is a suggestion of a small undersurface fracture of the acromion process anteriorly. Correlate clinically for symptomology in this location.*

Petitioner was diagnosed with a left shoulder sprain. A sling was applied and he was released to return to work with light-duty restrictions and prescriptions including Hydrocodone for pain. (Id.). Petitioner was discharged at 6:04 a.m. (Id.).

Upon his discharge from Delnor Hospital, Petitioner testified he was taken back to the Respondent's plant where he was then taken to Tyler Medical Center by the plant's nurse for a blood test. (R.43–44)

Records from Tyler Medical Services reflect that Petitioner presented on December 5, 2014 for a random drug screen. (PX2). The records further reflect:

> *[T]he patient is a stocker/machine operator for Johnson Controls* [who reported] *on 12/4/14 around 12:50 a.m., he was fixing a machine with a bar when the guard stuck between a bracket and as he was pulling it loose, he felt pain on his left shoulder. The patient points to the superior aspect and anterior aspect of the shoulder as the point of most discomfort."* (Id.).

Petitioner further reported he had been taking Norco as well as the Medrol Dosepack that was given to him at the emergency room on December 4, 2014. (Id.). Petitioner was instructed to continue with the Norco as prescribed by the ER at Delnor Hospital but not while working or driving or 6 hours prior to either due to sedative effect. He was further instructed to continue icing and wearing the arm sling and to follow-up on December 8, 2014. (Id.).

Petitioner testified that following his visit to Tyler Medical, he was again brought back to the plant, where he waited for the Plant Manager to arrive. Once the Plant Manager arrived, he asked Petitioner if he had been drinking or took drugs, which Petitioner denied, and which was

confirmed by the blood tests at Tyler Medical. (R.40,PX#2) Petitioner testified that the Plant Manager told him he didn't think the accident happened the way he said it did, then sent him home, but would not let him make a phone call before leaving. The Plant Manager told him to return on Monday. (R.42) Petitioner was then escorted out the door to his car. (R.42–43)

Petitioner testified he returned to work on Monday, December 8, 2014. (R.44) He was taken back to Tyler Medical by the plant nurse, then brought back to work. (R.47) He sat in the lunchroom for approximately 1.5 hours, before being taken back to his machine. (Id.) The Plant Manager and Mark Lyttle were there, and tried to re-create the accident again. (R.48) Petitioner testified that the bar used in this recreation was not the same bar that Petitioner was using at the time of his accident. (Id.) The Plant Manager said the bar didn't fit, to which Petitioner responded that it was not the bar he was using at the time of the accident. (R.49) The Plant Manager replied that it was the bar, which Petitioner again denied. (R.50) Petitioner was then taken back to the nurse's office, waited 20 minutes, before being told to come back the next day. (R.50)

Petitioner returned to work on Tuesday, December 9, 2014, and was sent to the lunchroom where he stayed for nearly the entire shift. (R.50–51). After the shift ended, he was taken by Roderigo Muzquiz to the conference room. (Id.) The Human Resources Secretary, a Union Representative and Mark Lyttle were also in the conference room. (Id.) Rodrigo Musquiz told Petitioner that since Petitioner missed three days where he was supposed to come in early for overtime, he was terminated. (R.52)

Petitioner testified that the days he was supposed to arrive early for work were in the week prior to the accident and that he was not written up at the time, and did not know he was supposed to come in early. (R.52–53) Petitioner worked his regular shifts those days. (R.53)

Petitioner also testified that two days prior to the accident he told Roderigo Musquiz that he was going to work at Caterpillar, and gave his two week notice. (R.53–54) The Caterpillar job was going to pay $30 per hour for programming machines, and Petitioner previously did this work elsewhere. (R.54–55)

After Petitioner received notice of his termination, he was taken by two employees to clean out his locker and escorted to his car. (R.55)

Petitioner testified he was then followed by two minivans from the company. (Id.) Using his law enforcement experience, he began driving in ever larger circles, but continued to be followed. (R.56) Petitioner then called the police who responded and intervened. (Id.) Based on his conversation with the officers, Petitioner understood that the two vans following him were private investigators. (R.57)

On December 15, 2014, Petitioner returned to Tyler Medical, and was released to return to full duty work. (R.57) He testified that his shoulder continued to be very painful. (R.58) After discussing the injury with representatives at Caterpillar, he did not begin the job due to his shoulder. (R.57–58)

On January 2, 2015, Petitioner was seen by Dr. Fajardo at Hinsdale Orthopedics. (R.58) Dr. Fajardo ordered an MRI, and released Petitioner to return to full duty work. (R.59) On January 13, 2015, Petitioner underwent the left shoulder MRI which was interpreted as revealing mild infraspinatus tendinosis and minor acromioclavicular joint degenerative changes. (PX3). Petitioner followed-up with Dr. Fajardo on January 19, 2015 at which time the doctor noted the

recent MRI revealed no evidence of full thickness rotator cuff tear but did show mild infraspinatus tendinosis. (Id.). Dr. Fajardo diagnosed a left shoulder rotator cuff sprain, took Petitioner off-work, recommended physical therapy and follow-up in one month. (Id.)

Petitioner underwent physical therapy at ATI three times a week from January 22, 2015 through April 24, 2015. (R.61)

The Arbitrator observed as Petitioner put his left arm through an active range of motion, and heard clicking and felt popping in Petitioner's left shoulder. (R.62)

Petitioner returned to Dr. Fajardo on March 17, 2015. Dr. Fajardo administered an injection to Petitioner's shoulder, had him continue therapy and kept him off work. (R.63,PX#3pp.21–23) Petitioner testified he received no benefit from the injection. He was then examined by Julie Morgan, Physician Assistant, on March 31, 2015 at Hinsdale Orthopedics. She recommended Petitioner be seen by Dr. Domb. (R.64)

On April 9, 2015, Petitioner was examined by Dr. Domb, recommended he undergo arthroscopic surgery, and authorized him off work until the surgery was performed. (R.64–65,PX#3,pp.28–31) Petitioner was then discharged from therapy on April 25, 2015. (R.65) Petitioner has not received medical care or undergone a Section 12 exam by Respondent since Dr. Domb's recommendation to remain off work until surgery was performed.

Petitioner requested authorization for the surgery by Dr. Domb from the Arbitrator. (R.65–66)

Petitioner identified the bills in PX#6 as remaining outstanding. Petitioner reviewed the faxes contained in PX#5, and testified the TTD has not been paid to him and surgery has not been authorized. Petitioner testified he returned to work on August 28, 2015. He averages approximately 30 hours per week working at a cashier at Wendy's. (R.67–69) He is paid $8.25 per hour. He identified in PX#6 his paychecks from this employment. (R.68–69) He took the job because he used $20,000 from his 401(k) and ran out of money. (R.70-71)

Prior to this accident, Petitioner testified he had never injured his left shoulder before or received medical care for it. He did have a gunshot wound to his neck 15 years prior that occurred while he was part of a special SWAT group for hostage situations in Mexico City. (R.34) He was rappelling down from a helicopter to a hostage situation at a bank when he was shot. (Id.)

Petitioner testified that he has a Master's Degree in Ballistics that he earned in Mexico City, and has a FIFA License A for coaching that took him three years to obtain.

Cross Examination of Petitioner

Petitioner testified that he understood Respondent's attendance policy consisted of incurring six demerit points, after which, he would be terminated. (R.72) He acknowledged that this is what happened to him. (Id.) He reviewed each of the point notices he received in RX#4-7. (R.73–76) He denied that he was supposed to come in early for overtime on December 4, 2014, and stated he was not told to come in early. (R.76–77) Petitioner was asked if he was told by Roderigo at the start of his shift the he had accumulated his sixth point and was going to be automatically terminated, but he insisted he was told after the accident he got a sixth point and signed the sixth point after the accident. (R.79)

Petitioner told Roderigo Musquiz he was leaving for Caterpillar and was supposed to start on December 19, 2014. (R.80) He was released by Tyler Medical to full duty prior to that date. (R.81) He told Tyler Medical personnel on December 5th and 8th that he had cracking and pain in his shoulder, and told them he still had pain on December 15. (R.85–87) He told Dr. Fajardo on January 2, 2015 that he hurt his shoulder pulling so hard on a bar that he injured himself. (R.90–91) Petitioner described the bar as 3 feet long, 1 inch wide and heavy. (R.91) He testified that the bar got stuck between the metal wall and the gear, and had to pull so hard on it he hurt his left shoulder. (R.94) Petitioner reviewed photos of a bar and testified this was not the bar he was using. (RX#2) He also examined an actual bar, RX#1, and testified that the bar he was using was half as thick as RX#1. (R.96) He testified that both the thickness of the bar he used was smaller and the width of the bar was smaller. (R.97) He reiterated that RX#1 was not the bar he was using when he got hurt. (R.98)

Petitioner then reviewed a video of an attempted re-creation of his accident. (RX#3,R.101) He reviewed several photographs of the machine he worked on and Mark Lyttle holding the bar at Petitioner's machine, but testified that the bar Mark was holding was not the bar Petitioner used, and the bar was not being held where Petitioner's bar got stuck. (R.101–109) In other photographs, Petitioner was not sure if the machine depicted was the machine he was working on. (R.110–112) In the video, he testified that Mark Lyttle was trying to put the bar on top of the gear, not in the gap between the gear and the wall. (R.113)

Concerning the accident, Petitioner testified that two hours after the accident, Mark Lyttle, Fernando Ortiz, two other employees and Petitioner went back to the machine. (R.114) Petitioner testified that Mark got the bar stuck at his machine at that time because he was using the same bar that Petitioner used. (R.114–115) Mark then brought another bar over and started taking pictures. (R.116) Petitioner told him that that was not the same bar, and Mark said it was the one that he had a few minutes ago. (R.116) Petitioner insisted that it was not the same bar, and an argument ensued. (Id.)

Petitioner testified he also went to the machine another time with Larry Boswell, Roderigo and Mark. (R.117) At that time, the bar that they used looked similar to the bar represented by RX#1. (R.117–119) Petitioner explained that when he put the bar into the machine, he grabbed the bar with his left hand and hammered it at the top, like in the video. (R.122–123) Petitioner testified that Fernando, Larry and Mark couldn't get the bar stuck because it was a different bar. (R.123) He testified that the accident was re-created three times. (R.124) The first time was with Fernando. The second time was with Mark and Fernando. The third time was with Larry, Roderigo and Mark. (R.124) The first time, with Fernando, the bar was just positioned how it happened and pictures were taken. (R.125) Fernando did not try to get the bar stuck. (Id.)

Petitioner was released to return to full duty work on December 15, 2014. He was supposed to return to work on December 19 at Caterpillar, and that job involved lifting. (R132) Petitioner looked for work through temp agencies, and worked for a company for three or four hours and another company for a few hours before taking the job at Wendy's. (R.134–136)

Testimony of Larry Boswell

Larry Boswell testified that he is and has been employed by Respondent for 13 years and is currently the Director of Manufacturing for Respondent's US plants in Milwaukee, Wisconsin and has held that position for one year. (R.156). On the date of Petitioner's alleged accident, he was the Plant Manager of Respondent's facility in Geneva, Illinois, a position he held for two and a half years. (R.157) In his capacity as Plant Manager, his duties included managing the facility

and accident investigation. (Id.). He further testified his duties include "ensuring that our employees are working safely building quality products meeting our customers' expectations." (Id.). He was involved in the re-creation of Petitioner's claimed accident. (R.159) Larry Boswell testified that Petitioner told him he took a pry bar to fix a piece of equipment and in doing so the bar got stuck in between a sprocket and the base rail of the machine. (Id.) Mr. Boswell testified that every machine has a pry bar, and RX#1 is the pry bar Petitioner said he used. (R.160) He testified that he went to Petitioner's machine and grabbed the pry bar and re-created the incident. (Id.) RX#1 was the pry bar that he grabbed, and is marked at the machine with #25. (Id.) Mr. Boswell testified that RX#1 is the pry bar for Petitioner's machine, and no other pry bars would be used at that machine. (R.161)

Mr. Boswell testified that when he tried to re-enact the accident, he couldn't get the pry bar to stick. (R.162) He then told Petitioner based on this re-creation he could not validate what Petitioner claimed as being the reason he was injured. (Id.) Mr. Boswell testified Petitioner responded that he didn't know what to tell him, that's what happened, but did not say it was the wrong bar. (R.163) He further testified that he, Mark Lyttle, and Roderigo Muzquiz were involved in Petitioner's termination.

On cross-examination, Larry Boswell testified he did not bring his investigative packet with him to the hearing, but he did review it three times, the last of which, was after Petitioner's termination (R.167) He did not recall the time or the date of the accident, despite the fact that Respondent's counsel had given him the date 10 minutes earlier in his testimony. (R.167–168) He testified that he was first notified of the accident in his office on the date of the accident, and was not notified at home before coming in. (R.169) He was not sure if Petitioner was in the plant when he got there, and was not sure what time Petitioner was taken to the doctor. (R.170) The first time Larry Boswell spoke to Petitioner was at 9:00 or 10:00 a.m. (R.170) He spoke to Petitioner about the accident that morning with Roderigo, but is not sure where. (R.170–171) He testified the first time he walked up to the machine, he wanted to see if it was still operating. (R.172–173) The machine was operating, he was not aware if it had been shut down, and did not know who was operating the machine that morning. (R.174)

Larry Boswell testified that the first time he took the pry bar in his hands was his second trip to the machine with Petitioner that morning. (R.174) Petitioner told Larry Boswell that RX#1 was the pry bar he used at the line during the reenactment. (R.175–176) Both Roderigo and Mark were present, and Larry didn't let Petitioner attempt to reenact the accident because Petitioner said he wasn't in a position where he could do it. (R.176) Larry testified that he spoke to the nurse when she came back from the doctor with Petitioner, was aware that Petitioner was on pain medications, and was not sure which shoulder Petitioner injured. (R.177) He stated that the investigative report from the date of accident did not indicate the Petitioner was in pain. (R.179) He testified it was up to the supervisor to decide whether to send the employee for medical care, but the employee could go on his own. (R.181) He testified that Fernando Ortiz was the supervisor in charge at the time. (Id.) Larry Boswell was not sure if Fernando Ortiz re-created the accident with Petitioner, but Larry Boswell reviewed his report. (R.182) He acknowledged that Fernando interviewed witnesses, but was not sure who the witnesses were. (Id.) He was also not sure if Fernando Ortiz's report had contained any photographs. (R.182–183)

Larry Boswell testified that RX#1 was on the machine between the time of the accident and when Larry Boswell first picked it up after Petitioner came back from the doctor. (R.184) Larry testified that the pry bar was sitting there when he went to the machine, but could not say whether it had been was moved by anyone. (R.184) He testified he was not aware that Petitioner

told others that RX#1 was not the pry bar he used. (R.185) Larry testified that Fernando Ortiz still works for Respondent in Geneva. (R.187)

Testimony of Mark Lyttle

Mark Lyttle was the COS Area Manager since 2001 in Geneva. (R.189) He made notes of his investigation within a week of the alleged accident, which were contained in RX#10. (R.193) He spoke to Petitioner in the nurse's office, and Petitioner immediately wanted to know why he was still at the Plant. (R.193) Petitioner told Mark that he was in pain at that time. (R.194)

Concerning the accident, Petitioner told Mark that he was attempting to adjust the chain on an accelerator sprocket and attempted to wedge in a bar to move the sprocket forward when the bar became jammed between the sprocket and the outer wall. (R.195) He tried to pull it out, and on the second try heard a pop in his shoulder. (Id.) Mark Lyttle went to the scene with Fernando Ortiz after Petitioner walked him through what happened. (R.196–197) Mark Lyttle testified that Petitioner used RX#1 as his pry bar. (R.197) He testified that RX#1 was the bar at the side of Petitioner's machine, that the bar has #25 on it but Petitioner's machine was stacker #24. (R.198) Mark testified that stacker 24 was the machine where the accident happened. (R.199) Mark testified he knew that RX#1 was the bar Petitioner used because it was at the machine when Mark went out there. (R.200) Mark testified that he attempted to wedge the bar into the machine and was unable, and couldn't put it in any of the other machines either. (R.202–203) He then went back to the office to ask Petitioner to go step-by-step how the accident occurred. (R.203) Mark concluded that it was impossible for the bar to fit into the spot Petitioner indicated, then came back to the office and took Petitioner to the hospital without discussing the accident or his conclusions with Petitioner. (R.206)

Mark took Petitioner to the hospital in a cab. They then returned to the plant in a cab together. (R.107–108) Mark testified that Petitioner could not come out onto the production floor after coming back from the hospital to walk through the events because he was on pain medications and company policy prohibited people on pain medications from going to the floor. (R.208) Mark testified that Larry Boswell was part of that decision. (Id.) After Petitioner was sent home, Mark took the bar off the floor and put it in Roderigo's office. (R.209) He does not recall if he tried to re-create the event with anyone else that day. (Id.)

Mark testified that he reenacted the accident with Larry Boswell, Roderigo, Mike Brown and Petitioner on Friday, December 5, 2014. (R.210) He testified that Petitioner never told anyone they were using the wrong bar and Petitioner admitted that RX#1 was the bar he was using. (R.219–220)

On cross-examination, Mark testified that Petitioner did not go to the production floor after coming back from the emergency room on the date of accident, and Larry Boswell was wrong if he said he took Petitioner to the floor at that time. (R.221) Mark testified that Petitioner's machine was back in operation after 45 to 60 minutes of investigation. (R.222) A relief operator worked Petitioner's machine after the accident. (R.223) Mark did not take the bar off the floor until after Petitioner came back from the emergency room, and can't say if the relief operator might have switched the bar with a bar from another machine during that time. (R.224) Mark also testified that nothing about the markings on the bar tie it to the machine, as Larry Boswell testified, and operators borrow tools from line to line from each other. (R.224–225) Whereas Larry Boswell testified that RX#1 was specific to Petitioner's machine, Mark testified that the bar could be used by any of the five or six stackers in the plant. (R.226) Mark did not know if

there are other pry bars in the plant, he did not investigate that. (Id.)

Mark acknowledged that Fernando Ortiz was part of the investigative team, even though he left him out of his testimony on direct examination. (R.228–229) Mark testified that Fernando still works at the plant in the same capacity and did not know why Fernando was not present to testify on behalf of Respondent. (R.229) Fernando Ortiz filled out the investigative paperwork. (R.230) Mark testified he was not aware that Fernando Ortiz and Petitioner reenacted the accident together. (R.232) Mark testified that the only reenactment he did with Petitioner was the day after the accident. (R.238) When specifically told that Larry Boswell said no other pry bars could be used for the #24 stacker other than RX#1, Mark said it could be used across multiple machines. (R.240–241) Mark also testified that there could be other pry bars at other machines that could be used at Petitioner's machine. (R.241)

On redirect examination, Mark again testified that Petitioner told him RX#1 was the bar he used. (R.243) On re-cross-examination, Mark testified that when he said Petitioner told him that RX#1 was the bar he used, it was actually Larry Boswell that Petitioner was speaking to, not him. (R.256)

Testimony of Roderigo Muzquiz

Rodrigo Muzquiz was present for the testimony of all of the witnesses as the Respondent's representative. Roderigo testified he received a call at 5:00 a.m. from Mark Lyttle about the incident at the plant. (R.271) He spoke to Mark Lyttle in his office at about 7:30 a.m. (R.273) He then spoke to Petitioner in the conference room that day. (R.274) He testified that Petitioner could not go out to the floor that day after coming back from Delnor due to the pain medications, so he was told to come back the next day. (R.275) After Petitioner went home, Roderigo got the bar from Mark.

On Friday, December 5, 2014, at approximately 8:00 a.m., Roderigo testified that he rounded up Larry Boswell, Mark Brown and Mark Lyttle, grabbed RX#1 from his office and took Petitioner to stacker #24. (R.278) Larry Boswell then reenacted the accident with Petitioner. (R.279–280) Larry Boswell couldn't get the pry bar stuck. (R.280) Roderigo took the pictures contained in RX#3 during this reenactment. (R.280–281) Roderigo is not aware of any other pry bars getting stuck at the plant. (R.281)

Roderigo testified Petitioner was terminated on December 5, 2014, a Friday. (R.282) He testified that on December 2, 2014, Petitioner told him he was leaving and that is last they would be December 19. (R.282–283)

On cross-examination, Roderigo admitted that Petitioner was not depicted in any of the pictures contained in RX#3. (R.295–296) He acknowledged that it was possible Petitioner was not told to come in four hours early for overtime, and did not know to do so, but was fired anyway. (R.303)

Testimony of Petitioner

The temp agency Petitioner referred to in his earlier testimony was Corporate Services, and the records are contained in RX#9. (R.304–305) He completed an application with them on December 17, 2014. (R.306) He worked for Johnson Controls for about four months, and decided to quit one week before the accident. (R.307–308) He testified that he worked for

Sonoco as a Quality Control Operator and left the job for more hours, although his application indicated he was laid off and did not quit. (R.309–310) He admitted that he lied on his application to Corporate Services to get hired and the purpose of the lying was to get money. (R.313) He worked in a forklift position for half a day and was sent home because they noticed he was injured. (R.314) He received several calls from Corporate Services, but didn't always call back. (R.319–320) Petitioner testified that Corporate Services kept calling even if he didn't, and the first thing they would ask is whether he was still working because they had a new opportunity. (R.320) He did speak to them several times, but did not call them back. (R.321) On cross-examination, he testified that he remained under Dr. Domb's care while looking for work, and was not receiving TTD benefits. (R.325) He had lost his apartment, was not receiving TTD benefits and those were the reasons he was looking for work. (R.325–326)
He also testified that he continued working at Wendy's from September 2015 through March 2016. (R.326) He identified as PX#8 his pay stubs. (Id.) His brother left Wendy's in March 2016, new management came in and wanted him to do heavy lifting and it caused pain in his left shoulder. (R.327) For that reason, he stopped working at Wendy's. His next appointment with Dr. Domb is on May 2, 2016. (R.328)

Conclusions of Law

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

The initial, and primary, issue in this case is whether Petitioner sustained an accidental injury arising out of and in the course of his employment. Based on a preponderance of the credible evidence, the Arbitrator finds that Petitioner did sustain an accidental injury arising out of and in the course of his employment with Respondent.

Petitioner testified that while working on his machine, the chain came off a sprocket. He grabbed a pry bar to get the chain back on the sprocket and to move the sprocket, when the pry bar got stuck. When he forcefully tried to move the pry bar he felt a pop in his left shoulder and immediate pain. Both Larry Boswell and Mark Lyttle agree that this was the history Petitioner gave to them. It is also consistent with the histories contained four hours after the accident in the Delnor Community Hospital Emergency Room records and in the records from the company's clinic, Tyler Medical Services.

The dispute arises from the fact that Respondent maintains the bar they claim Petitioner used was too big to get stuck in the manner Petitioner described. Respondent brought the bar they say Petitioner used to arbitration, and marked it as RX#1. It is depicted in the photograph in RX#2. Petitioner maintains that he did not use this bar, but used a smaller bar. Petitioner said that the bar he used was half as thick as RX#1 and the width was also smaller. There is very little consensus, among Respondent's witnesses concerning the details of the reenactments of the accident with exception that they all say petitioner specifically told them RX#1 was the bar he used. Petitioner denied RX#1 was the bar he used and was adamant that he told both Mark and Larry it was not the bar he used.

Petitioner testified that his supervisor, Fernando Ortiz, first showed up at his machine and began asking him questions. (R.22) Mr. Ortiz filled out a report and had Petitioner sign it. He then took Petitioner to the nurse's office and asked him more questions. Mr. Ortiz finished filling out the paperwork while Petitioner was in the nurse's office.

Petitioner then stated that Mark Lyttle showed up after two hours, which is consistent with Mark Lyttle's testimony. Petitioner testified that Mark took Petitioner to his machine with Fernando Ortiz and two other operators, told him to explain how the accident happened and started taking notes. Petitioner testified that Mark used to bar Petitioner was using to recreate the accident and the bar got stuck. (R.27–28) Mark denied going out to Petitioner's machine with Petitioner that morning. On cross-examination, Mark testified he was not aware that Mr. Ortiz reenacted the accident with Petitioner (R.239) and that Mr. Ortiz didn't tell him that he reenacted the accident with Petitioner (R.232), however, Mark's notes indicate that Fernando Ortiz told him how Petitioner was holding the bar when it got stuck, (RX#10,p.2)

Mark also testified on cross examination he did not know if Fernando Ortiz took photographs with Petitioner including one with the smaller bar Petitioner says he used, but assumed if he did they were in the investigative report, but had not looked at the report for a long time (R.232) The Arbitrator find that it strains credibility that neither Mark Lyttle nor Larry Boswell looked at the investigative report in preparation for their testimony and that neither one of them has reviewed it for "a long time" (R.232) in Mark's case or since just after Petitioner's termination (R.167) in Larry's case. Also, Mark testified he didn't know if Fernando Ortiz took any photographs (R.232), but his notes indicate that Mr. Ortiz did take photos. (RX#10p.3) Finally, Respondent did not produce Fernando Ortiz as a rebuttal witness to Petitioner's testimony that Mr. Ortiz was aware of the smaller bar Petitioner used and got stuck because Mr. Ortiz held it in his hands immediately after the accident, during his accident investigation.

Larry Boswell testified that on the accident date he arrived at work at about 6:45 a.m., and first found out about the accident when he got to his office. He testified that he was not notified of the accident at home. This testimony, however, is contradicted by Mark Lyttle's notes, which indicate that Mark conferred with Larry before agreeing to arrange for a taxi to take Petitioner over to Delnor at about 4:30 a.m. (RX #3, P.3) Larry Boswell also testified that he reenacted the accident with Petitioner after Petitioner returned from the emergency room, but Mark Lyttle and Roderigo Muzquiz contradicted this, saying that Petitioner could not have been taken out onto the machine floor after coming back from the emergency room since he was on narcotic medication.

The Arbitrator notes the lack of chain of custody Respondent exerted over the pry bar after the accident. Mark Lyttle indicated in his notes that he instructed Fernando Ortiz to keep Petitioner's machine shut down and not to restart it until he gave the okay. (RX#10, P.1) He testified that the machine was back in operation after 45 to 60 minutes of investigation. Since the investigation on the machine was concluded prior to taking Petitioner to the hospital, it must have been running again before 4:41 a.m., when Petitioner was first seen at the emergency room at Delnor Community Hospital. Mark Lyttle testified that a relief operator was called in and worked on the machine for the rest of the shift. Mr. Lyttle also testified that after Petitioner was sent home, he took the bar off the floor and took it to Roderigo's office, where it was stored. Petitioner was discharged from the hospital at 6:04 a.m. Petitioner testified that it was approximately two hours later before he was sent home by his Plant Manager, Larry Boswell. That means the bar was not taken off the floor until approximately 8:00 or 8:30 a.m. Mark Lyttle admitted that it was possible the relief operator could have switched out the bar before Mark took it off the floor.

There are also several versions of where the bar was located once the reenactment occurred. Larry Boswell testified that the reenactment occurred after Petitioner came home from the emergency room, and that RX#1 was the bar that Petitioner admitted using at the time of his alleged accident, because it was at the machine when Larry Boswell went there for the

reenactment. Even assuming that Larry Boswell had his dates wrong, and the reenactment took place the next day, he testified the bar was already at the machine when he arrived for the reenactment, and he grabbed the bar off the machine. (R.160) Mark Lyttle testified that a reenactment did occur on the morning of the accident, but it occurred before taking Petitioner to the emergency room, and it took place with himself and Fernando Ortiz, not with Larry Boswell. (R.196) Mark Lyttle testified Petitioner told him that Respondent's RX#1 was the bar he used in the alleged accident. On cross-examination, however, he admitted that Petitioner didn't tell him that, which Petitioner was actually speaking to Larry Boswell. (R.256) Larry Boswell testified that RX#1 was the pry bar Petitioner used, because the markings on the bar, (#25), corresponded to the machine that this was the pry bar for Petitioner's machine and there were no other pry bars for that machine. (R.160–161) Mark Lyttle contradicted that testimony in several regards. He first said that there was nothing about the markings on the bar to tie it to Petitioner's machine, since the bar was marked #25 and the stacker Petitioner was working at was #24. (R.225) He also acknowledged that operators borrow tools from line to line on a regular basis. (Id.) This testimony is particularly significant in light of Mark's earlier statement that he couldn't say if the relief operator might have switched the bar with another machine between the time of the alleged accident and when Mark Lyttle eventually removed the bar. Mark Lyttle testified that he didn't know if there were other bars in the Plant because he didn't investigate that issue (R.226), but later acknowledged there could be other pry bars used at Petitioner's machine. (R.241)

Roderigo Muzquiz testified that the bar was brought to his office by Mark Lyttle, and kept there until the next day, when he grabbed the bar, rounded up Larry Boswell, Mark Lyttle and others and went to the reenactment. (R.278) if Roderigo did bring the bar from his office and rounded up the rest of the investigative team and Petitioner for the reenactment, Larry Boswell could not have grabbed the bar still at the machine at the time of the reenactment.

What is clear to the Arbitrator is that Petitioner injured his arm early in the morning of December 4, 2014 where he arrived at approximately 4:41 a.m., reporting a history of left shoulder pain following an incident "around midnight" in which he was "working on a machine" when the "the tool he was using got stuck". (PX1). Petitioner further reported that "he pulled back on it very forcefully and developed immediate pain to his posterior shoulder." (Id.) Petitioner stated the shoulder was very painful to move." (Id.) On exam, "exquisite tenderness to posterior and lateral deltoid" as well as limited range of motion due to pain. (Id.). Petitioner was examined, x-rays were taken, a sling was applied to his left shoulder, and he was released to return to work with light-duty restrictions. (Id.). Petitioner was discharged from the hospital at 6:04 a.m. (Id.). Petitioner had limited movement of the shoulder, exquisite tenderness to the posterior and lateral deltoid and limited range of motion due to pain. (PX #1,P.35) He was diagnosed with a shoulder sprain, placed in a sling, prescribed Norco and a Medrol dose pack. (Id P.12,16) Petitioner testified he had no prior injuries to his left shoulder, and there was no evidence submitted to the contrary.

The Arbitrator finds that Respondent failed to demonstrate that RX#1 was the pry bar Petitioner used, and finds Petitioner's testimony credible that it was not. The Arbitrator notes that Mark Lyttle testified that the Petitioner's machine was stacker #24 the machine where the accident happened. (R.199)

Mark testified he knew that RX#1 was the bar Petitioner used because it was at the machine when Mark went out there.

The Arbitrator also finds that Respondent failed to preserve a proper chain of custody of the bar

following the accident and is therefore unable to prove that Petitioner ever used RX#1.

The Arbitrator also notes that Respondent did not present Fernando Ortiz to testify.

The Arbitrator also makes special note of testimony that was elicited when Petitioner was recalled to the stand by Respondent. Petitioner admitted that he left his employment with Johnson Controls off of his employment application to a temporary agency that he applied with to find employment during 2015. He testified that he lied on the application to get hired and the purpose of his lying was to get money. (R.313) In finding Petitioner credible on his testimony concerning accident, the Arbitrator considered this testimony. The Arbitrator was swayed by the fact that Petitioner admitted under oath that he had lied in order to get hired and earn money. Petitioner was terminated by Respondent on December 9, 2014. Other than a few hours, he did not work until August 24, 2015. He lost his apartment and went through $20,000 that he had in his 401(k). He was not receiving temporary total disability benefits from Respondent during this time, and had been ordered off work by Dr. Domb while awaiting surgery. Although Petitioner was not completely forthright in his application, he admitted so while under oath at arbitration hearing.

Furthermore, Respondent's actions towards Petitioner from the outset demonstrated a lack of concern for Petitioner's well-being. Petitioner had to wait four hours to be taken to the hospital, and had to threaten Mark Lyttle first with calling the police before it was agreed he would be taken. Petitioner was under the influence of Norco when he came back from the emergency room, which was the reason Mark Lyttle said he could not go out to the production floor. When Petitioner was sent home, he asked Larry Boswell if he could make a phone call, and was denied the opportunity. He was then escorted out to the parking lot to drive home. Both Mark Lyttle and Respondent's occupational nurse were present at the emergency room. The restrictions from the emergency room clearly indicate the Petitioner should not drive, yet he was escorted out to the parking lot to drive himself home and was not allowed to call for a ride. Petitioner was fired by Roderigo Muzquiz for generating his sixth point. On at least two occasions, Petitioner did not show up for four hours of overtime before his shift started. Petitioner testified he didn't know he was scheduled for overtime. Roderigo admitted that it is possible Petitioner didn't know he was scheduled for the overtime before leaving the Plant the day he was supposed to work his overtime. Nevertheless, Roderigo indicated that was grounds for firing. When Petitioner was escorted off the premises after being fired, he claims he was followed by two minivans. He testified his law enforcement training helped him recognize he was being followed, and was confirmed when he drove in circles of increasing size. He called the police, who confirmed that he was being followed by private investigators.

The Arbitrator does note that Petitioner lied on an application for employments but further notes this was in furtherance of supporting his family financially after losing his home and his savings. He admitted the lie under oath.

Respondent's witnesses' testimony was inconsistent concerning a work accident that they were insured to cover. Respondent's witnesses remain employed by the Respondent.

The Arbitrator accords Petitioner's testimony credibility noting the contemporaneous medical records of Delnor Hospital and Tyler Medical Center corroborate Petitioner's trial testimony.

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident. The histories Petitioner provided to the Delnor Community Hospital Emergency Room, Tyler Medical Center and Hinsdale Orthopaedics are all consistent with his testimony at trial of a pry bar getting stuck in his machine, pulling hard on it, hearing a pop in his left shoulder and feeling immediate pain. The Arbitrator finds that Respondent's dispute on causal connection is primarily based on accident. Finding that Petitioner sustained an accidental injury arising out of and in the course of his employment, the Arbitrator further finds for Petitioner on the issue of causation.

In addition, Petitioner credibly testified that he had no prior conditions to his left shoulder, injured it while pulling on the pry bar, and has been symptomatic since that incident.

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

Respondent's dispute concerning liability for Petitioner's medical bills was based upon its accident dispute. Based on the Arbitrator's finding that Petitioner did sustain an accidental injury arising out of and in the course of his employment with Respondent, the Arbitrator further awards Petitioner's medical expenses in the amount of $24,863.18, as follows:

Provider	Amount
Hinsdale Orthopaedics	$3,777.00
ATI Physical Therapy	$21,066.79
Reimbursement to Petitioner	$19.39
Total	$24,836.18

K. Is Petitioner entitled to any prospect of medical care?

After reviewing Petitioner's MRI and examining him, Dr. Domb diagnosed a left shoulder SLAP tear with significant crepitus. (PX#3,p.30) Dr. Domb recommended left shoulder arthroscopy, including subacromial decompression, AC joint resection, bursectomy, and a possible labral tear or rotator cuff repair. (Id.) In the absence of any medical opinion to the contrary, the Arbitrator awards Petitioner the prospect of medical care consisting of the surgeries recommended by Dr. Domb on April 9, 2015.

L. TTD

Petitioner claims he was temporarily totally disabled from December 10, 2014 through December 15, 2014, and again from January 19, 2015 through August 23, 2015 a period of 31 4/7 weeks. Petitioner is claiming an entitlement to temporary partial disability benefits from August 24, 2015 through March 6, 2016 representing 27 6/7 weeks. Respondent paid no benefits for either temporary total disability or temporary partial disability, based on its accident dispute. Petitioner testified he was called into work on December 9, and fired for accumulating his sixth point. Both Petitioner and Roderigo Muzquiz testified that Petitioner was fired by Roderigo. Roderigo testified he terminated Petitioner on December 5, 2014, a Friday. (R.282) Mark Lyttle testified that Petitioner came back into the office on December 8, 2014 for a reenactment of the accident. Mark testified that Larry Boswell and Roderigo were present for that reenactment. Larry Boswell testified that that reenactment occurred on the date of the accident, December 4,

2014. On cross-examination, Petitioner testified that he was paid by Respondent for December 8 and December 9. (R.138) Roderigo testified that it was possible Petitioner was not told to come in four hours early and did not know he was supposed to do so, but was fired anyway. (R.302) The Arbitrator finds Petitioner's testimony credible on the issue of the dates he was paid and the date of his firing. The Arbitrator does not find just cause for firing Petitioner if he was not told and did not know to come in for the overtime work, and finds that Respondent failed to establish that Petitioner was told or knew he was supposed to work overtime on the date of the accident or on December 3, 2014. The Arbitrator awards temporary total disability benefits from December 10, 2014 through December 15, 2014, a period of five days, following his full duty release.

Petitioner was seen by Dr. Fajardo on January 19, 2015. Dr. Fajardo reviewed the MRI results and took Petitioner off work. Petitioner was then seen by Dr. Domb on April 9, 2015, and ordered off work until he undergoes surgery. Although Petitioner did work a few hours with a few different employers before taking his job with Wendy's on August 24, 2015, the Arbitrator does not find that this work amounts to substantial gainful employment in such a way as to impact the award of temporary total disability benefits. Based on the opinions of Dr. Fajardo and Dr. Domb, the Arbitrator awards temporary total disability benefits from January 19, 2015 through August 23, 2015, a period of 30 6/7 weeks.

The evidence reflects the Petitioner continued working at Wendy's through March 6, 2016. After that, he stopped working because the new management made him lift too much and his left shoulder hurt. Based on the standing order from Dr. Domb to remain off work until surgery, the Arbitrator awards a further period of temporary total disability benefits from March 7, 2016 through April 18, 2016, the date of arbitration. That represents an additional six weeks of benefits. In total, the Arbitrator awards 37 4/7 weeks of temporary total disability benefits.

B. TPD

Petitioner claims he is entitled to temporary partial disability benefits from August 24, 2015 through March 6, 2016, representing 27 6/7 weeks. The parties stipulate that Petitioner's average weekly wage is $592.40 per week. Petitioner testified he was hired to work 30 hours on average and was paid $8.25 per hour. On average, this results in earnings of $247.50 per week. Subtracting this figure from Petitioner's average weekly wage, and multiplying by two thirds, the Arbitrator calculates Petitioner's temporary partial disability rate at $229.93 per week, and awards Petitioner 27 6/7 weeks of benefits at this rate for the period from August 24, 2015 through March 6, 2016.

M. Should penalties or fees be imposed upon responding?

The issue before the Arbitrator concerning penalties under section 19(k) of the Act and attorney's fees is the reasonableness of Respondent's conduct. Respondent is disputing this claim on the basis that the pry bar Petitioner allegedly used would not fit into the area between the sprocket and the housing wall as Petitioner claimed. Respondent's witnesses maintain that Petitioner identified RX#1 is the pry bar he used and that he never told any of them that he used a different pry bar. Petitioner adamantly disputed that. Petitioner testified that he used a smaller pry bar and that he got into arguments with both Mark Lyttle and Larry Boswell maintaining that he did not use the larger pry bar.

The first supervisor on the scene was Fernando Ortiz. Petitioner testified that he showed Fernando Ortiz the pry bar he used, and the record further reflects that Mr. Ortiz took pictures

of that pry bar. Neither Larry Boswell nor Mark Lyttle could remember initially if Fernando Ortiz took any pictures in his investigation, and both claimed they were unaware that he recreated the accident with Petitioner immediately after the event. Petitioner testified that once Mark Lyttle came to the plant, approximately two and half hours after the accident, he and Mark went to his machine and Mark got the smaller pry bar stuck as Petitioner had. Petitioner testified that Fernando Ortiz and two other employees were there and saw the pry bar get stuck. Mark Lyttle testified that Petitioner never went to the machine with Petitioner on the date of the accident, either before going to the hospital or after. It is clear to the Arbitrator that Respondent did not maintain a proper chain of custody of RX#1, the pry bar they are alleging Petitioner used. Mark Lyttle left that pry bar at Petitioner's machine before taking him to the hospital and another operator was operating that machine while Petitioner was at the hospital, who Mark said could have switched out the bars. Mark then took a pry bar from that machine around 8:00 a.m. and put it in Roderigo's office. Roderigo said he brought the bar to the reenactment the next day, but Larry Boswell said the bar was already at the machine when he came for the reenactment. Larry said the reenactment was on the date of the accident, not the day Roderigo said he brought the bar to the machine. Mark later admitted that the operator who was running Petitioner's machine after the accident could have switched that pry bar with another pry bar at another machine. Mark left for the hospital with Petitioner while the relief operator ran the machine, then came back with Petitioner and eventually sent him home. It was not until after Petitioner was sent home that Mark went back to the machine to retrieve the bar. By that time, Mark concedes that the bar could have been switched out.

The key witness for Respondent who could have put this dispute to rest was Fernando Ortiz. Petitioner testified that Fernando Ortiz had the bar that Petitioner was using and could have identified it. Fernando Ortiz was also allegedly present when Mark took Petitioner back to the machine immediately after the accident and got Petitioner's bar stuck in it. Four months passed between the time Petitioner testified to these things and when Respondent brought in its witnesses. Respondent did not bring in Fernando Ortiz to testify, despite the fact that he is still working in the same job at the same plant in Geneva. The Arbitrator draws two inferences from the fact that Respondent failed to bring Fernando Ortiz in to testify: the first is that Fernando Ortiz would not testify consistent with Respondent's other witnesses concerning RX#1 being the bar Petitioner claimed he used; the second is that Fernando Ortiz would testify contrary to Respondent's witnesses that Rx number one was not the bar Petitioner used, that Petitioner told Fernando Ortiz he used a smaller bar.

The Arbitrator is also troubled by the conflicting stories of Respondent's witnesses. Larry Boswell testified that he was the plant manager at the time of the accident. He said that he didn't hear about the accident until he got into work, that he was not notified at home of the accident before coming in. This is contradicted by Mark Lyttle's notes in RX#10. Petitioner testified that he got so aggravated with Mark Lyttle that he was not being taken to the hospital that he threatened to call the police. Petitioner then testified that Mark made a few calls, and then took him in a cab to the emergency room. This is consistent with Mark's notes, where he indicated that he conferred with Donna Brucher and Larry Boswell at which point they agreed to arrange for a taxi to take Petitioner to Delnor Emergency Room in Geneva. (RX#3,P.3) Since Petitioner was admitted to the hospital at 4:41 a.m., that conversation must have taken place around 4:30 a.m., well before the time Larry Boswell said he arrived at the plant for the morning and first heard about the accident. It also contradicts his testimony that he was not notified at home of the accident before coming in. Larry Boswell insisted that the reenactment took place after Petitioner came back from the emergency room, but Mark Lyttle contradicted that testimony by saying that it did not take place after coming back from the emergency room because Petitioner was on pain medication. Roderigo testified that he terminated Petitioner on

December 5, but it appears that the termination actually occurred on December 9. Petitioner testified that Mark Lyttle used the bar the Petitioner used at the first reenactment on the date of the accident before going to the emergency room in the presence of Fernando Ortiz and two other employees. Petitioner also testified that Fernando Ortiz had the actual pry bar he used and got stuck, and took pictures of it.

The Arbitrator finds that Respondents dispute of this case was not made in good faith. Respondent did not call Mr. Ortiz to contradict Petitioner's testimony that he gave Mr. Ortiz the smaller pry bar, and that Mr. Ortiz was present at the second reenactment with Mark when Mark got the pry bar stuck himself. Larry Boswell came from Milwaukee to testify, and Mark Lyttle came from Ohio. Mr. Ortiz still works for the Respondent in Geneva, and Respondent made no claim that he was an unavailable witness.

Based on the foregoing, the Arbitrator finds that Respondent's denial of this claim was unreasonable and awards Petitioner penalties as follows:

Section 19(k) Calculation:

TTD: 37 4/7@ $394.93	=	$14,838.08
TPD: 27 6/7 @ $229.93	=	$6,405.19
Medical	=	$24,863.18
Total	=	$46,106.45
Section 19(k) = $46,106.45 (50%)	=	$23,053.23

Section 16 Calculation:

TTD + TPD + Medical	=	$46,106.45
Section 19(k) penalties	=	$23,053.23
Total	=	$69,159.68
Section 16 = $69,159.68(20%)	=	$13,831.94

Section 19(l) Calculation:

Demand for payment of TTD: 1/22/15 (PX#5)
No written reason for delay within 14 days (2/5/15)
Arbitration date: 4/18/16

2/5/15–4/18/16	=	>333.3 days
Maximum award	=	$10,000.00

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

WALTER MISZCZSZYN,

Petitioner,

17IWCC0562

vs.

NO: 15 WC 005273

TRIANGLE PACKAGE MACHINERY CO.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner'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 Commission finds the Arbitrator erroneously factored the Petitioner's age at the time of the hearing when assessing Petitioner's permanent partial disability pursuant to §8.1b(b)iii of the Act. The Commission finds that Petitioner was 55 years old at the time of injury, however, the Arbitrator's reliance on the Petitioner's age at the time of hearing, in this case a difference of three years, is not consequential. The Commission agrees with the Arbitrator's reasoning under this factor noting that Petitioner is, nonetheless, advanced in his career.

The Commission also assessed Petitioner's permanent partial disability pursuant to §8.1b(b)v of the Act and finds that there is some evidence of disability to support Petitioner's current complaints in Dr. Cole's and Dr. Neal's 2016 reports. The Commission also finds that Petitioner's credibility is tainted by his denial of right shoulder complaints prior to the subject accident when there is evidence to the contrary in his primary care physician's medical record. This discrepancy affects the Commission's view of Petitioner's testimony regarding his current complaints. The Commission agrees with the Arbitrator and finds that Petitioner's lack of medical

17IWCC0562

care for his shoulder since February 2015, almost two years prior to the arbitration hearing, and the fact that he turned down additional interventions offered by his medical provider, do not support Petitioner's current complaints. Therefore, the Commission finds that the Arbitrator's reasoning under §8.1(b)v was proper, however, the Arbitrator neglected to assign weight to this factor with deminimus ramification. The Commission affords some weight to this factor with no impact on Petitioner's permanent partial disability award.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 7, 2017, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $662.88 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 12.5% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,600.00. 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: SEP 15 2017
KWL/bsd
O-8/15/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0562

MISZCZSZYN, WALTER
Employee/Petitioner

Case# **15WC005273**

TRIANGLE PACKAGE MACHINERY
Employer/Respondent

On 2/7/2017, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

0532 HOLECEK & ASSOCIATES
GRANT MILLER
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

17IWCC0562

Case # 15 WC 05273

Consolidated cases: _____

Walter Miszczszyn
Employee/Petitioner

v.

Triangle Package Machinery
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago IL**, on **January 24, 2017**. By stipulation, the parties agree:

On the date of accident, **January 7, 2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$57,449.60**, and the average weekly wage was **$1,104.80**.

At the time of injury, Petitioner was **55** 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 **$17,992.38** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$17,992.38**.

17IWCC0562

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 **$662.88**/week for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **12.5% loss of use of the person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **01/08/14** through **01/24/17**, 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.

David A. Kane
Signature of Arbitrator

February 7, 2017
Date

FEB 7 - 2017

STATE OF ILLINOIS)

)

COUNTY OF Cook)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

17IWCC0562

WALTER MISZCZYSZYN

Employee/Petitioner

v.

Case # 15 WC 005273

TRIANGLE PACKAGE MACHINERY

Employer/Respondent

FINDINGS OF FACT

Testimony of Petitioner

The Petitioner testified that he works for Triangle Package Machinery as a lathe operator. He testified that he began working there on March 8, 1985. He testified that for his job, he loads materials and parts onto a lathe, which is 3-feet-high from the floor. He testified that in late 2013, he was switched to a milling machine, which required him to load items above his shoulder level. The Petitioner testified that on January 7, 2014, he felt

and pain in his right shoulder when tightening a bolt. The Petitioner testified that he made his supervisor aware of his pain.

The Petitioner testified that he had never had treatment to his right shoulder before his January 7, 2014, work accident.

The Petitioner testified that he initially received medical treatment with Concentra, and received medication and physical therapy while working light duty. He testified that eventually, he was referred for an MRI and to an orthopedic doctor named Dr. Giannoulias. The Petitioner testified that he continued working light duty on the lathe machine, and did not go back to the milling machine. The Petitioner testified that he eventually chose to treat with Dr. Bresch upon recommendation by his primary care physician.

While treating with Dr. Bresch, the Petitioner received a total of three injections before he received surgery on September 5, 2014. The Petitioner testified that his surgery on September 5, 2014, was a right shoulder arthroscopy with subacromial decompression, biceps debridement, and repair over the posterior two-thirds of the supraspinatus rotator cuff tendon.

The Petitioner testified that after receiving his surgery, he continued physical therapy, having 48 visits. He testified that he had two additional injections after his surgery, for a total of five injections since his work accident.

The Petitioner testified that he presented for an Independent Medical Evaluation with Dr. Byran Neal on February 9, 2015. The Petitioner testified that after that evaluation with Dr. Brian Neal, he returned to his regular job as a lathe operator in February of 2015. The Petitioner testified that he has been working his regular job as a lathe operator since that time.

The Petitioner testified that he eventually saw his primary care physician again, and had an additional MRI on November 13, 2015. He testified that after that, he saw Dr. Cole at Midwest Orthopedics at Rush for another opinion. He testified that Dr. Cole recommended that the Petitioner receive a surgery, but stated that he could continue working his full-duty job. The Petitioner testified that he does not want to have a surgery.

The Petitioner testified that he has pain while working, and has to use his left arm to lift heavy items. The Petitioner testified that he is still working his full-duty job as a lathe operator. The Petitioner admitted that he is working the same job as he did before his injury. He also testified that he has continued to receive pay raises.

Testimony of Mark Swaine

Mark Swaine testified that he works as the safety director of Triangle Package Machinery. Mr. Swaine testified that he oversees safety and accommodations of injured workers. He testified that he is familiar with Walter Miszczyszyn, and that he works with him.

Mr. Swaine testified that the Petitioner has great attendance. He testified that the Petitioner has excellent production when compared to his coworkers, both before and after his surgery. He testified that the Petitioner is an extremely good employee.

Mr. Swaine testified that the Petitioner is earning the same amount of money now as he was before his injury. Mr. Swaine confirms that the Petitioner is working full-time in a regular-duty capacity.

Medical Records

Medical records show that the Petitioner received treatment from his primary care physician on November 29, 2010, for right shoulder pain. At that time, the Petitioner indicated that he had right shoulder pain after heavy lifting. The Petitioner was recommended to take prescription naprosyn for pain. This was before his January 7, 2014 work accident.

After his work accident, the Petitioner first treated with Dr. Simon at Occupational Health. He rated his pain constant, at 8/10. He was told to work light duty. He continued to receive physical therapy treatments upon recommendation by Dr. Simon and noted improvements. By February 18, 2014, his pain had decreased to 2/10. The Petitioner was taking over-the-counter medications for his pain. (PX 1).

Eventually, the Petitioner was sent for an MRI. The MRI report revealed a small, near-full-thickness perforation of the anterior distal supraspinatus tendon; a paralabral cyst and a tear of the inferior glenoid labrum. After the MRI, the Petitioner treated with Dr. Glannoulias, who recommended more PT before considering therapy. Dr. Giannoulias allowed the Petitioner to return to regular work as of May 9, 2014 and anticipated maximum medical improvement in early July, 2014. (PX 1).

The Petitioner then sought a second opinion with Dr. Bresch, despite his pending placement at MMI by Dr. Giannoulias. Dr. Bresch diagnosed a rotator cuff tear and a labal tear and performed an injection. Due to minimal relief from the injection, Dr. Bresch recommended a surgery. Dr. Bresch performed an arthroscopic surgery involving subacromial decompression, biceps debridement and repair over the posterior two-thirds of the supraspinatus rotator cuff tendon on September 5, 2014. (PX 3).

After his surgery, the Petitioner received physical therapy treatments. He returned to Dr. Bresch and was doing very well post-operatively on October 13, 2014. He denied significant complaints. Dr. Bresch later diagnosed cervical radiculopathy in November, 2014 which was causing the Petitioner's radiating pain, without giving a causal connection opinion regarding causal relationship to the Petitioner's January, 2014 work accident. (PX 3).

The Petitioner had his first IME with Dr. Bryan Neal on Febraury13, 2015. The Petitioner noted he had ongoing pain, but his pain was much more significant before his surgery. Dr. Bryan Neal stated that the Petitioner may benefit from injections, felt that the Petitioner had adhesive capsulitis and recommended a return to regular work. (RX 1).

The Petitioner presented for an AMA Impairment Rating with Dr. Neal on August 6, 2015. The Petitioner conveyed to Dr. Neal that he had not seen any doctor since March, 2015. He advised that he was still working regular work. He complained of pain at 5/10. He noted that he was performing activities of daily living, including cutting his grass, and using his right arm to shave in the mornings. Dr. Neal opined that the Petitioner's AMA impairment rating was 15% upper extremity, or 7% whole person. (RX 3).

After that, the Petitioner returned to his regular job and did not seek active medical care, spare an MRI in November, 2015. He returned for another IME with Dr. Neal on February 18, 2016. The Petitioner noted that he had only seen his primary doctor once in the last year. The doctor stated that the Petitioner had an MRI showed improvement in his shoulder. Dr. Neal recommended no further treatment, recommended Tylenol only if the Petiitoner was still symptomatic. The Petitioner did not wish to receive

another injection or additional surgery. Dr. Neal did not recommend an additional surgery. Dr. Neal placed the Petitioner at MMI. (RX 4).

The Petitioner sought a third opinion from Dr. Brian Cole on October 23, 2016. He admitted to having a surgery and 5 injections. He noted increased pain with overhead lifting. The doctor discussed a possible surgery with the Petitioner, but the Petitioner stated that he did not wish to receive a surgery. Dr. Cole stated that the Petitioner was at MMI and could continue working his regular job.

CONCLUSIONS OF LAW

The only issue in dispute is the nature and extent of the Petitioner's injury.

The Petitioner's injury occurred on January 7, 2014, which is after the September, 2011 Amendment to the Illinois Workers' Compensation Act. As such, the Arbitrator must consider the five factors listed in the Illinois Workers' Compensation Act when assessing the Petitioner's disability.

In applying the 5 factors in Section 8.1(b) of the Illinois Workers' Compensation Act, the Arbitrator finds as follows:

1. As to AMA impairment rating, Dr. Bryan Neal, after having seen the Petitioner several times, reported a 15% upper extremity converted to 7% loss of use of the person as a whole impairment. The Arbitrator gives weight to this factor, given that the Petitioner was seen by Dr. Bryan Neal on various occasions, and Dr. Neal performed various objective and thorough examinations and reviewed the Petitioner's

medical records and treatment. Further, the Arbitrator notes that Dr. Neal saw the Petitioner following his release by Dr. Bresch, and saw the Petitioner for several visits after he had finished his surgery, and thus had an excellent opportunity to determine the nature and extent of the Petitioner's injury and any impairments resulting therefrom. As such, the Arbitrator gives significant weigh to this factor in favor of a lower PPD award;

2. As to occupation, the Petitioner testified that he worked as a lathe operator, which requires him to lift items from the floor onto a lathe and work on them about 3 feet from the floor. The Arbitrator notes that this job does not require work overhead or over shoulder level, which appears to be where the Petitioner has his highest restriction. The Petitioner only complained of pain above his shoulder level. Further, the Arbitrator notes that the Petitioner continues to work in a full-duty capacity in this job and has for nearly 2 years since recovering from his surgery. Thus, the Arbitrator gives weight to this factor in favor of a lower PPD award;

3. As to the Petitioner's age, the Petitioner is 58 years old, and turned 59 years old the month after his hearing took place. The Arbitrator notes that the Petitioner is somewhat advanced in age, and only will likely work five more years in his current capacity and, as such, the Arbitrator finds that this factor favors a lower PPD Award;

4. As to future earning capacity, the Arbitrator finds that the Petitioner's future earning capacity is not significantly diminished, given the fact

that he continues to work his full-duty job in the same capacity. Further, Respondent's witness testified that the Petitioner's attendance, performance, and production are excellent, and he is making the same amount of money that he was before the injury. As such, the Arbitrator finds that this factor weighs to a lower PPD Award; and

5. As to Evidence of disability in the medical records, the Arbitrator finds that the Petitioner does have evidence of disability in the medical records, given that several medical providers indicated that the Petitioner has ongoing pain and diminished range of motion. However, the Arbitrator notes that the Petitioner was offered additional interventions, and has turned them down. Further, the Arbitrator notes that the Petitioner has not received active medical care for his shoulder since February, 2015, which was approximately 2 years prior to his hearing date during which time he worked regular work. The Arbitrator notes that if the Petitioner was having significant difficulties and pain, he likely would have continued active medical care. The Arbitrator notes the Petitioner testified to the same on the date of his trial, stating he did not wish to receive a surgery. Additionally, even though the Petitioner testified that he had never had treatment to his right shoulder before, the Arbitrator notes that the medical records from the Petitioner's primary care physician show that the Petitioner did receive treatment to his right shoulder for pain in late 2010. He was also prescribed Naproxen for the pain in his shoulder. This shows that he previously had deficits and issues with his right shoulder before his accident ever occurredf.

As such, considering all of the above, the Arbitrator awards the Petitioner 12.5% loss of use as to person as a whole for his occupational injuries.

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

Justin Johnson,

Petitioner,

vs. NO: 15WC008935

Safelite Fulfillment Inc.,

17IWCC0558

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19b having been filed by both parties herein and proper notice given, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care 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 February 2, 2017 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.

17IWCC0558

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,600.00. 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: SEP 8 - 2017
SJM/sj
7/13/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

JOHNSON, JUSTIN
Employee/Petitioner

Case# **15WC008935**

16WC012495

SAFELITE FULFILLMENT INC
Employer/Respondent

17IWCC0558

On 2/2/2017, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701-9531

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0558

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
19(b)

Justin Johnson
Employee/Petitioner

v.

Safelite Fulfillment, Inc.
Employer/Respondent

Case # 15 WC 08935

Consolidated cases: 16 WC 12495

An *Application for Adjustment 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 December 28, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, April 29, 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 $31,200.00; the average weekly wage was $600.00.

On the date of accident, Petitioner was 26 years of age, single with 1 dependent child(ren).

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

Respondent shall be given a credit of $454.53 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $454.53.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 14 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Petitioner's petition for prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of $400.00 per week for 29 2/7 weeks, commencing December 3, 2015, through June 24, 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)

January 30, 2017
Date

FEB 2 - 2017

Preliminary Ruling

These two cases were tried in Bloomington on December 28, 2016, in a 19(b) proceeding. At the conclusion of the trial, the Arbitrator closed proofs. On January 11, 2017, counsel for Petitioner filed a Motion to Reopen Proofs wherein he sought to introduce additional evidence which consisted of an e-mail from Petitioner to an agent of Respondent, and an e-mail response from the agent of Respondent to Petitioner.

Respondent's counsel filed a Response to Petitioner's Motion to Reopen Proofs on January 12, 2017. In that response, Respondent's counsel objected to Petitioner's Motion to Reopen Proofs. Copies of both Petitioner's Motion and Respondent's Response are included with the record the Arbitrator filed with the Commission.

On January 25, 2017, counsel for Petitioner and Respondent had an oral argument on the Motion to Reopen Proofs via conference call before the Arbitrator. At that time, the Arbitrator denied Petitioner's Motion to Reopen Proofs on the basis that there was no good cause for the reopening of proofs because the e-mails were available and could have been tendered into evidence at the time the case was tried.

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 15 WC 08935, Petitioner alleged that on April 29, 2014, he "...was injured while working for Respondent" and sustained an injury to the "low back, both legs." In case number 16 WC 12495, Petitioner alleged that on December 2, 2015, he "...sustained injuries to his low back/legs from his work activities." (Arbitrator's Exhibits 3 and 4).

These cases were consolidated and tried in a 19(b) proceeding wherein Petitioner sought payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In case number 15 WC 08935, Respondent stipulated that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship and specifically disputed liability for all medical services incurred after May 20, 2015. In case number 16 WC 12495, Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner started working for Respondent in June, 2005, as a glass technician. Most of Petitioner's work consisted of replacing windshields on cars and trucks. At trial, Petitioner testified that on April 29, 2014, he was in the process of lifting a windshield when he felt a "pop" and an electrical type shock in his low back as well as pain in his right hip. Petitioner estimated the weight of the windshield to be 30 to 50 pounds.

The accident was reported in a timely manner to Respondent and Petitioner initially sought medical treatment on April 30, 2014, at Advocate Medical Group (AMG). Petitioner was diagnosed as having sustained a back strain and was prescribed some medication and released to return to work with restrictions (Petitioner's Exhibit 3).

Petitioner continued his medical treatment at AMG in May and June, 2014. On May 2, 2014, the diagnosis was lumbar spine strain. Petitioner's work restrictions were no lifting over 10 pounds, no overhead lifting and no bending. During May and June, 2014, Petitioner received some physical therapy and the work restrictions remained in place (Petitioner's Exhibits 4 and 9). Petitioner continued to work for Respondent during that time as Respondent provided work to Petitioner consistent with his restrictions.

When Petitioner was seen at AMG on June 17, 2014, an MRI of the lumbar spine was ordered. The MRI was performed on July 8, 2014, and it revealed right paracentral disc herniations at L4-L5 and L5-S1. When seen at AMG on July 16, 2014, Petitioner was referred to an orthopedic surgeon (Petitioner's Exhibits 5 and 9).

On August 14, 2014, Petitioner was evaluated by Dr. Craig Carmichael, a physical medicine/rehabilitation specialist associated with McLean County Orthopedics. Dr. Carmichael examined Petitioner and reviewed the MRI scan. At that time, Dr. Carmichael recommended Petitioner undergo an epidural injection (Petitioner's Exhibit 7).

Dr. Carmichael administered epidural injections at the L5 level on September 5, and November 21, 2014. Dr. Carmichael saw Petitioner on November 24, and December 9, 2014. On those occasions, Petitioner still complained of low back pain with occasional pain down the legs. Dr. Carmichael suggested work conditioning or possible surgical consultation (Petitioner's Exhibit 10).

When Dr. Carmichael saw Petitioner on January 20, 2015, he reaffirmed his recommendation Petitioner undergo work conditioning. Petitioner was in work conditioning from February 3, 2015, through March 6, 2015. When seen on March 6, 2015, it was noted Petitioner had made good progress and was able to lift 60 to 65 pounds, but still had limitations with prolonged standing, kneeling, crouching and forward bending (Petitioner's Exhibit 10).

Dr. Carmichael saw Petitioner on March 12, 2015. At that time, Petitioner still had complaints of low back pain aggravated by increased lifting/activity. Dr. Carmichael recommended Petitioner undergo a functional capacity evaluation (FCE) which might determine whether Petitioner was at MMI (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. Andrew Zelby, a neurosurgeon, on May 20, 2015. In connection with his examination of Petitioner, Dr. Zelby reviewed medical records provided to him by Respondent. When seen by Dr. Zelby, Petitioner complained of pressure and pain in the low back with some symptoms in the right leg. Dr. Zelby opined that the MRI revealed disc abnormalities at L4-L5 and L5-S1; however, he did not note any radicular findings on examination. He opined that all of the medical treatment Petitioner had received was reasonable and necessary and related to the accident of April 29, 2014. He further opined

Petitioner was at MMI and could return to work with a lifting restriction of 60 to 65 pounds and no further medical treatment or diagnostic studies were indicated. He also stated that the onset of Petitioner's symptoms was in greater part due to the injury, but the perpetuation of the symptoms was, in greater part due to Petitioner's morbid obesity (Respondent's Exhibit 5). Based upon Dr. Zelby's opinions, Respondent disputed liability for medical expenses incurred subsequent to the examination of Petitioner by Dr. Zelby.

Petitioner continued to work for Respondent with restrictions until December 2, 2015 (the date of accident alleged in 16 WC 12495). At that time, Petitioner was at his girlfriend's house and bent over to tie his shoelaces when he experienced a sharp pain in his low back. Petitioner attempted to go to work afterward; however, his pain worsened and he went to the ER of Advocate Bromann Medical Center. Petitioner was diagnosed with a low back strain and was discharged (Petitioner's Exhibit 13).

The following day, December 3, 2015, Petitioner was evaluated by Dr. Carmichael who diagnosed Petitioner with lumbosacral radiculopathy. He ordered another MRI of the lumbar spine (Petitioner's Exhibit 12).

On January 4, 2016, Dr. Carmichael prepared a narrative report directed to Petitioner's counsel. In this report, Dr. Carmichael referenced both the accident of April, 2014, and the recent onset of pain in December, 2015. In regard to causality, Dr. Carmichael opined that the mechanism of injury of April, 2014, was consistent with his diagnosis of L4-L5 and L5-S1 disc herniations and there was a causal relationship between the injury of April, 2014, and the diagnosis. He further stated that Petitioner was off work and additional treatment recommendations would depend upon the results of the MRI (Petitioner's Exhibit 11).

Dr. Zelby was deposed on February 8, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Zelby's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He specifically stated Petitioner was at MMI and there was no reasonable expectation that further treatment would improve Petitioner's condition (Respondent's Exhibit 1; p 13).

Dr. Carmichael was deposed on February 25, 2016, and his deposition testimony was received into evidence at trial. Dr. Carmichael's testimony regarding his treatment of Petitioner was consistent with his medical records. In regard to the FCE he recommended, Dr. Carmichael testified that authorization for the FCE was denied by Respondent. Dr. Carmichael reaffirmed his opinion that the disc herniations at L4-L5 and L5-S1 were related to the accident of April, 2014, and further medical treatment, including an MRI, was indicated. He also stated that Petitioner should remain off work until the MRI was performed (Petitioner's Exhibit 1; pp 13, 15-17).

On cross-examination, Dr. Carmichael stated that Petitioner's morbid obesity contributed to his back condition; however, not to the extent the accident of April, 2014, contributed to Petitioner's two herniated discs. Dr. Carmichael also stated that because the FCE was not performed, he could not opine whether Petitioner had reached MMI between March and December, 2015 (Petitioner's Exhibit 1; pp 24, 28-31).

Dr. Carmichael saw Petitioner on April 5, 2016, and Petitioner still had lumbosacral radiculopathy. He noted he previously ordered an MRI, but was awaiting insurance approval (Petitioner's Exhibit 15). Petitioner had an MRI performed in April, 2016; however, the radiologist's report was not tendered into evidence at trial. Dr. Carmichael again saw Petitioner on April 29, 2016, and performed an epidural injection at L5-S1 on the right side (Petitioner's Exhibit 18).

Dr. Carmichael subsequently saw Petitioner on May 13, 2016, and Petitioner advised that following the epidural injection and some additional physical therapy, his condition was better, but he still had pain in the lumbosacral junction as well as the right buttock and thigh. Dr. Carmichael noted that the MRI revealed a very large right L5-S1 herniation and a moderate L4-L5 herniation. Dr. Carmichael noted that the L5-S1 herniation was much larger than it was on the prior MRI (because Dr. Carmichael compared the findings of two MRIs, it is the Arbitrator's belief that he had reviewed the more recent MRI of April, 2016, as previously stated, a copy of said report was not tendered). Dr. Carmichael ordered Petitioner continue physical therapy and then attempt to return to work on moderate duty (Petitioner's Exhibit 16).

On June 10, 2016, Dr. Carmichael performed an epidural steroid injection at L5-S1 on the right side. Following that injection, Petitioner received additional physical therapy through June 24, 2016. According to the physical therapy record of that date, Petitioner was able to lift up to 70 pounds; however, Petitioner stated he was fearful of returning to work and lifting because of his pain symptoms. It was noted Petitioner had participated in work conditioning, but with little success. It was suggested Petitioner discuss options with Dr. Carmichael, but the likely scenario was a change in profession. Petitioner was seen by Dr. Carmichael on June 24, 2016. Dr. Carmichael's diagnosis remained the same and he recommended Petitioner continue light duty restrictions and a home exercise program (Petitioner's Exhibits 17 and 18).

At trial, Petitioner testified he had not been able to work for Respondent since December 2, 2015, because Respondent would not accommodate his lifting restriction. Petitioner testified he was able to work from April, 2014, through December 2, 2015, because Respondent accommodated his light duty work restrictions, but Respondent did not accommodate his work restrictions subsequent to December 2, 2015.

Petitioner testified the windshields he worked with varied in weight with automobile windshields weighing 25 to 50 pounds and semi truck windshields weighing 75 pounds. When Petitioner was released to return to work to light duty with restrictions in the Spring of 2016, he stated that Respondent would not accommodate his restrictions. Petitioner testified he informed Jerod Grubner, the shop manager, of his work restrictions in April, 2016.

Jerod Grubner testified on behalf of Respondent when this case was tried. Grubner confirmed he was Respondent's shop manager. Grubner initially stated that the windshields Petitioner worked with would usually weigh approximately 45 pounds and the heaviest one Petitioner would have worked with would be about 60 pounds. Grubner also testified Petitioner never provided to him a release to work light duty in April, 2016, and he was not aware that Petitioner had been released to work light duty until the day of trial.

Petitioner testified in rebuttal and stated that the semi truck windshields weigh 75 pounds and some of the automobile windshields were made of thicker glass and weighed more as well. He also stated that he contacted Sade Woods, Respondent's HR director, in April, 2016, and informed her of his work restrictions. Woods did not testify when this case was tried.

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 causally related to the accident of April 29, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on April 29, 2014, that caused an injury to his low back.

Petitioner underwent MRI scans in July, 2014, and April, 2016, and both revealed disc herniations at L4-L5 and L5-S1.

Petitioner's primary treating physician, Dr. Carmichael, opined that Petitioner's low back condition was causally related to the accident of April, 2014. Dr. Carmichael did state that Petitioner's obesity contributed to his back condition, but not to the extent of April, 2014, accident which caused the disc herniations.

Respondent's Section 12 examiner, Dr. Zelby, agreed that the MRI of July, 2014, revealed disc abnormalities at L4-L5 and L5-S1, and that the onset of Petitioner's low back symptoms and the treatment he had received were related to the accident of April, 2014. At the same time, Dr. Zelby opined that Petitioner was at MMI and any perpetuation of his back symptoms would be related to his morbid obesity.

The Arbitrator is not persuaded by Dr. Zelby's opinion and finds it to be inconsistent. Dr. Zelby attempts to relate Petitioner's current condition of ill-being to his obesity while opining that the onset of low back symptoms occurred as a result of the accident of April, 2014.

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

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

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

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 14 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

There was no dispute in regard to the medical bills incurred prior to the Section 12 examination by Dr. Zelby. Respondent disputed liability for medical services incurred subsequent to Dr. Zelby's examination of Petitioner. As aforestated, the Arbitrator was not persuaded by Dr. Zelby's opinion regarding causality as it was inconsistent.

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

The Arbitrator concludes Petitioner is not entitled to prospective medical treatment.

In support of this conclusion the Arbitrator notes the following:

Dr. Carmichael last saw Petitioner on June 24, 2016, and the only future treatment recommendation made by him at that time was for Petitioner to continue a home exercise program.

While Dr. Carmichael previously recommended Petitioner undergo an FCE (the recommendation was made in March, 2015), Dr. Carmichael did not renew that recommendation when he last saw Petitioner on June 24, 2016.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of 29 2/7 weeks commencing December 3, 2015, through June 24, 2016.

In support of this conclusion the Arbitrator notes the following:

Dr. Carmichael consistently imposed work restrictions on Petitioner from the time he began treating Petitioner which included the time he first saw him following the incident of December 2, 2015, through his last visit of June 24, 2016.

While Dr. Carmichael did not state that Petitioner was at MMI as of the visit of June 24, 2016, he did not recommend any further active medical treatment. Further, Petitioner was discharged from physical therapy that same day with the physical therapy record noting that Petitioner might need to change his profession. The preceding strongly indicates that Petitioner was, in fact, at MMI at that time.

Petitioner testified he informed Jerod Grubner, Respondent's shop manager, and Sade Woods, Respondent's HR manager that he had light duty restrictions in April, 2016.

Grubner testified that Petitioner never informed him that he had work restrictions in April, 2016, or at any other time. Woods did not testify when this case was tried so Petitioner's testimony that he informed her of his work restrictions was unrebutted.

Given the fact that Petitioner had previously worked with restrictions for a significant period of time (April, 2014, through early December, 2015), which Respondent had accommodated, the Arbitrator finds it unlikely that Petitioner did not communicate his work restrictions to Respondent.

William R. Gallagher, Arbitrator

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 Causal Connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SCOTT W. PRIDDY,

Petitioner,

17IWCC0555

vs. NO: 15 WC 17128

CITY OF CARBONDALE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability benefits, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner has failed to sustain his burden of proving his current condition of ill-being requiring arthroplasty of the right knee was caused by his work-related accident. The Commission further remands this case to the Arbitrator for further proceedings for a determination of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact & Conclusions of Law

1. Petitioner testified he was 55 years old and currently worked at Public Works for the City of Royalton and had been so employed for two and a half months. Previously, he worked for Respondent for a little over 18 years. He started out in maintenance and became plant manager in 2000. Clearing ice and snow from the sidewalk, as needed, was part of his job. At the time of his accident, February 26, 2015, Brad Luebke was his supervisor.

17IWCC0555

2. Petitioner had two previous workers' compensation claims involving a 1988 accident and subsequent surgery. He also filed other incident reports in the course of his employment with Respondent. Petitioner did not dispute that these incidents occurred. Some of those incidents required medical treatment and some did not. He returned to work after treatment when he was released by his doctor. Prior to February 26, 2015, he had last seen a doctor for his right knee probably six or seven months ago.

3. Petitioner also testified that on the morning of February 26, 2015, at about 8:30 – 8:45, they were working on clearing several inches of snow and ice that had accumulated for a couple of days. He was breaking ice with a spade-like tool. He guessed he "pushed too hard," slipped, twisted, and fell. He experienced "very severe pain in" his right knee. He reported the accident to the plant manager and put ice on it. It was not getting better and was swelling up so he went to a hospital emergency department several hours later.

4. Later, Petitioner saw his primary care physician who referred him to Dr. Golz. Dr. Golz treated Petitioner conservatively from March 2, 2015 to June 16, 2015. He then recommended total knee replacement. He had an examination pursuant to Section 12 of the Act with Dr. Stiehl at Respondent's request. Thereafter, authorization for the knee replacement surgery was denied.

5. Dr. Golz released Petitioner to full duty on May 8th. He took the release to Respondent's human resources department. He was told he had to be examined by their doctor before he could come back to work. The human resources manager was supposed to make the appointment. By June 18th, the appointment had not been made and Petitioner used up his sick and vacation time. He retired from Respondent so he could look for another job.

6. Petitioner was wearing a brace at the hearing which was prescribed by Dr. Golz, probably in June. He is able to function with the brace but "just can't do anything" without it; he "pretty much can't walk" without it. He wants to have the surgery because "wearing this brace is very uncomfortable, and it's no way of life, and it's not the way it is supposed to be."

7. On cross examination, Petitioner testified Dr. Stiehl was not the "fit-for-work" doctor human resources wanted him to see. On June 18, 2015, he provided a handwritten retirement letter. He had a temporary brace several years previously, but it was not like the current permanent one. He did not have to wear a brace for two years prior to the accident. He recalled reporting that in 2007 he indicated his right knee was "bruised, crippled" in an emergency notification form.

8. Nobody was in the immediate area at the time of his accident. He told his co-workers that he hurt his knee and was going to an emergency room. He did not ask to fill out an accident report at that time.

17IWCC0555

9. Petitioner also testified he recalled telling staff at the emergency room that he did not know whether he hurt his knee when he slipped on ice, he had twisted his knee six or seven months ago, and it hurt "really bad for a week." Petitioner agreed that his knee hurt for about a week prior to the accident. He also agreed that in his May 14th statement he reported he slipped on a wet floor, caught himself with all his body weight, and twisted his knee.

10. After his visit to the emergency room, Petitioner talked to his supervisor, Mr. Luebke. He told Mr. Luebke that he hurt his right knee/leg, was off work, and would come in the next day to fill out the incident report and turn in the paperwork he had. Petitioner testified about surgery in 2000, but he believed he also had other knee injuries in 2001 and 2006. He was told in 2006 that he had osteoarthritis in his knee and he started taking Meloxicam. He was taking that medication regularly at the time of his 2015 accident.

11. Petitioner also recalled seeing an orthopedist in January 2009 for his right knee, who told him he would likely need a total knee replacement in the future. Nevertheless, he was able to do "everything and anything they asked" him to do. In his current job he rides around in a golf cart reading meters, drives a tractor, and loads/unloads chemical barrels. His knee was better while he was off work because he "wasn't doing anything." Petitioner agreed that his medical records indicate he rode a motorcycle, but he has only ridden it once since the accident.

12. On redirect examination, Petitioner testified he also told a physician's assistant in the emergency room that he slipped and fell on ice, had pain in the right lateral knee, and was not able to bear weight.

13. Brad Luebke was called to testify by Respondent for which he worked for 25 years. On February 26, 2015, he was Petitioner's supervisor. Petitioner did not tell him he had an accident that day. He first reported an incident the following afternoon. He did not indicate he had been to a hospital. Mr. Luebke arrived shortly after Petitioner had left work and was informed that he left. He was told by co-workers that Petitioner was taking an "emergency vacation." Mr. Luebke noted that removing ice and snow accumulated on the premises was a priority. It had not been snowing on February 25th or the 26th; but it snowed the previous week. It would have been their protocol to clear snow immediately. It was the witness' understanding that on the date of the alleged accident, Petitioner's primary job was cleaning the industrial building which would have been "just sweeping and basically dusting off machinery and piping and so forth." He was not directed to "attempt to clean off any sidewalk."

14. On cross examination, Mr. Luebke agreed that the incident report he filled out did not indicate that there was no snow or ice, or that Petitioner had left for an "emergency vacation." However, he did not remember there being any snow on that date.

15. On redirect examination, Mr. Luebke testified that he referred in the accident report that Petitioner was "allegedly shoveling snow" because it was his understanding that Petitioner was not shoveling snow on that date.

16. Petitioner testified in rebuttal. On February 26, 2015 there was snow and ice because it had snowed for several days previously. If there was no ice or snow he would not have tried to clear it. It was possible there was still snow/ice after days because there are "like seven acres of sidewalk, all spread out, and there's only two or three of" them working. He told Mr. Luebke that he went to an emergency room. An "emergency vacation" is a term used when a person leaves mid-shift in order to get paid for the day.

17. Selected medical records from before the alleged accident were admitted into evidence. On July 10, 2000, in a form for transferring medical care, Petitioner noted right knee surgery in 1990.

18. On March 8, 2001, Petitioner presented to Dr. Tiffin for follow up for knee strain. He still had weakness. He had positive McMurray's consistent with the previous meniscus removal. Dr. Tiffin ordered physical therapy.

19. On April 28, 2006, Petitioner presented to Dr. Barr for follow up for knee strain. He made good progress in physical therapy and wanted to return to work. Dr. Barr noted limited tenderness and mild discomfort but thought he could work. Dr. Barr diagnosed resolving right knee strain with underlying osteoarthritis.

20. Finally, on January 21, 2009, Petitioner presented to Dr. Nekzad, his primary care physician, for "follow up medical problems." He complained that his knees were hurting. He reported he saw an orthopedic surgeon in St. Louis the previous week who told him he needed a knee replacement but they weren't going to do it until he was 52. Dr. Nekzad prescribed Meloxicam.

21. Other prior documents were also admitted into evidence. On June 21, 1994, the Commission approved settlements of Petitioner's claims in 90WC11933 and 90WC11633. 90WC11933 was settled for $10,000 representing loss of 10% of the right leg and 90WC11633 was settled for $1,000 representing loss of 4.5% of the right leg.

22. On March 8, 2006, Petitioner reported walking to the control building when stepping "from catwalk" his feet got tangled and he fell on both knees. He claimed injury to his knees, and right lower leg/ankle/foot. The supervisor report indicated that Petitioner "tripped over his own feet."

23. On September 7, 2007, Petitioner indicated on a form that among other medical problems he had a "braced crippled right knee."

24. On May 15, 2014, Petitioner reported injuring his right knee exiting a bobcat. He "slipped on wet metal step" catching himself on the right leg with all his "body weight twisting" his right knee. He went to an emergency department for sprained knee. The supervisor's report suggested Petitioner be more careful when it was raining.

25. Regarding the instant alleged accident/injury, on February 26, 2015, Petitioner presented to the emergency department of Memorial Hospital with right leg pain. He stated: "I don't know if it is from slipping on ice. It has been hurting really bad for a week. I twisted my knee six or seven months ago." No swelling was noted and Petitioner was able to ambulate. Petitioner's knee was immobilized, crutches were provided, and Hydrocodone prescribed. The encounter was classified as "Workmens Comp." Petitioner was to follow up with Dr. Davis.

26. On March 2, 2015, Petitioner presented to Dr. Davis' office. On the patient questionnaire, Petitioner reported severe pain (9/10) in the right knee after multiple slips on ice and snow at work on February 26, 2015. He indicated he had severe arthritis in his right knee. He had similar symptoms six months previously after straining his knee. In the "prior surgeries" section he noted rotator cuff repair and vasectomy. Petitioner also reported to Dr. Davis he had a history of knee pain that was progressively worsening over the years but it was tolerable until this past week. X-rays showed severe medial compartment arthrosis but the lateral and patellofemoral spaces were pretty well maintained. Dr. Davis' assessment was exacerbation of underlying severe medial osteoarthritis. They discussed possible conservative treatment but Petitioner was interested in knee replacement. Dr. Davis referred him to Dr. Golz.

27. On March 27, 2015, Petitioner presented to Dr. Golz. Petitioner reported injuring his right knee (he denied left knee complaints) "because of" his job. He reported shoveling snow and ice at work in February. He had several slips and a near fall which caused the onset of acute pain in the right knee. He went to an emergency room where conservative treatment was begun. He was then evaluated by Dr. Davis (who performed shoulder surgery on Petitioner in 2009) and he referred Petitioner to Dr. Golz for further evaluation.

28. Petitioner also reported to Dr. Golz he was sent to a doctor in St. Louis who advised him "he would need surgery on his knees at some time." He also indicated he had one or two evaluations regarding "some mild intermittent degenerative complaints." He took non-steroids on occasions but was able to do what he wanted to do until the instant injury. X-rays showed advanced bone-on-bone arthritis with just a few degrees of varus but with some patellofemoral changes as well. Some early patellofemoral arthritis was also shown in the left knee. Dr. Golz thought surgery would be needed but that arthroscopy would not be beneficial. Petitioner was a candidate for knee replacement. Dr. Golz ordered an MRI.

29. The MRI taken on March 31, 2015 showed 5 cm medial meniscal tear, tricompartmental degenerative changes, greatest in the medial compartment where there was full-thickness cartilage loss with associated marrow edema, subcortical cysts/spurs, and possible mucoid degeneration of the ACL.

30. On April 10, 2015, Petitioner returned to Dr. Golz. He was "adamant again that it has been 18-1/2 years on concrete" and his fall in February which caused his knee condition. He had severe pain at rest which increased with ambulation. He still needed to use crutches full-time. Dr. Golz discussed Petitioner's condition with him and the case manager. He advised Petitioner that he had pre-existing advanced arthrosis/degenerative changes, which was fairly asymptomatic but the accident caused an acute exacerbation of that condition. Petitioner could not return to work as a laborer. Dr. Golz recommended total knee replacement.

31. On May 1, 2015, Petitioner returned to Dr. Golz and reported he "saw a quack" for an IME who opined his condition was not work related and his claim had been denied. Petitioner was "not at a point to consider surgery." Dr. Golz thought he was a good candidate for a medial unloader brace. A week later Dr. Golz released Petitioner to full duty.

32. On June 16, 2015, Dr. Golz noted that Petitioner had preexisting intermittent right knee complaints, but they were generally transient and did not limit functionality until his injury on February 26, 2015. Dr. Golz opined it was "unlikely that his February injury caused the degenerative arthritis in his knee. It certainly could have caused the meniscal tear, but the injury likely caused an acute exacerbation of some previously relatively asymptomatic underlying arthritis." The brace and medication were helping somewhat. Petitioner felt he could work full duty.

33. Dr. Golz testified by deposition on August 7, 2015. He first saw Petitioner on March 27, 2015 and last saw him on June 16, 2015. Petitioner had previously seen Dr. Davis in his office. Petitioner reported right knee pain after slipping on ice on February 26, 2015. "He had several slips and one near fall and with this he had acute onset of right knee pain. He was unable to bear weight, couldn't continue work," and symptoms were bad enough that he went to an emergency department. He had no complaints of left knee symptoms.

34. At the time of his examination, Petitioner was currently taking an antiinflammatory for osteoarthritis. Petitioner reported a history of recurrent injuries to the knee "with some mild intermittent degenerative complaints to his knees, generally related to weather and activity." He had a previous arthroscopic surgery. However, he reported no functional restrictions prior to the instant accident.

35. Dr. Golz opined that the accident did not cause Petitioner's underlying arthritis. But it did cause a "significant exacerbation of his previous underlying but relatively asymptomatic arthritis" based on his prior high-level functionality. Dr. Golz prescribed physical therapy, ordered an MRI, instituted work restrictions, and encouraged Petitioner to continue using the antiinflammatories.

36. Petitioner returned and continued to be non-weightbearing and needed crutches to ambulate. Dr. Golz repeated x-rays which showed bone-on-bone arthritis and 10 degree of varus, which was mal-aligned. He had subcondral cysts, large osteophytes, and advanced arthritis under the knee cap. The MRI showed a large meniscal tear, significant degenerative changes, and some bone marrow edema. It was difficult to determine whether Petitioner's accident caused the meniscal tear, but "likely it was at the very least aggravated by his fall." Thereafter, Dr. Golz recommended total knee replacement. Dr. Golz continued work restrictions.

37. Petitioner returned on May 1st. He indicated that he had an IME and surgery had been denied and therefore, he was not ready to consider surgery. He was not sure he could return to work but wanted to try. Dr. Golz ordered a special brace and told Petitioner to continue antiinflammatories until it arrived.

38. Petitioner returned on June 18th reporting that the brace and medication helped somewhat. He had better functionality, and no longer needed crutches to ambulate. However, he continued to have daily complaints. Dr. Golz wanted to return him to restricted work, but was informed Respondent would not let him return and there was litigation instituted. Petitioner indicated he was applying for temporary disability. Despite Petitioner's reluctance, Dr. Golz still believed he needed total knee replacement.

39. On cross examination, Dr. Golz testified he did not review the emergency department records. Any indication that he complained of pain a week before may or may not affect his causation opinion, depending on various factors including the degree of pain reported and associated functionality. Petitioner did not tell Dr. Golz that he had pain leading up to the accident nor that he injured his knee six months previously.

40. Petitioner did tell Dr. Golz that he had seen a doctor in St. Louis who opined that he would need surgery in the future. Petitioner reported a slipping, near fall, not a fall. He agreed that the degree of arthritis Petitioner had would take years to develop. The x-rays after the accident were probably very similar to those from prior to the accident. Dr. Golz agreed the meniscal tear could have been present prior to the accident. When asked whether Petitioner had returned to baseline when he last saw Petitioner, Dr. Golz responded he had not been able to return to his work duties. He released Petitioner to full duty only at his request, after he received the brace. He reiterated that the accident contributed to the current condition of Petitioner's knee.

41. Dr. Stiehl testified by deposition on August 26, 2015. He is board certified in orthopedic surgery with fellowship training in trauma surgery and adult reconstructive surgery. Currently nearly 50% of his practice involves "medicolegal work." He performed a Section 12 medical examination on Petitioner at the request of Respondent's insurance carrier.

42. Petitioner "claimed he fell shoveling snow" on February 26, 2015 and hurt his right knee. Dr. Stiehl indicated Petitioner was "not really clear" about whether he actually fell. There was some prior history that "he may have twisted his knee." Dr. Stiehl didn't "think he offered any real prior history of problems with his knee." He reported he had no prior surgery or treatment for his right knee. Petitioner reported difficulty with stairs and could not walk more than a block. His questionnaire indicated "fairly significant disability from his knee."

43. Dr. Stiehl reviewed the records of Dr. Golz but he did not think he had any other records. Dr. Golz' records indicated Petitioner had a condition that progressed for a number of years. He had severe medial joint line pain, bone-on-bone arthritis, 10 degree varus deformity, and "no anterior crucial ligament." Although he did not have the emergency department records when he examined Petitioner, he was shown emergency department records prior to the deposition. He interpreted the records as showing Petitioner "had been having some pretty substantial chronic problems with his right knee." There was some tenderness but no significant swelling.

44. On examination, Petitioner had significant varus deformity of 10 degrees and limited range of motion. Petitioner could not bear weight on his right leg and walked with crutches. Dr. Stiehl's diagnosed advanced degenerative arthritis. The emergency department records actually provided even more evidence that "he had a totally wore out knee" which "had been bothering him for a while."

45. Dr. Stiehl agreed with Dr. Golz' recommendation for a total knee replacement. However, he did not believe the need for knee replacement was causally related to "this reported slipping incident." For the injury to require knee replacement "it would have to be a significant aggravation of a knee condition.

46. Dr. Stiehl testified that "the kind of arthritis that he has, it's been there for many, many years." "So we know that for it to be related to your incident, there would have to be a fracture. There would have been a significant change in the status of the knee." Dr. Stiehl did not believe the bone-on-bone condition is any worse now than it was a year ago. Petitioner had reached maximum medical improvement from any injury he sustained in the February 26, 2015 accident.

47. On cross examination, Dr. Stiehl testified he spent between five and 15 minutes with Petitioner. He was not given any information that Petitioner did not suffer an accident.

He agreed that Petitioner reported previous twisting injuries. Petitioner's questionnaire was consistent with his history. He had not been provided any medical records prior to the accident. He agreed that notes he was provided showed minimal prior treatment.

48. Dr. Stiehl believed Petitioner suffered only a temporary aggravation of his condition because there was not any anatomical change in the knee. He agreed that a torn meniscus would be a significant anatomical change. Dr. Stiehl believed Petitioner probably magnified his symptoms because he wanted the knee replacement. He recommended that Petitioner could only perform sedentary work.

49. On redirect examination, Dr. Stiehl testified that assuming Petitioner actually suffered the accident, he believed Petitioner suffered a temporary aggravation which increased his symptoms. It would not take much to make a knee like that sore. "It can be just walking down the street and tripping on a curb: because the arthritis is significant." He would have needed knee replacement absent this twisting incident. The condition cannot get any worse than bone-on-bone.

50. Petitioner returned to Dr. Golz on May 20, 2016. He reported that in the interim he was "forced into retirement" from Respondent but got another job. He was able to perform his duties but with increasing difficulty. Dr. Golz again opined that Petitioner's advanced arthritis was previously asymptomatic but was acutely exacerbated by the work accident and was progressing. He again recommended total knee replacement.

In finding Petitioner proved accident, the Arbitrator considered his testimony credible; more credible than that of Mr. Luebke. He noted that the emergency department records indicated that Petitioner was shoveling snow/ice at the time of onset of symptoms and he appeared generally forthright with providers about his previous knee issues. He specifically noted that Mr. Luebke gave no explanation for his questioning whether Petitioner was indeed shoveling snow and would have specified in both his testimony and on his report that there was no snow to shovel if none was present at the time.

On this issue, the Commission sees no reason to reverse the Arbitrator's determination of accident. The Arbitrator's determination was based largely on his assessment of the credibility of the witnesses, and Petitioner's testimony was corroborated by his reports to treating providers.

While the Commission defers to the decision of the Arbitrator on the issue of accident, which was based on his assessment of relative credibility of witnesses, we do not defer to the Arbitrator's determination that the accident caused the condition of Petitioner's right knee which now requires arthroplasty. It is clear from the record that Petitioner had pre-existing, end-stage, bone-on-bone arthritis in the right knee. Both Dr. Golz and Dr. Stiehl agreed that the accident neither caused the underlying condition nor anatomically changed Petitioner's right-knee condition.

17IWCC0555

Petitioner even noted to his principal care physician as early as January 2009, which he confirmed in testimony, that a doctor in St. Louis informed him that he needed a total knee replacement but recommended the procedure be delayed until he reached 52. Petitioner was 54 years of age at the time of the accident. In addition, Petitioner indicated at the emergency department of Memorial Hospital that he was not sure his knee hurt because of his slips on ice because he twisted his knee six or seven months previously and it really hurt for about a week, prior to the accident. Therefore, the Commission finds that Petitioner's work accident did not cause the condition of ill-being of Petitioner's right knee requiring arthroplasty; rather that condition was caused by the natural progression of his underlying osteoarthritis.

The Commission also notes that both Dr. Golz and Dr. Stiehl agreed that Petitioner did sustain an exacerbation of his underlying arthritis and an increase of his symptoms. Regarding temporary total disability benefits and current medical expenses awarded by the Arbitrator, the Commission finds those awards appropriate for the time he was off work and treatment for the increased symptoms he had after the accident. However, the Commission vacates the Arbitrator's award for prospective surgery because of our determination that any additional treatment would be rendered to treat the underlying osteoarthritis and not the work-related injury.

Finally, although Petitioner did not sustain his burden of proving that his work injury necessitated arthroplasty he may be entitled to some permanent partial disability benefits for the exacerbation of his condition. Therefore, the Commission remands the claim to the Arbitrator to make that determination. The Commission also notes that it does not remand the claim for an adjudication of any possible temporary total disability benefits because based on the finding of the Commission Petitioner would not be entitled to additional temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $634.21 per week for a period of 10 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $$1,772.62 to Dr. Golz for medical expenses under §8(a) of the Act, subject to the applicable fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical treatment recommended by Dr. Golz is vacated.

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

17IWCC0555

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: SEP 7 - 2017

Deborah L. Simpson

DLS/dw
O-7/13/17
46

Stephen J. Mathis

Dissent

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christina Herron,

Petitioner,

17IWCC0579

vs.

NO: 15WC 20754

Kindred Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 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 $32,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2017
o072517
KWL/jrc
042

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the decision of the majority. I would reverse the Arbitrator's Decision and find that under a neutral risk analysis, the Petitioner failed to meet her burden proving an accident occurred arising out of her employment. Petitioner, worked for Respondent as a registered nurse for one year prior to the subject incident. Petitioner testified around 2:00 in the afternoon she was squatting down in a patient's room emptying out a Foley catheter. When she stood up with the graduated cylinder in her hand, she felt a pop in her lower back that radiated pain down her right leg & up her right to lower mid-back. The cylinder contained approximately 250 milliliters, or 8 oz. of liquid.

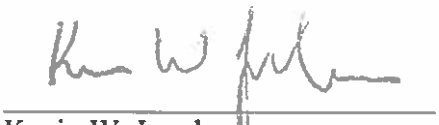
The Appellate court has categorized the risks to which an employee may be exposed as: "(1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics." *Metro. Water Reclamation Dist. of Greater Chi. v. Ill. Workers' Comp. Comm'n,* 407 Ill. App. 3d 1010, 944 N.E.2d 800. … employment-related risks are compensable while personal risks typically are not. Further, "[i]njuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan,* 407 Ill.App. 3d at 1014, 944 N.E.2d at 804.

The Arbitrator also found "Petitioner's job duties exposed her to this risk to a greater degree than the general public both qualitatively and quantitatively." (ArbDec. p. 5) The

Arbitrator never explained how he came to this conclusion and offered it without any further explanation or description of a quantitative analysis.

In a specially concurring opinion Presiding Justice Holdridge recently emphasized "a claimant may not obtain benefits for injuries caused by activities of everyday living (such as bending, reaching, or stooping), even if he was ordered or instructed to perform those activities as part of his job duties, unless the claimant's job required him to perform those activities more frequently than members of the general public or in a manner that increased the risk." *Noonan v. Illinois Workers' Compensation Comm'n*, 2016 IL App (1st) 152300WC, ¶ 41 quoting from *Adcock v. Illinois Workers' Compensation Comm'n,* 2015 IL App (2d) 130884WC.

Therefore, an analysis of the activity under the theory that the risk is incidental to employment should not be applicable in this case if we are to follow Justice Holdridge's analysis. The case falls under a neutral risk analysis and thus fails quantitatively and fails qualitatively. Petitioner never testified to the frequency and/or duration of squatting or that Foley catheter emptying was different from any of the everyday activities she testified she performs at home where she goes from squatting to standing with something in her hand. To pass muster qualitatively, Petitioner must prove some aspect of the employment which contributes to the risk. The act of squatting and standing back up is a movement consistent with normal daily activity and by itself is not an activity associated with a risk of employment even with 8 oz. of liquid in hand. Similar activities were described in *Adcock* and the Appellate court characterized "squatting" as an activity of daily living. For the reasons set forth I would reverse the Arbitrator's Decision and find that under a neutral risk analysis, the Petitioner failed to meet her burden proving an accident occurred arising out of her employment.



Kevin W. Lamborn

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

17IWCC0579

HERRON, CHRISTINA
Employee/Petitioner

Case# **15WC020754**

KINDRED HOSPITAL
Employer/Respondent

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:

5847 THE LAW OFFICE OF DAVID HUNT
245 N E PERRY AVE
PEORIA, IL 61603

4876 ARNETT LAW GROUP
BETHANY WHITE
500 W MONROE ST SUITE 2010
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0579

CHRISTINA HERRON
Employee/Petitioner

v.

KINDRED HOSPITAL
Employer/Respondent

Case # 15 WC 20754

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 **ROCK ISLAND**, on **04/05/2016**. 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, **2/27/2015**, 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 **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **36** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$1,236.45** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,236.45**.

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 $733.33/week for 45 6/7 weeks, commencing 05/21/2015 through 04/05/2016, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Kube, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Michael K. Nowak, Arbitrator

6/24/16

Date

ICArbDec19(b)

JUL 28 2016

FINDINGS OF FACT

On February 27, 2015 Petitioner was employed by Respondent, Kindred Hospital, as a registered nurse. On that date she was assigned to medical/surgical duties. In the process of performing her duties she was emptying a Foley catheter bag for a patient. The bag was attached to the rail of the patient's hospital bed and hung below the mattress. She was required to squat down to reach the bag. Once she had done so she placed a graduated cylinder, used to measure urine output, on the floor. She then opened the drain clip on the catheter bag and allowed the contents to drain into the cylinder. After the bag had drained she closed the drain clip and arose from her squatting position holding the graduated cylinder. As she did so, she felt a pop in her back and experienced an immediate onset of pain in her lower back as well as pain shooting down into her right leg. The cylinder contained 250 milliliters of urine weighing approximately one half pound.

She notified her supervisor, who referred her to the Occupational Clinic at OSF, where she saw Dr. Braun. She gave a history of accident consistent with her testimony at Arbitration. (PX 1, p. 59-61). Dr. Braun treated Petitioner conservatively, initially prescribing pain medication and placing her on work restrictions. Additionally, Dr. Braun ordered an MRI of her lumbar spine. (PX 1). Respondent initially accommodated Petitioner's restrictions.

Petitioner underwent an MRI at the Peoria Imaging Center on March 18, 2015. The impression was a central posterior disc protrusion and posterior annular fissure at L5-S1contacting the dural sac and S1 nerve roots without mass effect on them. (PX 3, p. 25). Dr. Braun then referred Petitioner for therapy at Professional Therapy Services (PX 2). Finally, Dr. Braun referred Petitioner to the OSF Central Illinois Pain Center for an epidural steroid injection. Petitioner underwent this injection on April 30, 2015. The postoperative diagnosis on that date was "lumbar disc herniation L5-S1" (PX 3, p. 45). Despite these conservative measures Petitioner continued to have pain and discomfort in her low back and down into her right leg.

Petitioner was examined by Dr. Kern Singh on May 18, 2015 pursuant to §12. It was Dr. Singh's opinion that Petitioner had sustained a soft tissue muscular strain and that her leg complaints were non-anatomic in nature (RX 2). Following the examination Respondent refused to accommodate any light duty restrictions and all other benefits were denied.

Petitioner then sought medical attention from her family physician, Dr. Todd Lanser, at the Graham Medical Group. Petitioner first saw Dr. Lanser for these injuries on May 21, 2015. On that date she gave a history to Dr. Lanser consistent with her testimony at Arbitration. Dr. Lanser immediately removed Petitioner from work and set up a referral for her to see Dr. Richard Kube at the Prairie Spine and Pain Institute (PX 4, p. 53-65).

Petitioner was first seen at the Prairie Spine and Pain Institute on June 18, 2015. Petitioner was once again treated conservatively with epidural steroid injections and physical therapy. Additionally, Petitioner underwent an SI joint injection to rule out that area as the cause of her problems.

Dr. Kube testified by way of deposition. Dr. Kube opined that because Petitioner received no relief from the SI joint injection, the pain that she was experiencing in the right center and lower back corresponded with the L5-S1 disk (PX 6, p. 12-15). Given that the Petitioner had failed conservative treatment, Dr. Kube was then recommending a surgical procedure where the L5-S1 disk would be removed and fused at that level as well as

make additional room for the S1 nerve root on her right side. (*Id.*, at 15). Dr. Kube further testified that Petitioner should remain off work until the surgery could be performed. (*Id.*, at 16). When asked about the causal relationship between the accident and the right sided annular tear for which he was treating Petitioner, Dr. Kube testified "[b]ased upon the patient's history that was provided to me, the lack of significant history prior of any of these kinds of symptoms, and the contemporaneous onset of the symptoms that she had, it would be more likely than not that she would have an association of the symptoms she's having now with the incident that she described." (*Id.*, at 23). Dr. Kube opined that Petitioner's right sided complaints were consistent with the MRI findings as well as the physical examinations performed during her office visits. Dr. Kube also testified that he had detected no positive Waddell signs during any of his examinations of the Petitioner. He stated:

> she has complaints that correlate with exam findings that correlate with MRI findings, you know. I mean, that's -- those are all things that are kind of adding together. ...the notes indicate that she, you know, went to PT. She went there regularly. She participated in exercise. You know, there's not been any evidence of any drug seeking behaviors. There's not been anything I would consider a red flag in this person. And, like I say, I have a history - - a history and an exam and an imaging study all kind of pointing at the same spot, and so, you know, there's not really a reason for me to have any kind of big second guesses there. (*Id.*, at 79-80).

Dr. Singh also testified by way of deposition. Dr. Singh testified that he personally reviewed Petitioner's MRI films, which he interpreted to show an L5-S1 disc protrusion with annular tear. Although the MRI report reflected a left-sided disc bulge with encroachment on the left-sided nerve root, he did not agree with that finding. (RX 2). Dr. Singh diagnosed Petitioner with a lumbar strain as a result of the accident on February 27, 2015. He felt she had reached maximum medical improvement four weeks following the injury, was able to work full duty, and did not require any further treatment as a result of her injury. Dr. Singh believed that the Petitioner had non-anatomic pain complaints, as her complaints of pain did not correlate to findings on MRI or physical examination. (*Id.*). Dr. Singh opined that the only pathology of import shown on the MRI was a L4-5 disc bulge that caused compression on the left. However, that disc bulge would not explain her right-sided symptomology. (*Id.*, at 16-22). Dr. Singh further opined that neither the injections that were performed nor Dr. Kube's recommended decompression and fusion were reasonable and necessary treatment because there was no pathology at L5-S1 that would warrant this treatment. (*Id.*, at 27).

Petitioner testified at Arbitration that prior to February 27, 2015, she had never experienced the type of symptoms she had immediately after the accident. She further testified that the accident in question took place at approximately 2:00 p.m. on February 27, 2015. She stated that her shift that day began at 7:00 a.m. and that she was not suffering from any symptoms prior to the incident. Petitioner also testified that she has not suffered any other accidents or injuries to her low back since February 27, 2015. She continues to experience pain in her low back and right leg. Although Petitioner continues to perform a myriad of daily activities of normal life, she continues to have pain and discomfort in her low back and right leg while performing these activities.

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).

It is clear that the incident in this case arose during the course of Petitioner's employment. The only legitimate issue for analysis is whether the claimant's injuries arose out of her 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)).

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.

In this case, Petitioner was injured when she was arising from a squatting position while holding a graduated cylinder after she had emptied a patient's Foley catheter bag. As she did so, she felt a pop in her back and experienced an immediate onset of pain in her lower back as well as pain shooting down into her right leg. The cylinder contained 250 milliliters of urine weighing approximately one half pound.

Nothing in the record suggests that Petitioner's injury was the result of a risk personal to the employee. The act of squatting down to empty a catheter bag while holding onto a graduated cylinder and then arising, being careful not to spill the contents of the cylinder, are risks associated with Petitioner's employment. While the risk of squatting and arising from a squatted position may be argued to be a risk to which the general public is exposed, the Arbitrator finds Petitioner's job duties exposed Petitioner to this risk to a greater degree than the general public both qualitatively and quantitatively.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner sustained injuries which arouse out of and in the course of her employment with Respondent.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

As indicated above both Petitioner's treating surgeon and Respondent's §12 examiner testified by way of deposition. Dr. Kube opined that Petitioner's symptoms corresponded with L5-S1 disk pathology. Given that the Petitioner had failed conservative treatment, Dr. Kube recommended a decompression and fusion at L5-S1. Dr. Kube opined Petitioner's condition was related to the accident. Dr. Kube explained why Petitioner's right sided complaints were consistent with the MRI findings as well as the physical examinations performed during her office visits. Dr. Singh was of the opinion that Petitioner's MRI films show an L5-S1 disc protrusion with annular tear. Dr. Singh diagnosed Petitioner with a lumbar strain from which she had reached maximum medical improvement four weeks following the injury. He felt she was able to work full duty, and did not require any further treatment as a result of her injury. Dr. Singh further opined that neither the injections that were performed nor Dr. Kube's recommended decompression and fusion were reasonable and necessary treatment because he felt that there was no pathology at L5-S1 that would warrant this treatment. (*Id.*, at 27).

The Arbitrator finds the testimony and opinions of Dr. Kube more persuasive than those of Dr. Singh 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 her current condition of ill-being is causally related to the accident and that she is entitled to prospective medical care.

Respondent shall authorize and pay for the treatment recommended by Dr. Kube, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

Prior to Petitioner being seen by Dr. Singh, she had been placed on light duty by Dr. Braun at OSF Occupational Health, where she had been sent by Respondent. Respondent was able to accommodate these restrictions and Petitioner was paid partial benefits for the hours that she missed. Based upon Dr. Singh's opinions, Respondent discontinued Petitioner's benefits on May 20, 2015 and refused to accommodate any light duty restrictions.

On May 21, 2015, Petitioner began treating with Dr. Todd Lanser, her primary care physician. Dr. Lanser opined that Petitioner was not ready to return to full duty at work and referred Petitioner to Dr. Kube. Dr. Kube testified that he has continued to keep the Petitioner restricted from work and will continue to do so until after the surgical procedure he has recommended.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability benefits from May 21, 2015 through April 5, 2016, the date of hearing. Respondent shall pay Petitioner temporary total disability benefits of $733.33/week for45 6/7weeks, commencing 5/21/15 through 4/5/16, as provided in Section 8(b) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
ROCK ISLAND

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesse Arteaga,
Petitioner,

v.

NO: 15 WC 25524

Cloverleaf Cold Storage,
Respondent.

17IWCC0566

DECISION AND OPINION ON REVIEW

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

The Commission strikes the following sentence from the Arbitrator's Order: "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." As Petitioner's claim is denied, there is no award and the standard *Thomas v. Industrial Commission* language is inapplicable.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2016 as modified 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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: SEP 18 2017

L. Elizabeth Coppoletti

LEC/mck

O: 8/1/17

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

ARTEAGA, JESSE
Employee/Petitioner

Case# **15WC025524**

CLOVERLEAF COLD STORAGE
Employer/Respondent

17IWCC0566

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:

4342 REHN & SKINNER LLC
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

1337 KNELL LAW LLC
ILIR IMERI
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JESSE ARTEAGA,
Employee/Petitioner

v.

CLOVERLEAF COLD STORAGE,
Employer/Respondent

Case # 15 WC 25524

Consolidated cases: _____

17IWCC0566

An *Application for Adjustment 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 **Rock Island**, on **6/8/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/7/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$6,681.62**; the average weekly wage was **$628.88**.

On the date of accident, Petitioner was **41** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 7/7/15, or that his current condition of ill-being as it relates to his left shoulder is causally related to the alleged accident. The petitioner's claim for compensation is denied.

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

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

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

Signature of Arbitrator

6/24/16
Date

ICArbDec19(b)

JUL 1 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 41 year old high reach forklift operator, alleges he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 7/7/15. Petitioner has a high school degree and an Associate Degree from Wyoming Tech Institute. Petitioner testified that respondent is a warehouse and trucking service that dispenses food around the United Stated for Farmland foods. Petitioner stated working for respondent in May of 2015. Petitioner was hired as a high reach forklift operator on the second shift. His duties included getting pallets from 4 stories up and taking them to the dock and putting them on semi-trucks to distribute. Petitioner denied any problems with his shoulders prior to 7/7/15. He testified that in 2012 he had surgery to his right shoulder. Petitioner denied any treatment or surgery for his left shoulder before 7/7/15.

Petitioner testified that 15 years ago, on his first day in the minor leagues he threw his arm out. That ended his minor league career. Petitioner testified that he did not tear it. He underwent physical therapy to rebuild the muscle and tissue. On 8/1/12 petitioner presented to Dr. Currie at Medical Arts Clinic. He reported that he injured his right shoulder 15 years ago. He stated that he was told at that time that he had a torn rotator cuff, but did not have any surgery done. He indicated that it began very suddenly after throwing a baseball. He indicated that three months ago he was playing softball and threw the ball and again had a sudden onset of pain in his right shoulder and had pain ever since. His MRI on 8/21/12 showed a degenerative tear of the labrum; marrow edema of the distal clavicle and acromial process associated with arthritic changes; and rotator cuff tendinosis. On 10/29/12 petitioner was scheduled for an arthroscopic surgery of his right shoulder on 11/2/12.

On 7/7/15 petitioner testified that he was working the 1st shift. He testified that at about 9:30 am he had gotten off his forklift and walked over to assist a co-worker, Riedel, whose forklift was stuck to a semi in the loading dock. He testified that while he was standing behind Riedel's forklift talking to her, another forklift struck the forks of Riedel's forklift and her lift was pushed backwards about a foot and struck his left elbow. Petitioner testified that when the forklift struck his elbow the impact pushed it upwards towards his head and he bent over. He testified that he felt an electrical shock, as if his funny bone had been struck. Petitioner testified that he thought it was alright and he shook it off. When Riedel asked him if he was okay he stated that he was.

Petitioner completed an Employee Incident Report on 7/7/15 at 12:00 pm. He wrote that he was asking a coworker what she needed and got off his fork lift and stood by Riedel's and a coworker drove by with his forklift and hit her forklift and it was pushed into him and hit his elbow.

A First Report of Injury was completed on 7/7/15 at 11:30am. It was filled out by Philip Walsh, petitioner's supervisor. It noted that petitioner was standing near another operator's lift while loading an outbound trailer. It noted that petitioner was leaning on another employee's lift when that lift was struck by Ryan's lift. Ryan's outrigger log caught the fork on Shelley's lift jarring petitioner's arm, which was leaning on Shelley's lift.

Petitioner testified that he did not complete the rest of his shift. He testified that when he started picking items in the freezer he noticed pain in his left shoulder when steering the wheel of the forklift. He complained of pain in the front shoulder joint and behind the shoulder. Petitioner testified that he reported this to his supervisor, Rolin. He testified that Rolin then went to Phillip, another supervisor. Petitioner then left work to see his primary care physician.

After he left work petitioner presented to Dr. Rosa Leland, his primary care physician, at Cottage Clinic of Monmouth. Petitioner reported an injury to his left elbow. He complained of pain up to his shoulder. He reported that a forklift pushed into his forklift which hit him in his left elbow at 9:15 am. He complained of hot sharp pain in his shoulder. He reported that his shoulder was popping and stiff. He complained of discomfort in his left shoulder and distal clavicle area. He stated that his pain was dull with sharp pain at times. He reported that it was aggravated by movement and relieved by rest. He complained of a popping sensation when rotating the shoulder. He denied any numbness/tingling in the left arm.

An examination of the left elbow showed no deformity, induration, redness, swelling, or warmth and normal carrying angle. Tenderness was noted upon palpation. Petitioner's range of motion and strength of his left elbow was normal. An examination of the left shoulder revealed left distal clavicle tenderness. Tenderness was also noted of the proximal chest wall and shoulder. Petitioner's range of motion and strength of his left shoulder was normal except for his abduction, which was 5/5. Petitioner underwent x-rays of his left elbow, left clavicle and left shoulder, all of which were negative. The x-rays of the left elbow showed no effusion.

On 7/8/15 Shelley Riedel completed a Witness Incident Report. She noted that she was standing next to her lift on the dock plate and petitioner's lift was parked to the side. She noted that petitioner was between his lift and the railing. Ryan came through and bumped into petitioner's fork and jolted the truck. She noted that she looked over and asked petitioner if he was okay, and he said "yes, it didn't hit me". She noted that after that they all went back to work. Riedel claimed she was not part of this incident, only a witness.

On 7/8/15 Ryan Calkins also completed a Witness Incident Report. He noted that the incident occurred on the dock around door 2T dock plate. He noted that he was driving down the dock putting pallets away in the freezer and came upon petitioner's truck parked along the dock plate with his forks sticking out in the aisle. He noted that petitioner was talking to Riedel, and Rusty was on his fork truck directly across from petitioner's truck. He thought he had enough room to fit between the 2 trucks. As he started to drive between the trucks he ran over the tips of petitioner's forks with his outrigger on his truck. He noted that it made a bang so he turned around and saw petitioner standing there. He asked petitioner if he was okay and he said he was fine. He noted that the truck of the forks he ran over bumped petitioner's arm, but he was okay. He noted that petitioner got on his truck and drove away and he went back to putting pallets away. He noted that he thought all was well.

Calkins testified that he no longer works for respondent. He testified that while driving the forklift he thought he could make it between two other forklifts, but was not able to. As a result, his forklift hit the forks of another forklift. He stated that he did not make contact with the body of the forklift. He testified that the forklift he struck shook a little, but did not move. He stated that he was going less than 1 mph. Calkin testified that after the impact he asked petitioner what happened and petitioner told him that he bumped his arm and was good.

Petitioner followed-up with Dr. Leland on 7/9/15. He reported that his pain was about the same. Petitioner complained of pain with certain movements, especially overhead. He reported that most of the pain was in the shoulder area. He reported a popping sound and stated that his joint felt unstable. He reported that his left elbow was mildly tender. He also complained of tingling in his arm for the first time since the accident. He denied any numbness. He stated that he was off work. An MRI of the left shoulder was ordered.

On 7/10/15 Shelley Riedel provided a written statement. (PX14, RX7). She stated "On approximately the 18th of June I was involved in a conversation with Jesse Arteaga, about him not helping throw cases or go into the cooler/freezer. He stated that he couldn't and wouldn't go into the freezer or was not able to throw cases because of injuries he sustained while in the minor league. He had stated that he had to quit playing baseball because of a few surgeries he had on his "pitching arm" and showed her the scar to prove it. And also stated that he really needed surgery on the other arm as well. I don't believe for one second that his problem for surgery now has anything to do with the incident that happened at Cloverleaf". Petitioner denied he ever talked to his coworkers about a prior left shoulder injury.

At trial Riedel testified that she no longer works for respondent. She testified that when the forklift accident occurred she was standing 5-6 feet from petitioner and nothing was blocking her view. She stated that her forklift was running when it was struck. She testified that the forklift did not shut off when it was struck despite the fact that the sensors are so sensitive that sometimes they go off if you drive over a crack in the floor. She testified that when Calkin hit the forks of her forklift there was a loud bang and her forklift was jolted. She was not sure if it moved. She did not believe it moved a foot. Riedel testified that she was talking to petitioner when the accident occurred and she did not see petitioner get struck. She testified that she even asked him if he was okay and he stated that he was. She further testified that he told her that the lift did not hit him. She testified that she did not see petitioner grab his left arm and go down in pain. Nor did she see petitioner's shoulder ever move.

Riedel testified that a couple days after petitioner was moved to the first shift she had a conversation with him, Wilson, and Landon while they were in the break room about work. She testified that petitioner stated that the people on the 1st shift were lazy. Riedel stated that she asked petitioner why he did not go into the freezer and he said it was because of his shoulder, but she could not recall if he specified which shoulder, if any. She further testified that during that conversation he showed her his surgery scars on his right shoulder, and stated that he needed surgery on the other shoulder. She also testified that he told them he could no longer play baseball.

On cross examination Riedel testified that if you are going to be 20-25 feet from the forklift you must shut it off. She testified that she was not sure if it was her forklift that was hit, but her forklift was at the entrance of the dock. She stated that there was another forklift a few feet away. She testified that the sensors go off with every impact. She stated that she did not see petitioner bend over. Petitioner reiterated that she did not see petitioner's left arm get hit by the forklift.

On 7/14/15 petitioner was terminated. The reason given was unsatisfactory probation.

On 7/16/15 petitioner returned to Dr. Leland. He reported that his left shoulder was still sore. He stated that when he moves his shoulder he can hear it grind. He reported numbness and tingling in his left arm. He stated that the pain in his left elbow had subsided. Petitioner reported that he was fired on 7/15/15. Based on the fact that petitioner's left shoulder pain was not improving, Dr. Leland referred petitioner to orthopedics for further evaluation.

On 7/21/15 petitioner signed his Application for Adjustment of Claim with respect to this claim. He alleged that he was struck by a forklift that was run into by another forklift. He alleged injuries to his left shoulder/arm/elbow. This Application was filed on 7/27/15.

On 7/27/15 petitioner underwent an MRI of the left shoulder. The impression was rotator cuff tendinosis and bursal surface partial thickness tear of the supraspinatus, and large tear of the labrum. No full thickness rotator cuff tear was noted.

On 8/3/15 petitioner presented to Dr. Myon Stachniw, an orthopedic surgeon, on the referral of Dr. Leland. Petitioner complained of pain in his left shoulder at a 8/10. He reported that the pain in his left shoulder was in the front and back of the shoulder, and radiated into and down the arm. Petitioner gave a history of an injury to his left shoulder one month ago. He reported that he was hit by a forklift and sustained an injury to his left shoulder. He complained of severe pain in his left shoulder, and pain along the medial border of the scapula anteriorly, as well as pain and numbness going down his arm. He also reported clicking in his left shoulder. He denied any previous pain or difficulty in his left shoulder. Dr. Stachniw was of the opinion that petitioner needed to have an arthroscopic repair of the labrum, but told petitioner he does not do this type of surgery.

On 9/21/15 the recorded statement of Christine Wilson was taken by Jessica Nieves, Senior Resolution Manager with Gallagher Bassett Services, regarding the incident on 7/7/15. Wilson is a warehouse worker. She stated that she only knew petitioner from work. She started working for respondent in May of 2015. She stated that she did not know petitioner until he transferred to day shift. She stated that she worked with him for about a month before the incident at issue. She stated that they would talk in the break room, and she helped on the job because petitioner usually loaded and unloaded trucks. She testified that there was a conversation one day about petitioner playing ball and injuring one shoulder and having surgery on it, and also injuring the other shoulder and was still needing surgery on that shoulder. She believed the surgery was due to his ball career. She stated that the other girl in the conversation had said something about him possibly being in the minor leagues. She got the impression that petitioner was kind of boasting about the past. She stated that she thought he grabbed his right shoulder and said that that was the shoulder he had surgery on, and that the left still needed surgery. She stated that she could not remember 100% which shoulder he grabbed, but said he had surgery on this shoulder and still needed surgery on the other. She noted that she thought petitioner had stated that he had a torn rotator cuff. She stated that this conversation was had a couple weeks before the incident on 7/7/15. She stated that petitioner stated that he was not going to do anything but work on the dock

because the cold bothered him. She stated that petitioner told her he was not going into the freezer to work. She stated that she did not feel it was right that petitioner was accusing someone else of hurting him. Petitioner denied he ever told his co-workers about prior left shoulder injuries.

At trial, Wilson testified that she no longer works for respondent. Wilson testified that she was part of a conversation in June of 2015 where petitioner was talking about being a baseball player. He also talked about moving to the 1st shift from the 2nd shift. He talked about his shoulders and because he was a baseball player he had surgery on one shoulder and needed surgery on the other shoulder. She testified that he showed them the scars where he already had surgery. She could not recall which shoulder had the scars on them. She testified that petitioner told her that he needed treatment for his rotator cuff injury, just like he had already had on the other shoulder. She testified that petitioner projected that it was because of his baseball career. Wilson testified that she has no animosity against petitioner or respondent, and left her employment with respondent of her own accord. Wilson testified that petitioner told them during the conversation that the cold bothered one of his shoulders, but could not recall which one. She testified that this conversation lasted only 10-20 minutes and was in the break room. She testified that Riedel and petitioner were part of the conversation. Wilson testified that she spoke up because she had heard another employee, Calkin, may lose his job because of the incident, and she wanted respondent to know that petitioner had a preexisting injury to his left shoulder.

On 1/27/16 the evidence deposition of Dr. Myron Stachniw was taken on behalf of the petitioner. Dr. Stachniw opined that the surgery he was recommending was reasonable and appropriate treatment for petitioner's left shoulder and is related to his injury at work. Dr. Stachniw was of the opinion that an impact to the left elbow can cause an injury to the shoulder. He opined that it can transmit a compressive force that compresses the head of the humerus against the socket, and then it can shear off a part of the labrum. He further opined that the complaints petitioner had of sharp pain, grinding, and popping in the shoulder, and tenderness of the proximal chest wall and shoulder were consistent with the labrum type of injury.

On cross examination Dr. Stachniw testified that he was not aware petitioner had a right rotator cuff tear that was surgically repaired, or that petitioner played baseball and was a pitcher. Dr. Stachniw could not opine the amount of compressive force to the elbow that was needed in order to cause a tear in the labral. He testified that a trauma to the elbow is transmitted through the humerus and pushes the ball into the socket. He then stated that there would also be twisting and this is the type of mechanism that can tear a labrum. However, he opined that the compression force would have to be significant. He could

not state whether a very minor hit to the elbow or tap to the elbow could cause a tear of the labrum. He stated that the force does not necessarily have to result in significant injury to the elbow. Dr. Stachniw was aware that one of the leading causes of labrum tears, specifically in pitchers, is the fact that they throw the ball in the motion of throwing a ball, and that is one of the prevailing injuries to pitchers. Dr. Stachniw also agreed that the motion of pitching a baseball can put stresses on the labrum and has the mechanism necessary to cause a large tear of the labrum. Dr. Stachniw could not recall if petitioner told him he was hit in the left elbow or shoulder. He was of the opinion that when petitioner was struck in the elbow it would have needed to push his shoulder in, up or in some direction. He then stated that a minor bump to the elbow would probably not have caused a large tear of the labrum. Dr. Stachniw testified that his opinion was that petitioner see somebody that does arthroscopy of the shoulder who is experienced in injuries of the labrum, and be evaluated by that specialist, and that specialist would then decide if surgery was needed. Dr. Stachniw opined that throwing a baseball could cause a rotator cuff tear. He further opined that the rotator cuff tear could have been something that was degenerative or asymptomatic and could have become symptomatic later. He did not opine the same for the labral tear, which he believed is more of a acute injury, even though he did not review the MRI films and the radiologist did not identify that the labral tear was acute. Dr. Stachniw was of the opinion that he would not need to see swelling or tenderness, or a bump, or redness, or black and blue on the elbow as a result of an injury significant enough to cause a labrum tear. Dr. Stachniw was of the opinion that it is possible to have a tear in the labrum that perhaps was smaller and over time with degeneration can become larger. Dr. Stachniw was of the opinion that a labrum tear would require restrictions on overhead activities.

On 2/2/16 Dr. Lawrence Li performed a record review regarding this case. This included witness statements, surveillance video of the accident, and petitioner's treating records. After reviewing the video Dr. Li noted that he did not see anything that resembled a forklift hitting someone's left elbow, and did not see any reaction indicating pain from any of these individuals. Dr. Li was of the opinion that it is clear from the MRI of the left shoulder on 7/27/15 that petitioner had a partial thickness bursal surface tear of the rotator cuff from chronic tendinosis. Based on the review of petitioner's medical records, Dr. Li diagnosed chronic left rotator cuff tendinosis and a bursal thickness partial tear. He recommended a corticosteroid injection, physical therapy, and anti-inflammatory medications for petitioner. Dr. Li opined that petitioner's current left shoulder issue was not caused by the alleged work incident because he told Christine Wilson he hurt both his shoulders playing baseball. He noted that Wilson stated that petitioner told her one already had surgery on it and the other one still needed surgery, and the medical records showed that petitioner already had surgery on the right shoulder. His opinion is based in part on

Wilson's statement that petitioner told her in June, a month prior to the incident, that he needed surgery on the left shoulder. He also relied on the statement of Shelley Riedel that supports petitioner was not hit in the left elbow. He also relied on his review of the video, in which he saw no evidence of anyone being hit anywhere on the body with the forklift. Dr. Li opined that petitioner's chronic rotator cuff tendinosis could be due from overuse in playing baseball. He also opined that the MRI findings of tendinosis and bursa partial surface tears were chronic in nature and not acute.

On 5/2/16 the evidence deposition of Dr. Li an orthopedic surgeon, was taken on behalf of the respondent. Dr. Li opined that rotator cuff tendinosis and bursal surface rotator cuff tears are typically not an acute event. He opined that these are degenerative findings. Based on the records he reviewed he did not think petitioner needed surgery. He opined that with corticostroid injection, physical therapy and anti-inflammatory medications petitioner's prognosis was good. He opined that the partial thickness bursal surface tear was not related to any work accident because petitioner told Wilson that he had hurt both shoulders playing baseball and that he would need surgery on both, and already had surgery on the right. He also relied on the statement of Riedel who stated that petitioner was not hit in the left elbow, and the fact that the video did not show anyone being hit in the left elbow. He opined that petitioner's left shoulder condition could have been caused by his baseball playing. He opined that chronic rotator cuff tendinosis and bursal partial thickness tears are chronic in nature and could be caused by overuse by playing baseball. Dr. Li opined that even if petitioner had been struck in the left elbow and his left hand was not grabbing onto anything that would not cause any shoulder injury. He opined if the elbow was struck it would move, but there would not be any counterforce that would transmit the force into his shoulder. He opined that if petitioner had been stationary and grabbing onto something, then got hit at the elbow, that would transfer force across the upper extremity. He also opined that getting hit closer to the shoulder (i.e., elbow rather than hand), would actually transmit less force. He opined that if petitioner was resting his elbow on a stationary object and that stationary object suddenly moves, that would transmit very little force, if any at all. Dr. Li opined that the findings on petitioner's MRI of the left shoulder could be caused by any sport, especially baseball. He opined that petitioner played a much higher volume of baseball that just the recreational athlete, based on the fact that he made it to the minor league.

Dr. Li testified that he did not see any forklift hit another forklift in the video. Dr. Li testified that if petitioner was a right hand pitcher he would be raising his left arm up to catch the ball from the catcher repeatedly. Dr. Li testified that even if petitioner's elbow did get hit via the forklift that would not have

caused the shoulder injury because Mr. Calkins' statement that he only ran over the forks would not cause a great deal of force. He opined that to sustain the kind of tear petitioner had in his left shoulder, he would have had to have been struck in the shoulder, not in the elbow, and the force would have had to have been enough to move him forward several steps. Dr. Li opined that it would take a lot of force to move a stationary truck.

An undated written statement by Christine Wilson was offered into evidence. (PX12, RX5). It stated "On or about June 18 I was involved in a conversation with Jessie Arteaga, Shelley Riedel and Cheryl Landon. During this conversation Jessie stated that he was unable to lift and throw cartons or stay in the cold due to shoulder injury that resulted in 2 surgeries and that his other shoulder was also injured and needed surgery and that was the reason he was only on the dock to load and unload trucks".

Petitioner testified that he worked for Wells Pet Food. On his application he noted that he was able to lift/push/pull and/or carry 75 pounds or less, but it would be limited. He alleges he was hired for the biscuit line, but was instead placed in "premix" on his first day. He testified that this job required him to pick up bags weighing up to 50 pounds, and empty them into a huge mixer. He testified that he did this most of the day. He also testified that he would pull bags, cut them open and pour them into the mixer at waist level. Petitioner offered into evidence paystubs from Fleet Staff, Inc. for his work at Wells Pet Food for week ending 3/13/16, 3/27/16, 4/3/16, 4/10/16, 4/24/16, and 5/22/16. Petitioner testified that he stopped working there because he had to travel 1 hour and 20 minutes each way and based on the pay he was receiving and the stress on his arm, he determined it was not worth it. He testified that he did not report that he had any restrictions because he wanted to work. While working for Wells Pet Food he testified that he worked overtime.

Respondent offered into evidence pay statements for respondent from period ending 5/16/15 through the period ending 7/11/15.

Respondent also entered into evidence various absence reports. There was one dated 6/8/15 that indicated petitioner took a lunch that went over by 8 minutes. On 6/8/15 petitioner was also noted as being absent without proper notification claiming he was sick. On 6/11/15 petitioner was also written up for being absent without proper notification. Petitioner claims these instances were related to his car breaking down, and developing an earache from working in the freezer.

On 6/12/15 petitioner was moved to the 1st shift. Petitioner testified that he requested this move from the second shift, because he wanted to work on the 1st shift even if it meant a decrease in his hourly

rate, because he would no longer have to work in the freezer. On the Pay Change Form handwritten changes were made that indicate petitioner was demoted to Specialist from High Lift. It is unknown if these hand written changes were made on the date the form was signed, or if it was at a later date.

On 6/16/15, petitioner was written up again for being absent without proper notification. It was also noted that he was a no show, no call. Petitioner alleged this was because his schedule changed and he did not know that.

At trial, petitioner complained of pain in his shoulder every day at a 4-5/10. He testified that he takes 15 ibuprofen or Advil every day to keep his pain down. He also testified that he uses icy hot. Petitioner's partner is a massage therapist and gives him massages for his back and shoulder twice a week. Petitioner testified that his pain has improved since the injury. Petitioner has not had any treatment since August of 2015.

Petitioner admitted that the forklifts have sensors on them, and they go off if it hits something extremely hard. Once they get off the engine is cut off. He denied that simply going over slight bumps could trigger the alarm going off. He testified that Riedel's forklift was off so no alarm would go off it was struck.

Tom Hardy, Safety and Compliance Manager, was called as a witness on behalf of respondent. Prior to working for respondent, petitioner was in law enforcement for 27 years with the Nebraska State Patrol and Dakota County Sheriff's Office. Hardy is familiar with respondent's forklifts. He testified that the forklifts have impact detectors and there is preshift monitoring. He testified that the impact detectors come standard with the forklifts, and measure the sensitivity of the stopping of the machine. He testified that if a collision occurs the forklift will shut down and the alarm will sound and record the force of impact. He stated that they are sensitive and if the forklift is going too fast and hits a crack in the road it will go off. He also testified that if a forklift is jolted the sensor will go off. Hardy testified that the sensors on the forklifts did not go off upon impact of the forklifts. He believed if the forklift had been moved a foot, the sensor would have gone off. He even stated that a hard slap could set off the alarm. He testified that after viewing the video, if appeared that upon impact the forklift looked like it rolled back a foot. Hardy testified that the angle of impact will determine if the sensor goes off. He testified that if the machine was off the sensor would not go off. He did not know if the forklift that was hit was off or on when it was struck.

Lisa Svob was called as a witness on behalf of respondent. She is the Area Manager for Fleet Staff. She found petitioner employment at Wells Pet Food in March of 2016. She testified that when she interviewed petitioner and he completed his application he never told her that he had any restrictions or limitations. She also testified that after petitioner began working for Wells Pet Food he never told her he could not do the job. She stated that he never reported any pain in his shoulder.

Eric Anderson, Operations Manager at Wells Pet Food, was called as a witness on behalf of respondent. He testified that petitioner began working for Wells Pet Food on 3/7/16 in the premix department. He testified that he was not hired for any other position. He testified that this position requires dumping totes, beating on pins, cutting 50 pound bags open and loading trucks. He testified that petitioner would never have to work overhead. He testified that petitioner worked there for three months, and he told petitioner that after he worked 550 hours he would be hired. Anderson noted that petitioner worked overtime while working at Wells Pet Food. He testified that petitioner never reported any problems with his shoulders. He also never saw petitioner have any trouble performing his work duties. Anderson testified that on the day petitioner quit he was upset about not getting a shift differential. He testified that most lifting was waist to chest level.

Jermaine Peoples was called as a rebuttal witness for petitioner. Peoples has known petitioner since he was a kid. He testified that petitioner moved in with him last year and helped him fix up his house. He testified that petitioner did some floor work, painting, trim, cleaning gutters, and examined and patched the roof. He testified that petitioner stopped doing this work when he told him that he had an injury at work. He testified that all he knew about the injury was that petitioner told him he was helping someone and a forklift bumped into him. He stated that petitioner told him that he was injured in July of 2015. Peoples told him that petitioner left his home October or November of 2015. Peoples did not know much about petitioner's baseball, but did know petitioner had a prior shoulder injury.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims he injured his left shoulder when his left elbow was struck by a forklift on 7/7/15. Petitioner testified at trial that he was standing next to Riedel's forklift when the forks of it were struck by another forklift and the forklift moved and struck his left elbow. He testified that when his left elbow was struck the impact caused his elbow to be pushed upwards towards his head causing him to bend over. However, the medical records most contemporaneous to the alleged accident, and co-workers statements and testimony, do not fully support this alleged accident history.

On 7/7/15, after the alleged accident petitioner completed an Employee Incident Report stating that a coworker drove by in his forklift and hit Riedel's forklift causing Riedel's forklift to be pushed into his left elbow. Prior to petitioner completing his report, Walsh, his supervisor, completed a First Report of Injury that noted that petitioner was leaning on the forklift when the forklift forks were struck by another forklift, and his left arm was jarred.

The next accident history was given to Dr. Leland later that same day. Petitioner reported an injury to his left elbow, with pain up to his shoulder. He gave a history of a forklift pushing another forklift into his left elbow. He complained of hot sharp pain in his shoulder among other complaints. The arbitrator notes that petitioner made none of these complaints at the time of the incident or in his report earlier that day. An examination of the left elbow showed absolutely no signs of impact, not even any redness, swelling or bruising. X-rays of the left elbow also showed no effusion.

The next day, Witness Incident Reports were drafted by Riedel and Calkin. Riedel wrote in her report that she was standing near petitioner when the incident occurred. She wrote that after the impact she turned to petitioner and asked him if he was okay and he said "yes, it did not hit me". Calkin also wrote that after his forklift struck the forks of the other forklift he turned around and saw petitioner there. He wrote that when he asked petitioner if he was alright petitioner told him that he bumped his arm but was good.

On 7/10/15 Riedel provided a written statement. In it she talked about a conversation she had on or about 6/18/15 in the break room with petitioner and Wilson. She noted that petitioner told her he was not able to go in the freezer or throw cases because of injuries he sustained in the minor leagues. She noted that he also told them that he had to quit playing baseball because of a few surgeries he had on his pitching arm (right arm), and that he really needed surgery on the other arm as well (left arm).

On 9/21/15 the recorded statement of Wilson was taken on behalf of respondent's insurer. Wilson stated that she was part of the conversation in the break room a couple weeks before petitioner's alleged injury. She stated that she was there with Riedel and petitioner, and petitioner was kind of boasting about his minor league baseball career. She stated that petitioner told them he had played ball and injured one shoulder and had surgery on it (right shoulder), and also injured the other shoulder and was still needing surgery on that shoulder (left shoulder). She believed the surgery on the left was related to petitioner's ball career. She stated that she thought petitioner stated at that time that he had a torn rotator cuff that needed to be repaired. She also stated that petitioner told them that he could not do any work on the dock or in the freezer because the cold bothered him.

At trial, both Riedel and Wilson testified. The arbitrator finds Riedel's testimony was not totally consistent with her Witness Report and written statement, and therefore, gives less weight to the credibility of her testimony at trial. Alternatively, the arbitrator finds Wilson's testimony was totally consistent with her statement to respondent's insurer in September of 2015. The arbitrator found Wilson to be a very credible witness.

On 7/9/15 Dr. Leland ordered an MRI of the left shoulder, based on petitioner's complaints.

On 7/14/15 petitioner was terminated. The reason given was unsatisfactory probation that included many unexcused absences.

Within a week of his firing petitioner sought legal representation and signed an Application for Adjustment of Claim on 7/21/15 alleging he was struck by a forklift that was run into by another forklift. He alleged injuries to his left arm/elbow and shoulder.

On 7/27/15 petitioner had an MRI of the left shoulder that revealed rotator cuff tendinosis and bursal surface partial thickness tear of the suprapinatus, and large tear of the labrum.

Petitioner then presented to Dr. Stachniw. The history petitioner provided Dr. Stachniw was that he was hit by a forklift and sustained an injury to his left shoulder. He also denied any previous pain or difficulty with his left shoulder. The arbitrator notes that petitioner did not provide any history of being struck in the left elbow. Also there is no history of his elbow being struck with such impact that it forced his elbow upwards toward his head and he bent over. The arbitrator notes that the first time petitioner presented this accident history was at trial.

Dr. Stachniw was of the opinion that an impact to the left elbow can cause an injury to the shoulder by transmission of a compressive force that compresses the head of the humerus against the socket, and then it can shear off part of the labrum. However, Dr. Stachniw could not opine how much compressive force to the elbow was needed in order to cause a tear in the labral, but it would have to be significant. On cross-examination Dr. Stachniw admitted that he was not aware that petitioner played baseball and was a pitcher. Based on this, he was of the opinion that one of the leading causes of labrum tears, specifically in pitchers, is the motion of throwing a baseball, because the motion of pitching a baseball can put stresses on, and has the mechanism necessary to cause a large labrum tear, and rotator cuff tear. Dr. Stachniw opined that a minor bump to the elbow would not have caused a large tear of the labrum. He opined that when the petitioner's elbow was struck it would have needed to have pushed his shoulder in, up, or in some direction, to have caused a labrum injury. However, he did not think there would need

to be swelling, tenderness, bump, redness, or bruising of the elbow, as a result of the an injury, to cause a labrum tear. The arbitrator finds these two statements inconsistent in that Dr. Stachniw opines the impact needed to cause a labrum tear must be significant, but then states that such significant impact would not even result in some redness, bruising, bump or tenderness. The arbitrator also finds it significant that it was not until after Dr. Stachniw gave this history of what the mechanism of injury would have needed to be in order for petitioner to have sustained a labrum tear as a result of the injury that petitioner's history and mechanism of the injury changed, and he used this mechanism of injury when he testified at trial, despite the fact that no such accident history was provided prior to this date.

Dr. Li performed a record review on behalf of respondent, but did not perform a physical examination. Dr. Li also had the opportunity to view a staggered video of the incident. Dr. Li did not see a forklift hit anyone's elbow. He opined that petitioner's left shoulder condition was not caused by the alleged work incident. He relied primarily on the statements of Wilson and Riedel, who reported that petitioner told them, prior to the alleged accident, that he hurt both his shoulders playing minor league baseball and needed surgery to his left shoulder. He opined that petitioner's current condition of ill-being as it relates to his left shoulder could very well have been caused by overuse when playing baseball. Dr. Li opined that if petitioner's elbow was hit while his arm was hanging that would not cause a shoulder injury, because there would not be any counterforce that would transmit the force into his shoulder. He further opined that even if petitioner had been stationary and had been grabbing onto something, then got hit in the elbow, that would transfer force across the upper extremity, but that force would be less because the elbow is closer to the shoulder, and the closer the hit area is to the shoulder, the less actual force is transmitted. He opined that if petitioner was resting his elbow on a stationary object and the stationary object suddenly moved, that would transmit very little force, if any. Dr. Li opined that even if petitioner was a right hand pitcher, he would repeatedly be raising his left shoulder to catch the ball as it was thrown back from the catcher, and this could cause injuries to his left shoulder with the amount of baseball he played.

Hardy spent a significant amount of his testimony addressing the sensors on the forklifts. He noted that the forklifts have safety detectors on them and upon impact the sensor would go off. However, upon impact, the sensors on the forklift that was struck in the forks did not go off. Hardy testified that to him it looked like the forklift was pushed back about a foot.

The arbitrator also viewed the video. It appears that petitioner was walking over to a forklift by the dock door. The forklift was backed into the area, with the forklift body nearer the wall and the forks

sticking out. At approximately 9:09:13 am petitioner passes the forks of the forklift and is seen just starting to pass by the body of the forklift between the forklift and the wall. At approximately 9:09:14 am Calkin is seen backing up his forklift near the forks of the forklift petitioner is walking past. By 9:09:15 am it appears that petitioner has nearly passed the forklift and was on the side of the forklift near the back of the forklift, between the forklift and the wall. At 9:09:16 am it appears the impact had already occurred and the forklift was jolted and moved very slightly as is seen by the change in distance between the back of forklift petitioner was passing and the right fork of the forklift to the left of it. Based on this video the arbitrator finds petitioner was not leaning on the forklift when it was struck, but was rather walking past it when the impact occurred. Based on the opinions of Dr. Li, the arbitrator finds the fact that even if petitioner's elbow was struck by the forklift, it appears his left elbow was hit while his arm was hanging down while he walking past the forklift, and that would not cause a shoulder injury, because there would not be ;ny counterforce that would transmit the force into his shoulder.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 7/7/15, or that his current condition of ill-being as it relates to his left shoulder is causally related to the alleged accident. The arbitrator finds the discrepancies in the mechanism of history; the fact that petitioner did not file his Application of Adjustment of Claim until after he was fired, the testimony of Wilson regarding the fact that his left shoulder condition and need for surgery predated the injury by a month; the findings on the MRI for the left and right shoulder were similar; and the video itself, were very significant in reaching these findings.

J. WERE THE 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?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left shoulder that arose out of and in the course of his employment by respondent on 7/7/15, or that his current condition of ill-being as it relates to his left shoulder is causally related to the alleged accident, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cody Harris,

Petitioner,

vs.

NO: 15 WC 33018

United Parcel Service,

17IWCC0550

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2017, 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.

17IWCC0550

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: SEP 7 - 2017
TJT:yl
o 7/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. I would find that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment. Much discussion has occurred across many contested interpretations of the evidence. I would assert that this is a simple issue of credibility. The majority has found the Petitioner credible I am not persuaded. The Petitioner must carry the day and ultimately prove her case by the preponderance of the credible evidence. I am not persuaded that Respondent asked Petitioner to come into work early as a random early starter on the morning of the incident. I am not persuaded that Petitioner was driving a PITO unit throughout the facility looking for tubs for the bulk line. I am not persuaded that Petitioner ever explained why she was "badged" into the facility at 3:06am for a shift starting at 5:30am.

I am left with the question was the Respondent on site driving a PITO unit as part of her job responsibilities or as part of a personal errand and if it was personal does the personal comfort doctrine apply? The personal comfort doctrine provides:

"Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the *** method chosen is so unusual and unreasonable that the conduct cannot be

considered an incident of the employment." 2 A. Larson & L. Larson, Workers' Compensation Law §21.00, at 5-5 (1998).

"[I]f the employee voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment. [Citation.] The employer may, nevertheless, still be held liable for injuries resulting from an unreasonable and unnecessary risk if the employer has knowledge of or has acquiesced in the practice or custom. Karastamatis v. Industrial Commission, 306 Ill. App. 3d 206 (1st Dist. 1999), citing " Eagle Discount Supermarket v. Industrial Commission, 82 Ill. 2d 331, 340 (1980).

Regardless of the majority's belief that the Petitioner after ostensibly having "badged" in was in the course of her employment as she ate french fries while attempting to operate a PITO unit, the glaring issue remains whether the accident arose out of the employment. I am not persuaded that this behavior was anything other than an unreasonable and unnecessary risk, and would recommend a reversal.

Kevin W. Lamborn

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

HARRIS, CODY
Employee/Petitioner

Case# **15WC033018**

UNITED PARCEL SERVICE
Employer/Respondent

17IWCC0550

On 4/4/2016, 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 0.47% 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:

2811 CIARDELLI CUMMINGS CAMPAGNA
MARC R CAMPAGNA
70 E LAKE ST SUITE 1000
CHICAGO, IL 60601

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

17IWCC0550

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)

CODY HARRIS
Employee/Petitioner

v.

UNITED PARCEL SERVICE
Employer/Respondent

Case # 15 WC 33018

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **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 ____

17IWCC0550

FINDINGS

On the date of accident, **October 2, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,110.54**; the average weekly wage was **$415.45**.

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

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

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

ORDER

Respondent shall pay temporary total disability benefits of **$276.97** per week for **15-6/7th weeks** commencing **10/2/15** through **1/20/16** as provided in Section 8(b) of the Act.

Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$82,692.52**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay for and authorize the medical treatment as recommended by Dr. Erling Ho.

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

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

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

Signature of Arbitrator

4-4-2016
Date

APR 4 - 2016

FINDINGS OF FACT

Cody Harris ("Petitioner") testified as of the date of trial, she was single with no children. she testified she was hired by UPS ("Respondent") in May 2004. Her duties include working the bulk line and working as a collection roller.

In the bulk line, she said her duties involve making sure she has enough carts and tubs to pick up packages. She explained she works the bulk line approximately 45 minutes before start time, which is the time everyone usually starts their shift. That start time differs every day.

Regarding collection, her duties include working a conveyor and making sure packages come down the line in a single file. She explained that packages are diverted to her when those packages are not loaded into a truck and her job is to place them back in line. Under cross, petitioner testified that when packages come down a conveyer, her position is stationary and does not require her to drive a PITO unit. She testified she usually works the sunrise shift, which is 4 am to 9 am, Monday through Friday at that the Hodgkins facility.

On 10/2/15, a Friday, Petitioner began her work at 4:32 am per a swipe card she used. She said she swiped in near the front of the bulk line located near Outbound 1 Area. Petitioner testified that a "random early starter" is someone randomly picked by Respondent to "start up" every day. Duties include setting up the bulk line earlier than regular start time. petitioner had been chosen before and had been chosen as the random early starter on the date of the injury.

After punching in, she immediately walked over to a PITO unit, which is a vehicle unit one can attach a tub to. The unit has 3 wheels, 1 headlight, a brake and gas pedal and a horn. She testified her duties also include inspecting a PITO unit to ensure it is in proper working order. Petitioner confirmed the unit depicted in Px6a and 6b as the same or similar unit she used on 10/2/15. Petitioner testified employees are given hands-on and classroom training before getting a license. Employees are given licenses by Respondent to operate a PITO unit. She was first a license in 2011 but it expired 3 years later. Petitioner identified Px8, which was used for demonstrative purposes only, as her license issued by Respondent. She confirmed it was expired.

On the date in question, Petitioner testified she was aware her license was expired and had previously discussed this with supervisor Matt Delhotal. She testified Matt did not set anything up and told Petitioner that the instructor. She testified Matt was aware other employees were also operating PITO units with expired licenses.

She testified the PITO is used every day to carry packages from one part of the facility to another part of the facility. One can attach tubs as needed, up to 3. The tubs are used for packages over 75 pounds and packages considered irregular. She said anything under 75 pounds, push carts are used. Petitioner identified Px7 as depicting the bulk line, orange colored tubs used to pull packages and push carts. She testified this accurately depicted what a bulk line would have looked like on the morning in question.

On 10/2/15, Petitioner said she started work at 4:32 am and start time for that day was 5:30 am. She was performing bulk duties all 5 days worked. On cross, she agreed that although she clocked in at 4:32 am, she is not paid for work until 5:30 am. That day, she got onto the PITO, drove from across the break room and noticed carts she needed to set up her bulk line. She then used keys belonging to Carey Hall to use the PITO unit as she had never been given her own key. She was not aware borrowing keys was against policy or that

driving without a license is against policy. She stated that not all drivers have their own key and was told she could borrow keys.

She then drove up to the bulk line and noticed 2 additional tubs she needed. She explained usually 8 tubs on each side of the bulk line are required but that morning, she had only 6. I got back on unit and drove to look for tubs. In the first area located outside Outbound 1 Area she found no tubs. She continued to drive to see if other tubs were available. She testified tubs are not in any specific location but rather randomly located about the facility. She testified she must actively seek and look for carts.

Petitioner testified she then drove to the south side of the facility and she decided to purchase an order of fries because it was quick and convenient. She testified break times are allowed but it depends on how busy work is. She testified she has previously gone to the cafeteria to buy food while working, depending on how busy work is. She has eaten food while working and has observed others do the same. She testified she had never been reprimanded for going to the cafeteria to buy food prior to the incident in question.

She ordered the fries, returned to the PITO unit and drove toward entrance 2 to look for tubs but found none in that area. She then drove away, holding the fries in her left hand and operating the steering mechanism with the right. She attempted to make a left turn but the steering wheel got "stiff," causing her to make a sharp right turn, otherwise she would have ran into items located on the left. After she made the hard right turn, the PITO unit overturned, landing on her right leg. She testified she sustained injuries to the right leg. On cross, she testified this occurred between 4:40am and 4:42am. On cross, she disagreed that the unit flipped prior to the start of her shift. She agreed that at the time of the incident, she was not hauling tubs or packages. She further agreed that she was not instructed to drive that day but that she is also not told every day to do her job every day.

She testified she recalled her bones were broken and sticking out of her leg. Respondent's exhibit 3 depicts the actual event immediately following the PITO unit turning over. Rx3. Petitioner testified she was assisted by her co-workers and her supervisor, including Matt. An ambulance was called and Petitioner was transported to LaGrange Memorial Hospital.

Petitioner's Medical Treatment

Petitioner was taken by ambulance to LaGrange Hospital where she was diagnosed with an acute non-displaced fracture of the distal tibia and fibula and medial malleolus. Px3. Petitioner underwent and Dr. Erling Ho performed debridement of the wound, intramedullary rodding of the right tibia fracture and medial malleolus fracture and open reduction and internal fixation of the distal fibular fracture. Px3. Petitioner was in the hospital following surgery for several days and taken off of work indefinitely. Medical records noted the injury was work related. Petitioner followed up with Dr. Ho's offices, where medications were continued and Petitioner was ordered to remain off of work. There was discussion of transition from home exercise to outpatient physical therapy. Petitioner was given a walker to use in the interim. Petitioner received home nursing and therapy through Advocate Home Health for three weeks following the surgery. Px5. Petitioner is currently receiving orthopedic care from Dr. Ho at Orthopaedic Associates of Riverside. Px4. She is currently receiving out-patient therapy at the University of Chicago. Px4. Petitioner last followed up with Dr. Ho in January 2016 and was scheduled for follow up in March 2016. At that last visit, Petitioner was instructed to continue therapy with Universtiy of Chicago and to remain off of work.

Witness Testimony of Matt Delhotal

Matthew Delhotal ("Delhotal") testified on behalf of Respondent. He said he has been employed by Respondent for 16 years as full time supervisor. His duties include managing supervisors who in turn manage employees. On 10/2/15, he testified he was working and was returning from a meeting back into operations. Around 4:50 am, he was returning from meeting with Jason, Manuel and others. He testified he found Petitioner lying on her side. He saw a turned over PITO unit. He observed Petitioner's condition at that time and saw bones protruding through her skin. Rx3. He ran and called 911.

After the incident, he testified the entire area that works with PITO units was recertified and retrained. He then completed a write-up for this incident and he identified it as Rx1. On cross, he testified that only page 2 was his write up or summary. He testified he spoke with Shatara Patterson, a part-time supervisor, immediately after the incident. Delhotal said Patterson/Young told him she did not witness the accident. (T.68-69).

Delhotal testified Respondent records confirm Petitioner "badged in" at 3:06 am and her shift was scheduled to start at 5:30am. He did not know why she presented so early. Delhotal testified Petitioner flipped the PITO unit prior to her shift beginning. He testified that on the date in question, Petitioner was to work as a collection roller employee, whereby she would maintain packages from one belt to the next. This job did not involve driving a PITO unit.

Delhotal testified that he did not instruct Petitioner to drive the PITO unit on the date of her injury and had never seen her drive the unit previously. On cross, he stated he did not know Petitioner to be certified to use a PITO unit. When shown Petitioner's certification badge, used previously as demonstrative evidence, he testified on cross that she may have approached him for re-certification but that he never knew anyone to have expired certifications. Following the injury, Delhotal visited Petitioner at the hospital where he testified she told him the purpose of her using the PITO unit was to get fries.

Regarding random early starters, Delhotal testified that if employees are needed and available, then we ask them to set up areas for those who do not have a start time. Early starters do not use or operate PITO units unless certified. Petitioner may have asked him to be re-certified. Delhotal testified Petitioner has been a random early starter before.

On cross, Delhotal explained that a key card provides access inside the facility whereas the time card is swiped in and out and records time. He testified he was not aware Petitioner swiped in at 4:32am on the date in question but acknowledged he had previously seen Rx1, which showed Petitioner swiped in at Hub Com at 4:32am. When shown Px9, he agreed that Petitioner's time detail demonstrated fluctuating start and end times, depending upon need. For example, on 9/4/15, Petitioner swiped in at 4:05am but her start time would have been 5:30am. Delhotal testified it appeared she started early that day. On re-direct, Delhotal stated that even if Petitioner was a random early starter that day, she would have begun around 5:15am prior to the line start time.

Witness Testimony of Shatara Patterson/Young

Shatara Devon Young ("Patterson/Young") testified on behalf of Respondent. She said she was employed for 10 years and 11 months and that her current job title was that of part-time operations supervisor. His duties include supervising hourly employees and helping load packages onto trailers. On 10/2/15, Patterson/Young was coming through the building with a few minutes to spare to be at her job assignment. As she rushed past Outbound 1, she saw Petitioner come from direction of the primary, driving faster than normal and Petitioner tried to turn corner, hitting the pole and flipping over. Patterson/Young did not observe Petitioner

hauling tubs nor was anything attached to the PITO unit. Patterson/Young ran to Petitioner, offered aid and called 911. Following the incident, she completed a write-up. She identified her write up as part of Rx2. Patterson/Young testified she did not know Petitioner's start time and did not observe fries or food at the accident site. Patterson/Young further testified she knows who Delhotal is but that he did not interview her the day of the incident.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator concludes that Petitioner testified in a credible and forthright matter regarding her work, the circumstances before, during and after her injuries, her medical treatment and her current condition of ill-being. The Arbitrator notes Petitioner presented with the aid of a walker to trial.

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

a. Arising Out of

An injury *arises out of* one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Indus. Comm'n,* 167 Ill. 2d 385,393, 657 N.E. 2d 882 (1995). An injury sustained by an employee arises out of his employment if the employee at the time of the occurrence was performing acts he was instructed to perform by his employer, acts which he has a common law or statutory duty to perform while performing those duties for his employer or acts which the employee might reasonably be expected to perform incident to his assigned duties. *Howell Tractor & Equip. Co. v. Indus. Comm'n*, 78 Ill. 2d 567, 573, 403 N.E.2d 215 (1980). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Ill. Workers' Comp. Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523 (1st Dist. 2007).

The Arbitrator concludes Petitioner's accident arose out of her employment. There is a dispute as to whether Petitioner was working at the time of the accident. Evidence established that Petitioner was clocked in or "swiped in" as early as 4:32 am before the accident occurred. Rx1. Petitioner testified that she was early at work, having been selected as a random early starter and that part of those employment duties included using the PITO unit to gather tubs to the bulk line. Petitioner had been selected in the past as a random early starter. Petitioner said she could not recall who asked her to be a random early starter but records confirm she nonetheless began work at 4:32 am. Petitioner acknowledged on cross-examination that she is not paid for her work performed during this pre-shift or prep time. Despite Respondent's admission it does not pay its employees for this period of work performed for a benefit it clearly derived, this fact of non-payment does not equate to a claimant being off duty where the evidence demonstrates otherwise. Delhotal testified he did not know why Petitioner was at work early, that he did not ask her to be a random early starter and that he did not ask her to use a PITO unit. However, his testimony is contradicted by the fact that she began work before the start of the machines and Delhotal himself acknowledged that she had come in early to prep the bulk line. Rx1.

Thus, at the time of the accident, Petitioner was performing work for the employer as a random early starter to prep the bulk line; specifically looking for tubs to attach to the PITO unit to take to the bulk line.

These duties were being performed *after* she had already bought food. Petitioner also testified that she was forced to make a sharp turn when the steering wheel became stiff. These two facts together demonstrate employment-related risks undertaken by Petitioner at the time of her injuries, which occurred on Respondent's premises and using Respondent's equipment.

Respondent asserts that Petitioner's job duties on the date in question were that of a collection roller and therefore any risk associated with her accident was not related to the employment to which she was assigned to perform that day. Respondent relies on Delhotal's testimony in this regard. Petitioner credibly testified that she was hired to work both the collection roller area and bulk line area. Respondent does not dispute this. Petitioner explained that a collection roller usually starts at "start time" and those duties include sorting packages. That job is stationary and does not require the use of a PITO unit nor does it require one to gather tubs. The bulk line job, on the other hand, can require the use of a PITO unit and can require an employee to gather empty tubs to be placed at the bulk line for use once the start time begins. Petitioner's testimony is supported by Delhotal's testimony, who also testified bulk line workers use PITO units. Petitioner also testified that random early starters use PITO units to prep the bulk line. She had been a random early starter in the past and had used PITO units in the past. See also, Px9. Petitioner credibly testified that on the date in question, she was scheduled to work as a random early starter to prep the bulk line after which she was then scheduled to work her other duties as collection roller. Delhotal acknowledged this fact when he wrote "Cody comes in 10mins [sic] early to help pull off bulk prior to her going onto the collection rollers." Rx1. Even if Petitioner was, as Respondent suggests, scheduled only as a collection roller that day, Respondent knew of and allowed Petitioner to perform work for which it has previously admitted it does not pay its employees to do despite the benefit derived.

Finally, Respondent also asserts that Petitioner was in violation of a safety rule such that her actions constituted a personal risk for which her injuries cannot be said to have arisen out of her employment. In support thereof, Respondent presented evidence that Petitioner's certification to operate the PITO unit was expired at the time of the accident and had been so expired for over one year. Petitioner did not deny that her certification was expired and explained that she attempted on prior occasion to obtain re-certification, having asked Delhotal. She also testified that Delhotal was aware that others were operating PITO units without certification. Delhotal testified that he did not know anyone without certification operating a PITO unit and said that driving a PITO unit without certification was a disciplinary offense. He agreed that Petitioner may have approached him previously to become re-certified. The Arbitrator has weighed the competing testimonial evidence on this issue and finds Delhotal's testimony is not credible and is therefore entitled to less weight. Having had an opportunity to observe the witnesses, the Arbitrator notes Delhotal's testimony on this issue waffled and he did not appear certain. Petitioner, on the other hand, was unequivocal and express in her testimony that Delhotal knew PITO units were being operated by employees with expired certifications. Petitioner's testimony is supported by the fact that following her accident, Delhotal admitted that the very next thing he did was to re-certify everyone to operate PITO units. In the Arbitrator's view, it would appear most perplexing that Delhotal corrected a fact he claimed to know nothing about. The Arbitrator also notes that although Delhotal said operating a PITO unit on expired certification was a rule violation, Delhotal never disciplined Petitioner for this alleged violation at any point leading up to trial. See also, Rx1. Therefore, to the extent such a rule existed, Delhotal's testimony is not credible that it was actually enforced and evidence suggest Respondent allowed individuals to operate these units without current certification to its benefit. The Arbitrator rejects this argument and finds Petitioner's accident arose out of her employment.

a. In the course of

An injury occurs "in the course of" the employment when it occurs within the period of employment, at a place where the claimant may reasonably be in performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto.

As previously mentioned, Respondent asserts, in part, that Petitioner's accident was not in the course of her employment as she was not asked to be at work early, was not asked to be a random early starter nor asked to operate a PITO unit. Respondent also asserts violation of a safety rule such that Petitioner was not in the course of her employment. The Arbitrator rejects these arguments for the same reasons stated above; evidence shows Respondent was aware Petitioner was at work early to start as a random early starter and derived a benefit from that. Rx1. Further, evidence suggests Respondent allowed the rule violations to occur, derived a benefit from same, later attempted to correct the fact that its employees were not current in certification and did not enforce this rule against Petitioner. *Saunders v. Indus. Comm'n*, 301 Ill. App. 3d 643, 705 N.E.2d 103 (2d Dist. 1998).

Respondent also argues Petitioner was not engaged in an act of personal comfort as it was done in an unreasonable manner and therefore she was not in the course of her employment. It is well established that employees are allowed to engage in personal acts necessary to their health and personal comfort. If they are injured *while performing* these acts, their accident is not deemed to be outside the course of their employment. *Schipper v. State of Illinois*, 15 IWCC 0573 (Jul. 23, 2015) (Emphasis added). Evidence established that Petitioner had already swiped in and because she did not know if and when she would get a break, she decided to purchase fries. She testified they are allowed breaks but the Arbitrator notes the breaks do not appear to be consistent. The Arbitrator finds that Petitioner purchasing an order of French fries at Respondent's cafe constituted an act of personal comfort as contemplated under the rule. However, Respondent is correct that Petitioner was not engaged in any act of personal comfort, as the act ended and was otherwise completed when by the time of her accident. After buying fries, evidence established that Petitioner elated the PITO unit once again and began looking for tubs to attach to the PITO unit. She found none and decided to drive back to her work area. She was injured when the PITO's steering wheel became stiff, causing her to make a sharp turn at which time she was injured. In this regard, the purchasing of the French fries is nothing more than a red herring. She was not injured while purchasing the fries. The sequence of events demonstrates Petitioner was still in the course of her employment and her injuries occurred at a time and place she would reasonably be expected to be; that of using the PITO unit to collect tubs. For the foregoing reasons, the Arbitrator finds that Petitioner's accident arose out of and in the course of her employment with Respondent.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same. Having resolved the disputed issue of accident in favor of Petitioner, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence she provided timely notice of the accident to Respondent.

There was conflicting testimonial evidence as to whether anyone actually witnessed the accident occur. Young, a part time supervisor on duty that day, testified she saw Petitioner driving faster than normal and that Petitioner tried to turn a corner, hit a pole and flipped over. Young testified she completed an incident report, introduced as Rx2. The Arbitrator notes that at the time Young drafted the document, she used the last name Patterson and these individuals are one in the same. Patterson/Young testified Delhotal never interviewed her. Delhotal's documentation, however, suggests that he did interview her. Rx1. Delhotal even testified he spoke with Patterson/Young, who told him she did not witness the accident. (T.68-69).

Patterson/Young's recollection that Petitioner struck a poll is also at odds with Petitioner's more credible testimony, who did not describe hitting a pole but rather stated that she attempted to turn left, the steering wheel locked or stiffened, forcing her to make a sharp right turn, causing the PITO to flip over.

In summary, for notice purposes, the Arbitrator is not persuaded that the accident was actually witnessed by anyone and therefore finds Delhotal's and Patterson/Young's testimony not credible in this regard. Having found no one witnessed the accident, the evidence still establishes that Respondent had actual notice based on Delhotal arriving at the scene, completing an investigation and then completing his incident report. Delhotal's testimony that Petitioner confessed to him at the emergency room that the used the PITO unit to purchase fries is also entitled to less weight in light of the Arbitrator's findings and conclusions of law on the foregoing issues.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same. Having resolved the foregoing disputed issues in favor of Petitioner, the Arbitrator further concludes that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being for the right ankle is causally related to her work accident. Petitioner had no prior injuries or problems to the right ankle immediately before the accident. Petitioner testified she injured her right ankle when the PITO unit flipped over onto her right leg. Photographic and testimonial evidence supports such an injury occurring. Petitioner's medical treatment records further support an injury to the right ankle following the accident. Respondent presented no medical opinion contrary to the conclusion reached by the Arbitrator. Therefore, under a chain of events theory, the Arbitrator finds Petitioner's current condition of ill-being causally related to her 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?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same. Having resolved the foregoing disputed issues in favor of Petitioner, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her medical treatment for the right ankle to date has been both reasonable and necessary and that Respondent has not yet paid all appropriate charges for same. Petitioner alleged outstanding medical bills for Adventist LaGrange Hospital, Orthopaedic Associates of Riverside and Advocate Home Health. Ax1. The Arbitrator notes the following unpaid medical bills:

Px3	Adventist LaGrange/Neil Greene	$58,971.32
Px4	Orthopaedic Associates of Riverside	$21,073.00
Px5	Advocate Home Health Service	$3,648.20
TOTAL		**$82,692.52**

Records confirm that the above outstanding medical bills correspond to treatment rendered in connection with Petitioner's right ankle injuries stated herein. The Arbitrator notes that Petitioner's medical records suggest payment by Blue Cross Blue Shield. At trial, it was not discussed whether such payments represent group medical payments for which a credit may be appropriate. Nevertheless, the Arbitrator finds that Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$82,692.52**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of for medical benefits that have been paid and

17IWCC0550

Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same. Having resolved the foregoing disputed issues in favor of Petitioner, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to temporary total disability (TTD) benefits for the time period lost from work as a result of her injuries.

The medical evidence established that during the period sought, Petitioner was either off of work or on light duty disability per doctor order. Respondent presented no contrary evidence on this issue as its primary defense was based on accident. Thus, the unrebutted medical evidence demonstrates that Petitioner's condition of ill-being relative to the right ankle has not yet reached a state of permanency and that she has not otherwise been determined to be a maximum medical improvement. Respondent shall pay temporary total disability benefits of **$276.97** per week for **15-6/7th weeks** commencing **10/2/15** through **1/20/16** as provided in Section 8(b) of the Act because the injuries sustained caused the disabling condition of the Petitioner and such disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

ISSUE (K) Is Petitioner entitled to any prospective medical care?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies on same. Having resolved the foregoing disputed issues in favor of Petitioner, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she is entitled to prospective medical care. Respondent shall pay for and authorize the medical treatment as recommended by Dr. Erling Ho. Px4.

Signature of Arbitrator

4-4-2016
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jon Pichon,

Petitioner,

17IWCC0580

vs.

NO: 15WC 34103

Woodworth & Sons,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2017 is hereby affirmed and adopted.

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

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

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

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

DATED: SEP 25 2017
KWL/jrc
O-08/15/17
042

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0580

PICHON, JON
Employee/Petitioner

Case# **15WC034103**

WOODWORTH & SONS
Employer/Respondent

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:

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

3150 JAMES M KELLY LAW FIRM
BRETT D KOLDITZ
4801 N PROSPECT RD
PEORIA HEIGHTS, IL 61616

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0580

JON PICHON
Employee/Petitioner

v.

WOODWORTH & SONS
Employer/Respondent

Case # 15 WC 34103

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 **Springfield,** 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. ☐ 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 2, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,841.45**; the average weekly wage was **$1,327.26**.

On the date of accident, Petitioner was **58** 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 **$46,168.19 in benefits paid to August 31, 2016** for TTD, $- for TPD, $- for maintenance, and **$97,026.09** for other benefits, for a total credit of **$any amounts paid**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$128,821.36**, as provided in § 8(a) and § 8.2 of the Act.

Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit, pursuant to § 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$884.84**/week for further period of 6 2/7 weeks, as provided in Section 8(b) of the Act, for Petitioner's period of disability from **August 31, 2016,** through October 13, **2016**. Respondent shall pay the Petitioner maintenance benefits at the same rate from October 14, 2016 through November 23, 2016, a period of 5 6/7 weeks, November 23 having been the date of arbitration.

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.

17IWCC0580

D. Dylan McCarthy

Signature of Arbitrator

12-29-2016
Date

ICArbDec19(b)

JAN 6 - 2017

FACTS

Petitioner has been an over-the-road semi-tractor trailer/oil tanker driver for 35 years. (T.11) He began working after graduating 8th grade, first pumping gas and then driving a truck for a furniture company. (T.11-12)

The Parties stipulated that Petitioner sustained an accident arising out of the course and scope of his employment on September 2, 2015, when, while putting a trailer in the dock and exchanging a non-functional jack stand with a jack stand from another trailer, the jack stand jerked out of his hand, crushed his toe, and caused him to fall on his right side. (T.13; AX1) Respondent does not dispute that Petitioner sustained accidental injuries to his right shoulder and great toe, but disputes causation with regard to Petitioner's cervical spine, the need for additional treatment related to the cervical spine and the temporary total disability arising therefrom. (AX1)

Following the accident, Respondent took Petitioner back to its facility and then to Carle Foundation Hospital in Urbana. (T.13-14; PX3, 9/2/15) While there, Petitioner gave the history as follows:

> While at work as a mechanic, a stainless steel floor jack weighing about 50 pounds landed on his right great toe. He was not wearing steel toed shoes. Also, upon injuring himself, he fell to the side and jarred his neck. He is complaining of pain in the right neck area without radiation to the right upper extremity. *Id.*

A later progress note taken by the nurse during the same visit indicates:

> Jack stand pulled out from under the truck. The stand fell and landed on his Right foot he then fell landed on his right arm [sic]. He states he feels stiff and that he has numbness in all 5 of his fingers. Updating tetanus status. *Id.*

Petitioner was referred by his employer to the Carle Clinic Occupational Medical Physicians for attention to his toe. (PX4) There he was seen by Dr. Logsdon, a podiatrist who diagnosed him with crushing injury to his right hallux. (PX4, 9/3/15) Petitioner was given narcotic pain medication and a walking boot. *Id.* When x-rays revealed a comminuted fracture of his right hallux, surgery was done by Dr. Sarah Anderson on September 11, 2015. (PX4, 9/11/15) She avulsed the nail, removed the hematoma to the level of the bone, and debrided necrotic tissue which had formed as a result of the crush injury. *Id.* Following surgery, Petitioner was given more narcotic pain medication and put in a boot. *Id.*; (PX4, 9/14/15)

During the time he was seen and Carle Clinic, the records repeatedly reflect that Petitioner continued to suffer from shoulder and neck symptoms. (PX4, 9/8/15; PX5, 9/17/15) On September 17, 2015, Petitioner was referred for physical therapy to his neck. (PX5, 9/17/15) The history taken at Respondent's physical therapy facility reads as follows:

> Pt stated that he was pulling atraylor [sic] jack and it flipped over and landed on his toe and he fell back and his neck and shoulder got tighter and tighter and now is getting

> headaches with this as well [sic]. soreness and tightness right lateral neck and into upper trap and to right temple at times [sic]. headaches comes and goes . [sic]. morning is the worst for the headaches [sic]. (PX5, 9/17/15)

The closing physical therapy note indicated that Petitioner, while progressing, was still having tightness in his neck and right shoulder as well as decreased strength and increased pain in his right shoulder:

> JON was seen today for an outpatient PT visit at: Carle Therapy Services in Danville. Pt. stated that his neck is tight in the mornings and has to keep stretching but is improved. shoulder [sic] ROM is better but still has the ant right shoulder pain. (PX5, 10/27/15)

Physical therapy was put on hold for further physician recommendations. *Id.*

On November 9, 2015, Petitioner was seen by Danny McFarlin, a physician's assistant for the Carle Clinic Orthopedic Department, on referral from the Occupational Medicine Department. (PX4, 11/9/15) He noted that Petitioner was still having pain primarily over the anterior portion of the shoulder, along with significant neck pain and stiffness. *Id.* He noted that for these, Petitioner was taking Ibuprofen and engaging in physical therapy, but without significant improvement. *Id.* Petitioner's examination was markedly positive for limited range of motion, stiffness, and significant pain. *Id.* X-rays showed minimal arthritis at the AC joint. *Id.* P.A. McFarlin recommended an MRI and Prednisone "more for the neck rather than the shoulder." *Id.* Cervical x-rays were also viewed and showed spurring and C6-7 and loss of cervical lordosis; however, it was noted that Petitioner had no prior problems with either his neck or right shoulder. *Id.* The plan was as follows:

> I would be concerned about his inability to move the arm and the weakness that he has. I think and MRI would be warranted for this patient. I am also going to give him around [sic] of Prednisone, more for the neck rather than for the shoulder. I did review his neck x-ray. He has significant spurring at C6-C7 with near bridging anteriorly with joint space narrowing. There are also some changes of the cervical lordosis at the lower portion of the cervical spine, so we have some arthritic changes of the neck, but he states that he had no problems previously. Certainly I think he has exacerbated the problem with this fall. We are going to see if the Prednisone does not help. Hopefully it will help the shoulder as well as the neck. We are going to start with 60 mg daily for 3 days, go down to 40 mg for 3 days, 30 for 3 days, 20 for 3 days, 10 for 3 days, and 5 for 3 days. I have discussed the side effects of the medication. I will see if we can get the MRI done for him. He can add Tylenol or Hydrocodone if needed for pain. Ice or heat may be effective for the shoulder. I would recommend heat for the neck and the upper back. *Id.*

On November 13, 2015, Petitioner sought treatment on his own for the first time when he saw Dr. Nathan Mall, an orthopedist. (PX6, 11/13/15) Dr. Mall took the history of the injury, noted that Petitioner had significant objective findings on clinical examination, diagnosed a possible rotator cuff/superior labral tear, and recommended a right shoulder MRI as well as a cervical spine MRI.

An MRI was performed on December 1, 2015, and read by Dr. Dusek of MRI Partners of Chesterfield, Missouri. (PX 7) His interpretation of the cervical study was annular bulge with disc/oteophyte complexes contributing to sever bilateral neural foraminal exit stenosis at C2-3; a similar finding at C3-4 and disc/osteophyte complexes at C6-7 contributing to mild bilateral neural foraminal exit stenosis.

On December 1, 2015, Dr. Mall noted that the shoulder MRI was markedly positive, demonstrating a labral tear along with AC joint inflammation. (PX6, 12/1/15) In addition, he believed the MRI of the cervical spine demonstrated disc pathology and he recommended that Petitioner see Dr. Matthew Gornet. *Id.* For Petitioner's shoulder, Dr. Mall proceeded with a diagnostic/therapeutic injection into the AC and glenohumeral joint. *Id.* This was done and Petitioner's symptoms substantially improved for two weeks. (PX6, 12/30/15) When Petitioner returned to Dr. Mall on December 30, 2015, and reported the recurrence of his right shoulder pain, Dr. Mall noted positive objective findings on examination and continued symptoms:

> Today he has a positive O'Brien's test to the right shoulder. He has 5-/5 strength in the supraspinatus and infraspinatus and 5-/5 strength in the subscapularis on the right side compared with 5/5 on the left side. He continues to have some pain to palpation over the AC joint and pain with cross-body adduction. *Id.*

Dr. Mall recommended surgery on Petitioner's right shoulder. *Id.*

Surgery was done on February 25, 2016, and during same, Dr. Mall was rewarded with objective findings of a right shoulder superior labral tear along with AC joint arthrosis, subacromial impingement, and extensive synovitis. (PX11) These were repaired as described in the operative report and Petitioner's right shoulder condition improved. (PX11; PX6, 3/9/16) Physical therapy following right shoulder surgery improved Petitioner's shoulder condition further, and he candidly acknowledged same at Arbitration. (T.17)

In regard to his cervical spine, Petitioner first saw Dr. Gornet on January 18, 2016. (PX8, 1/18/16) Dr. Gornet also took the history of the injury and also noted Petitioner had no previous problems of significance with either his neck or shoulder. *Id.* Petitioner consistently reported to Dr. Gornet as he did to Respondent's physicians at Carle Clinic that he had right arm pain but no left arm pain and occasional numbness/deadness/tingling into his arm. *Id.* Dr. Gornet's examination showed mild decrease in biceps tendon on the right at C4-5 and decreased sensation in C6 dermatome on the right. *Id.* Dr. Gornet reviewed the MRI of 12-01-15 and agreed that it showed a small disc protrusion at C5-6 along with a lesser protrusion at C6-7. *Id.* There was a bilateral lobular disc herniation at C3-4, which was causing foraminal stenosis, and in addition, an annular tear at C4-5 with central herniations at C2-3 and C3-4. *Id.* In his impression/plan Dr. Gornet stated:

> I have discussed with Mr. Pichon that I believe he has a multilevel problem and this I am sure accounts for his continued neck pain and headaches. Our working diagnosis is disc

> injury at C3-4 and C6-7 with aggravation of preexisting foraminal stenosis at C3-4 and C6-7. My recommendation for him would be a steroid injection at C6-7 and I have referred him to Dr. Granberg. If he is not improved, our recommendation would be a CT myelogram to evaluate his facet joints. I will see him back in six weeks' time. At this point, I believe he is capable of working light duty with no commercial driving and no lifting greater than 20 pounds, no overhead work. Based on the information I have, I do believe the patient's current symptoms are causally connected to his work related accident as described. *Id.*

Petitioner returned to see Dr. Gornet after the injections with Dr. Granberg. (PX8, 3/31/16) He told they had given him only limited relief. *Id.* Dr. Gornet continued to believe that Petitioner had aggravated his underlying degenerative condition in his cervical spine and sustained new disc injuries and annular tears. *Id.* Given the fact that he failed injections, Dr. Gornet recommended surgery. *Id.*

On Petitioner's follow-up visit on July 14, 2016, Petitioner returned with a copy of a report he'd received from Respondent's examining physician, Dr. Petkovich. (PX8, 7/14/16) Dr. Petkovich opined that while Petitioner injured his shoulder and required surgery, he sustained only a cervical strain and should have recovered after 6 to 8 weeks. *Id.* Dr. Gornet noted that Petitioner had tried and failed conservative treatment and that he continued to believe that Petitioner's next best option would be disc replacement surgery at C3-4 and C6-7. *Id.* In order to identify certain specific levels which needed to be treated, Dr. Gornet recommended a CT Myelogram. *Id.* This was done on August 1, 2016, and showed that Petitioner had a fusion at C4-5 with narrowing of his foramen on the right at C2-3 and C3-4. (PX8, 8/1/16; PX12) In addition, Petitioner had pathology in the form of a right-sided disc herniation at C3-4 and osteophytes at C3-4 and C6-7. *Id.* After reviewing the CT Myelogram, Dr. Gornet believed that surgery now would not help Petitioner, as the risk of non-union was great. (PX8, 8/1/16) Instead, Dr. Gornet recommended rhizotomies at C2-3 and C3-4 on the right. *Id.*

Petitioner returned on October 13, 2016, with continued neck pain and headaches. (PX8, 10/13/16) While the rhizotomies helped, they did not resolve all of Petitioner's problems. *Id.* Dr. Gornet believed that Petitioner had reached maximum medical improvement and that he would have permanent restrictions of no lifting greater than 20 pounds and no overhead work, and he did not believe Petitioner could return to commercial driving. *Id.*

Dr. Gornet also testified by way of Deposition taken on September 29, 2016. (PX14) Dr. Gornet is a board certified orthopedic surgeon who specializes in treatment and surgery of the cervical spine. (PX14, p.4) He sees approximately 120 patients a week and performs 5 to 10 operations per week. *Id.* at 4. After testifying to Petitioner's lack of cervical problems prior to his accidental injury, Dr. Gornet testified that Petitioner's objective findings of decreased biceps on the right and decreased sensation at C6 dermatome on the right indicated a nerve root problem at C6 and possibly C7. *Id.* at 9-11. He also testified that Petitioner has a potential problem in the cervical

spine localizing to C5-6 versus C6-7. *Id.* at 10-11. He further noted that Petitioner's subjective complaints of trapezial pain correlated with his pathology at his C3-4 level. *Id.* at 11.

When Dr. Gornet reviewed Petitioner's x-rays that showed an ankylosed or spontaneous fused segment at C4-5, and the MRI that showed disc protrusion at C5-6 and C6-7, disc herniation at C3-4 and annular tearing at C4-5, he believed Petitioner injured his disc at C3-4 and C6-7 as well as aggravated some preexisting foraminal stenosis at those levels. 11-13. Dr. Gornet stated that Petitioner's physical trauma sparked the inflammation around Petitioner's bone spur which further narrowed the preexisting narrow condition, creating a "vicious cycle." *Id.* at 13. He stated:

> Well, we know that if he has a bone spur, that is something that preceded the accident that was not caused by the accident itself. But we also know that when you have narrowing of the nerve channel, if you have a sudden mechanical load, that can cause that bone spur to compress the nerve.
>
> Generally when there's an injury, there's swelling that occurs with that, and swelling in the face of an area that's already narrowed creates more nerve or microtrauma, and it creates this vicious cycle that starts as a direct result of the trauma, even though the narrowing was there beforehand. And it is the cycle of inflammation and irritation that we're trying to stop. And so that is the actual condition.
>
> The anatomic status of the foraminal stenosis was clearly there, but it was not producing a condition of abnormality in that particular individual. Now the anatomic condition of foraminal stenosis in conjunction with the microtrauma that occurred creates a scenario where the patient is symptomatic and remains symptomatic, and that's what we're trying to really deal with. *Id.* at 13-14.

Dr. Gornet testified to his opinion that Petitioner sustained both disc injury and aggravation of his preexisting spinal condition:

> I believe it did cause an injury to the disc mechanism. We clearly see an objective herniation, but I also believe, again, there is some preexisting foraminal stenosis which was aggravated.
>
> . . .
>
> The basis for that opinion is, one, the objective tests; two, the correlation with his physical examination; three, the correlation with his subjective complaints; four, my experience in dealing with like or similar patients; five, the published medical literature, including our recent publications in the Journal of Bone and Joint surgery discussing treatment of the cervical spine in injured workers. All of that is what I based my opinions on. *Id.* at 14.

Dr. Gornet further testified that the fact that Petitioner was asymptomatic prior to the accidental injury furthered his causation opinion. *Id.* at 14-15. He stated, "[T]here is no confounding variable that could cause us to not believe that the accident played a role in his current symptoms." *Id.* at 15. He testified that there is no evidence that Petitioner's condition was simply

a cervical strain, as Petitioner's condition persists and he has not improved; nor was there evidence that Petitioner's condition was due to degeneration, as Petitioner was entirely asymptomatic prior to the accidental injury. (T.19-21)

Dr. Petkovich, Respondent's examiner, also testified by way of deposition. (RX2) Dr. Petkovich testified that he is a general orthopedic surgeon, with only part of his practice being focused on treatment of the cervical spine. (RX2, p.6-7) Dr. Petkovich acknowledged that Petitioner made complaints regarding his cervical spine when he was initially treated at Carle Clinic. *Id.* at 10-11. He testified, however, that his physical examination of Petitioner was "normal," despite Petitioner's report of discomfort on range of motion and tenderness to palpation in the right paraspinous cervical areas. *Id.* at 12-13. He attributed Petitioner's condition to a resolved strain and chronic degeneration, and did not believe the incident on September 2, 2015, caused any aggravation or acceleration of Petitioner's condition. *Id.* at 15. He testified that Petitioner "never had any radicular symptoms and never had any shooting extremity pain," characterized all of Petitioner's complaints as axial, and thus believed there was no need for injections. *Id.* at 18. He acknowledged, however, that Petitioner's shoulder surgery was appropriate, but he did not believe any further treatment was indicated for Petitioner's cervical spine beyond Petitioner's last visit with Dr. Cohen. *Id.* at 18-20.

On cross-examination, Dr. Petkovich testified that he has not performed any spine surgery over the last 4 to 5 years. *Id.* at 21-22. Dr. Petkovich denied awareness of who paid for his services, but acknowledged that his report was addressed to counsel for Respondent. *Id.* at 24-25 Dr. Petkovich admitted that there was no record of prior neck pain or symptoms or diagnostic tests before September 2, 2015. *Id.* at 35-36. There was no prior recommendation for injections or surgery before September 2, 2015. *Id.* at 36. He acknowledged that these facts were supported by the records, and Petitioner's intake questionnaire. *Id.* at 36-37. Although he testified on direct examination that Petitioner had no radicular symptoms, on cross-examination, he was presented with a record detailing tingling down Petitioner's right arm into his hand with numbness and weakness. *Id.* at 37-38. Dr. Petkovich acknowledged that these was a radicular symptoms, but stated in rebuttal that these were not present when Petitioner was seen by Dr. Cohen or when Petitioner presented for his independent medical evaluation. *Id.* at 38-39.

Dr. Petkovich acknowledged that Dr. Cohen recommended that Petitioner have an MRI of his cervical spine and see a specialist for his shoulder. *Id.* at 42. Even though there was no prior MRI film to compare Petitioner's cervical spine MRI to, he believed that there was no evidence of acute injury to Petitioner's spine as a result of his accidental injury. *Id.* at 45. He disagreed with the findings of disc herniations with annular tears at several levels in the cervical spine on Petitioner's MRI films, as interpreted by Dr. Gornet. *Id.* at 46. He believed Petitioner's cervical strain would have resolved within 6 weeks of the injury and Petitioner would have been at maximum medical improvement at that time, even though Dr. Cohen was recommending a cervical spine MRI beyond that period of time. *Id.* at 49-51.

Despite the fact that Petitioner was symptom free before the accident, he believed Petitioner's exacerbation was by definition temporary and that he returned to baseline, even though Petitioner is not symptom-free as he was before the accidental injury. *Id.* at 52-54. Although he agreed Petitioner's shoulder injury and treatment was related to the injury and reasonable, and he made no mention of Petitioner being a malingerer or him exaggerating his symptoms, he did not believe Petitioner's cervical spine care was necessary or related to the accidental injury, though he declined to use the term "unreasonable" in relation to same. *Id.* at 60-62. He concluded his opinion in his report by indicating that Petitioner sustained no impairment to his cervical spine. (RX1) In a supplemental report, he reiterated his opinion as to Petitioner's spine, and opined that Petitioner sustained 5% impairment of the right upper extremity for Petitioner's right shoulder. (RX3) He acknowledged during his deposition that if his diagnosis is incorrect, then the impairment rating, which is diagnosis based, would be incorrect. (RX2, p.66-67)

CONCLUSION

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

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill.App.3d 92, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 442 N.E.2d 908 (1982). A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the workers' compensation claimant's injury. *Shafer v. Illinois Workers' Comp. Comm'n,* 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011).

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007). Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 797 N.E.2d 665 (2003). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003). [Emphasis original]. "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 (3d Dist. 2000). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist., 1999) citing *General Electric Co. v. Industrial Comm'n*, 433

N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

Based on the foregoing law and the irrefutable evidence in the record, the Arbitrator finds that Petitioner met his burden of proof in establishing that his current condition of ill-being in his neck is causally connected to the undisputed accidental injury of September 2, 2015. The Arbitrator does so based on the facts below.

The Arbitrator does not find the opinion of Dr. Petkovich to be credible or supported by the record. Aside from the clear chain of events establishing that Petitioner had no neck complaints prior to the accidental injury but persistently experienced complaints afterward, the Arbitrator notes that he was ignorant of relevant facts in Petitioner's medical records. While he stated that Petitioner had no radicular complaints during his deposition, the record reflects the exact opposite. At Carle Clinic, a nurse noted, "He states he feels stiff and that he has numbness in all 5 of his fingers." (PX3, 9/2/15) Dr. Gornet also noted that Petitioner suffered occasional numbness/deadness/tingling into his arm. (PX8, 1/18/16)

Dr. Petkovich presented no credible evidence to support his opinion that Petitioner's condition is a strain that resolved in six weeks, when the physician's at Carle Clinic were recommending imaging studies of and prescription pain medication for Petitioner's spine beyond that point. Petitioner was recommended by Carle Clinic for a cervical spine MRI and was given prednisone "more for the neck than the shoulder" on November 9, 2015. (PX4, 11/9/15) Dr. Petkovich presented no credible evidence to support his opinion that Petitioner's condition is merely the result of degeneration, when Petitioner was asymptomatic before the injury. (PX4, 11/9/15; PX8, 1/18/16)

The Arbitrator relies on the causation opinions of Dr. Gornet, a spinal specialist whose practice is devoted to the care and treatment of the cervical spine. Dr. Gornet believed that Petitioner injured his disc at C3-4 and C6-7 as well as aggravated some preexisting foraminal stenosis at those levels. (PX14, p.11-13). Dr. Gornet noted that Petitioner had no prior treatment or symptoms in his cervical spine and that Petitioner's complaints have been consistent since the date of the injury.

The other medical evidence supports his opinion. Throughout his treatment with Dr. Cohen from September 2 through October 28, 2015, the Petitioner complained of right sided cervical pain. The doctor's examination findings included consistent limitation of cervical motion, and as of his last visit the doctor ordered ongoing physical therapy. When the Petitioner was examined by Danny McFarlin, a P.A. with Carle's Orthopedic Department on November 9, 2015, he showed decreased range of cervical motion and tenderness. Mr. McFarlin's diagnosis was an exacerbation of cervical arthritic changes as a result of his accident. He recommended the

Petitioner apply heat and take Prednisone. (PX 4) Dr. Mall's examinations of November 13 and December 1, 2015 produced similar findings. (PX 6) Dr. Gornet, who was treating the Petitioner specifically for his cervical problems, made consistent similar findings from his first visit of January 18, 2016 through his last visit in October 2016. (PX 8)

All of the evidence supports an unbroken chain of symptoms involving the cervical spine since the accident, and refutes Dr. Pekovitch's contention that the injury represented only a temporary exacerbation. As such, the Arbitrator finds that Petitioner met his burden of proof on establishing causal connection.

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

The Arbitrator finds Petitioner's care and treatment has been conservative and reasonable. Petitioner attempted to manage his cervical spine complaints through therapy, but these persisted. (PX5, 9/17/15, 10/27/15) Dr. Gornet recommended rhizotomies for Petitioner's persistent symptoms and ultimately, based on the significance and persistence of Petitioner's condition, placed Petitioner under permanent restrictions with regard to same. (PX8, 10/13/16)

Consequently, the Arbitrator hereby awards the medical expenses contained in Petitioner's group exhibit. Respondent shall be given credit for medical benefits that have been paid and 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 temporary benefits are in dispute? (Maintenance & TTD)

Having found for the Petitioner on the issue of causation, he is entitled to receive Temporary Total Disability benefits through October 13, 2016, when he was deemed to be at MMI by Dr. Gornet. As of that date, he was on permanent restrictions. He had not been released to work full duty since his accident date. Pursuant to Commission Rule 9110.10, which became effective on October 19, 2016, and its predecessor, Rule 7110.10, the Respondent is ordered to provide, with the Petitioner's input, a rehabilitation assessment. The Petitioner is entitled to receive maintenance benefits from the date of MMI through the date of arbitration.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINCOLN WHITAKER,

Petitioner,

vs. NO: 15 WC 34562

MENARD CORRECTIONAL CENTER,

Respondent.

17IWCC0559

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was hired by Respondent as a State employee in February 1996 as a Correctional Nurse II. He usually worked the 11p.m. to 7a.m. shift. He prepared medications by popping them out of a bubble card. Some medications required him to crush them with a hand crusher that had to be screwed tightly.

2. Petitioner's duties also included popping hundreds of bubble cards nightly, carrying medications, syringes and other equipment in a plastic container that had a handle in the center and a well on each side. When full, the container weighed seven to eight pounds. There was great torque required to carry the container (and to keep the medications separate from the sterile materials). Petitioner spent up to 4 hours per shift preparing

medications. He was not assisted by inmate helpers. He also handled files daily, pushed a cart weighing five to ten pounds up to five times daily, and when there were cell house emergencies, he carried a bag weighing twenty-five pounds up five flights of stairs.

3. Petitioner is left handed. He submitted a workers' compensation claim for left handed carpal tunnel syndrome in 2009. This claim was settled. His left-handed injury led to him overcompensating with his right hand, which developed his right-hand issues.

4. Petitioner complained of right hand symptoms on September 30, 2015.

5. Petitioner noticed symptoms in his right hand after his pill crushing and medication prepping decreased from 4 hours per shift to two to three hours per shift, but his handling and gripping of slippery files increased his right-hand pain as the files became heavier over the years. He pulled and handled files for two to two and-a-half hours daily.

6. Eventually, Petitioner began noticing severe numbness and pain in his right fingers. He continued working after filing an injury report and undergoing an EMG and nerve conduction study with Dr. Peeples. The nerve conduction study was performed very professionally, and Dr. Peeples took measurements beforehand.

7. Petitioner retired on April 1, 2016 due to his pain and sleep deprivation caused by his symptoms. He was eligible for retirement in February 2016 but delayed it for two months.

8. Petitioner eventually underwent surgery on his right hand and arm up to his elbow. The surgery helped his pain and numbness tremendously. However, he still suffers from right hand weakness.

9. Dr. Mall is an orthopedic surgeon who saw Petitioner September 30, 2015. He noted that an October 2009 nerve conduction study revealed no evidence of right median or right or left ulnar neuropathy. However, he noted that the October 2015 electrodiagnostic tests performed by Dr. Peeples revealed increased right sided latency in comparison to the 2009 tests. Dr. Peeples diagnosed significant carpal tunnel syndrome. He also noted that Petitioner had no non-work related risk factors related to carpal tunnel syndrome. Surgery was recommended.

10. Dr. Peeples opined that Petitioner's job duties could contribute to the development of carpal tunnel syndrome. Carrying a tote required elbow flexion, and Petitioner had to manipulate other items in his hand while carrying said tote. Petitioner also had to lock and unlock cell doors and dispense medications, which were wrist/hand intensive acts.

11. Dr. Peeples found no evidence of ulnar neuropathy.

12. Dr. Mall has witnessed popping pills out of bubble packs, which he states also can contribute to carpal tunnel if performed frequently. He opined that Petitioner's work duties were a causative factor in the development of his right hand carpal tunnel

syndrome.

13. Dr. Sudekum is a board certified upper extremity surgeon. He performed an Independent Medical Examination (IME) on Petitioner on December 15, 2015. Dr. Sudekum noted that his nerve conduction study performed revealed no objective evidence of significant upper extremity peripheral neuropathy.

14. Dr. Sudekum denied telling Petitioner that he had carpal tunnel syndrome. He acknowledged, however, that he may have told Petitioner that he had symptoms which could be consistent with carpal tunnel syndrome.

15. Petitioner testified that the IME nurse who performed the nerve conduction study on behalf of Dr. Sudekum did not take measurements beforehand, nor did she insert any needles into Petitioner before the exam. She simply placed some pads on his arm.

The Commission reverses in part and affirms in part the Arbitrator's finding of accident. The Commission views the evidence slightly different than the Arbitrator, and finds that there is enough objective evidence based on Petitioner's job duties and the opinions of Drs. Mall and Peeples to support Petitioner's claim for carpal tunnel syndrome. The Commission also took note of the fact that Dr. Sudekum relied upon Dr. Peeples' finding of no evidence of ulnar neuropathy, yet ignored Dr. Peeples' findings of median entrapment neuropathy at the right and left carpal tunnels.

The Commission affirms the Arbitrator's denial of accident in relation to Petitioner's claim for cubital tunnel syndrome.

In keeping with this ruling, the Commission also awards to Petitioner all reasonable and necessary medical expenses related to treatment for his right carpal tunnel syndrome.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has proved accident in relation to his right carpal tunnel syndrome.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,250.00 per week for a period of 20.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 10% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to his right carpal tunnel treatment under §8(a) of the Act.

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

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

17IWCC0559

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 11 2017
O: 7/13/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITAKER, LINCOLN
Employee/Petitioner

Case# **15WC034562**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

17IWCC0559

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:

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 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 MANGEMENT 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

JAN 6 - 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lincoln Whitaker
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # **15** WC **34562**

Consolidated cases: **N/A**

17IWCC0559

An *Application for Adjustment 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 **Mt. Vernon**, 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 _____

FINDINGS

On **August 23, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$108,331.81**; the average weekly wage was **$2,083.34**.

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

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

Respondent is entitled to a credit **for all amounts paid** for bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act as stipulated by the parties at the time of arbitration.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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

Melinda M. Pace-Sullivan

Signature of Arbitrator

1/2/17

Date

ICArbDec p. 2

JAN 6 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lincoln Whitaker
Employee/Petitioner

Case # 15 WC 34562

v.

Consolidated cases: N/A

State of Illinois/Menard Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he served as a Correctional Nurse II for 20 years, predominantly on the night shift. He testified that on his shift he prepared for "medication pass" or dispensing of medications for offenders. He testified that he had to pop most medication out of a "bubble card" while other medication had to be crushed with a hand crusher. He testified that this was a screw mechanism that had to be screwed tightly until the medication was crushed. He testified that for a time, some medication had to be "floated" or placed in water, meaning he had to carry water with medication. He testified that this was necessary because some offenders were "cheeking" their medication, or avoiding taking the medication by hiding it under their tongue.

Petitioner testified that he opened hundreds of bubble packages each night. He testified that this was an activity that required the use of both of his hands. He also testified that some packages were difficult to open because of tough backing and almost impossible to push out without tearing the back of the package first. He testified that he carried his medical supplies, including sharps and insulin syringes, in a tote that weighed approximately 7-8 pounds. He testified that the tote was hard to balance and that it required grip strength to carry it. He testified that when the facility was short-staffed he covered the entire institution and had to work overtime, and that during such times, he would walk over 10 miles per shift. He testified that he did not have inmate helpers. He further testified that many times he lifted patients and cared for patients alone.

Petitioner testified that he also served as a first responder to the cell houses. He testified that the response bag weighed 25 pounds. He testified that he carried his supplies throughout the cell houses, which had five flights of stairs to their top level. He further testified that he pulled medical files, and that this also required forceful gripping.

Petitioner testified that first began developing symptoms in his left dominant hand. He testified that filed a claim for carpal tunnel syndrome in 2009, which was settled. He testified that he underwent surgery which consisted of left carpal tunnel decompression with Dr. Brown. He testified that after the surgery, he returned to performing the same activities. He testified that, because of his left-sided injury, he began overcompensating with his right upper extremity. He testified that he thereafter began developing symptoms in his right upper extremity. He testified that he does not suffer from diabetes, gout, hypothyroidism, hypertension or obesity. He testified that he has hobbies of bee keeping, hunting, fishing and gardening.

Petitioner testified that he attempted to work through his symptoms, but Respondent's facility was poorly staffed and his symptoms progressed. He testified to difficulty with pulling medical files. He further testified that it was difficult to balance and carry his tote because it would "torque [his] wrist and arm" based on how much weight he had on either side of the tote. He testified that he could tell if he had too much weight on one side. He testified that he could not balance the tote because he refused to mingle his biohazard container with his sterile supplies.

Gayle Walls was called as a witness by Petitioner at the time of arbitration. She testified that she is employed by Respondent and that her job title is that of Health Care Unit Administrator. She testified that she knows and worked with Petitioner as his supervisor. She testified that nothing that Petitioner testified to was incorrect.

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. Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 30, 2015, at which time he reported right hand complaints including a complaint of a band-like feeling around his wrist, a feeling like his fingers were numb and any movement of his wrist out of neutral produced significant discomfort. It was noted that Petitioner had a wrist splint provided by the physician's assistant at his primary care physician's office for carpal tunnel complaints, which he wore for 8-9 months and helped. It was noted that the symptoms had been worsening more recently, that he had difficulty with gripping objects and that he had numbness and tingling at night as well as when driving. It was noted that Petitioner worked for Menard Correctional Center and worked in the cell house where he passed out medications and insulin injections, and that he spent about 1½ hours carrying a tote and popping out medications for inmates. It was noted that Petitioner also spent a lot of time doing paperwork and documentation of medications, preparing for his routes, that he had to pull files and do paperwork and that he estimated that the tote weighed about 5 pounds. It was noted that Petitioner also had to turn the large, heavy keys on multiple occasions as he was moving in and out of the cell house, and that he also had to use the keys a lot to lock up the medications. It was noted that Petitioner had prior left carpal tunnel surgery about 5 years ago. The assessment was that of right-sided carpal tunnel syndrome, and it was recommended that Petitioner use an ulnar nerve night brace and undergo and EMG/nerve conduction study for the right side to evaluate for carpal tunnel syndrome and cubital tunnel syndrome. The note further indicated that Petitioner had no significant risk factors for carpal tunnel syndrome or cubital tunnel syndrome, that he was not obese, that he did not have any diabetes or thyroid issues and that he did not have any outside activities that were potentially a cause of carpal tunnel syndrome. Dr. Mall noted that he believed Petitioner's work-related duties were only a causative factor, but the prevailing factor in the cause for him to become symptomatic in the right hand with carpal tunnel syndrome and cubital tunnel syndrome. A work slip was issued on that date, allowing Petitioner to return to work full duty effective October 1, 2015. (PX3).

The records of Dr. Mall reflect that Petitioner was seen on October 20, 2015 for continued complaints of right upper extremity symptoms which began with his employment and his job duties associated with Respondent. It was noted that Petitioner was present for EMG follow-up given his diagnosis of carpal tunnel syndrome and cubital tunnel syndrome on the right side. The assessment was noted to be that of right cubital and carpal tunnel syndrome. It was noted that Petitioner had failed conservative treatment. Petitioner was instructed to continue to use his cubital tunnel brace and carpal tunnel brace, and surgery was recommended. A work slip was issued on that date, allowing Petitioner to return to work full duty effective October 20, 2015. At the time of the November 24, 2015 visit, it was noted that Petitioner stated that the night splint helped him substantially for a period of time, and that he still had some numbness throughout the day. It was noted that Petitioner had been on vacation recently as well, which had improved his symptoms slightly. It was noted that Petitioner estimated that he turned 20-

30 locks per day. The assessment was that of right cubital and carpal tunnel syndrome, possibly mild left cubital tunnel syndrome. Petitioner was recommended to continue to wear the night brace, and it was noted that he had failed conservative treatment. A right carpal tunnel release and cubital tunnel decompression, possible transposition, was recommended. (PX3).

The records of Dr. Mall reflect that Petitioner was seen on January 5, 2016 with continued complaints of numbness and tingling in his ulnar distribution of the right upper extremity as well as median distribution in the right upper extremity and symptoms into the left upper extremity in the ulnar nerve distribution. It was noted that Petitioner recently underwent an IME. It was noted that on December 31, 2015, Petitioner was at work and one of the offender's back went out and they had difficulty lifting him. It was noted that Petitioner had to up against a wall when trying to transfer the patient and was pinned against the wall when he picked him up to turn him, which resulted in right shoulder blade pain and cervical spine pain and stiffness. It was noted that Petitioner admitted that he had had scapular pain in the past due to his carrying the basket in the right upper extremity but had never had cervical spine symptoms in the past, other than following this injury. The assessment was that of (1) right cubital and carpal tunnel syndrome, mild left cubital tunnel syndrome; (2) cervical strain and scapulothoracic bursitis. It was recommended that Petitioner undergo a cortisone injection to the scapulothoracic bursa and physical therapy for his cervical spine discomfort and stiffness. It was noted that Petitioner was recommended to undergo a carpal and cubital tunnel release with cubital tunnel decompression and possible transposition, depending on the stability of the ulnar nerve. A work slip was issued on that date, allowing Petitioner to return to work full duty effective January 5, 2016. (PX3).

The records of Dr. Mall reflect that Petitioner was seen on February 23, 2016 for his right upper extremity cubital and carpal tunnel syndrome as well as a cervical strain and scapulothoracic bursitis. It was noted that Petitioner stated that his cervical strain and scapulothoracic symptoms got substantially better after physical therapy and the injection that was performed at the last visit, but he still felt the numbness symptoms into his hand and right upper extremity. It was noted that Petitioner stated that when he had decreased activities because of his new injury in the right upper extremity that his numbness and tingling into the upper extremity also was better, but when he returned back to work full duty the symptoms returned. The assessment was that of (1) right cubital and carpal tunnel syndrome, mild left cubital tunnel syndrome; (2) cervical strain and scapulothoracic bursitis, improved. It was noted that Petitioner was placed at maximum medical improvement and full release as it related to his scapulothoracic bursitis and cervical strain, and that Dr. Mall continued to recommend right elbow ulnar nerve decompression ad possible transposition with right carpal tunnel release. At the time of the April 12, 2016 visit, it was noted that Petitioner stated that his symptoms had improved in the posterior aspect of his shoulder, that he had continued numbness and tingling in the right upper extremity and that he had minimal symptoms with the left side. The assessment was that of (1) right cubital and carpal tunnel syndrome; (2) mild left cubital. Petitioner was again recommended to undergo right carpal tunnel release and cubital decompression with possible transposition. (PX3).

The records of Dr. Mall reflect that Petitioner was seen on June 28, 2016, at which time it was noted that Petitioner continued to have numbness and tingling in his right upper extremity which had actually forced him to retire from his job as it was bothering him dramatically. The assessment was that of right carpal tunnel and right cubital tunnel syndrome. Petitioner was again recommended to undergo surgery. At the time of the July 26, 2016 visit, it was noted that Petitioner was being seen in follow-up of his right elbow and wrist carpal and cubital tunnel decompressions and ulnar nerve transposition and was doing well and had minimal complaints. The assessment was that of status post right carpal tunnel release and cubital tunnel decompressions with ulnar nerve transposition. It was noted that Petitioner was feeling better, that his hand felt better, that his numbness had resolved and that he was doing quite well. At the time of the August 23, 2016 visit, it was noted that Petitioner was doing remarkably well and was quite satisfied with his progress. Petitioner was recommended additional strengthening for the right upper

extremity for the next three weeks. At the time of the September 27, 2016 visit, it was noted that Petitioner was doing quite well, had minimal complaints and was back to basically doing all of his normal activities, and that his numbness and tingling had improved and was basically gone at that point. Petitioner was recommended to continue his home-based physical therapy, was released to full activity and placed at maximum medical improvement. (PX3).

The medical records of Dr. Peeples were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on October 20, 2015 for electrodiagnostic evaluation of right greater than left hand numbness and question of carpal and cubital tunnel syndromes. It was noted that Petitioner reported gradual onset of symptoms of right hand pain and numbness, described right much more prominent than left numbness and had no neck pain, characteristic radicular, myelopathic or generalized neuropathic symptoms. It was also noted that Petitioner had a left carpal tunnel decompression five years ago. It was noted that the impression/diagnosis was that of electrodiagnostic findings for a median entrapment neuropathy at the right and left carpal tunnel; no evidence for a right or left ulnar neuropathy. (PX4).

The medical records of Mercy Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent x-rays of the right hand on September 30, 2015 which were interpreted as revealing no identifiable bone abnormalities. (PX5).

The medical records of Orthopedic and Ambulatory Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent a right carpal tunnel release and cubital tunnel decompression with ulnar nerve transposition on July 21, 2016 for a pre- and post-operative diagnosis of right carpal and carpal tunnel syndrome. (PX6).

The medical records of Rehab Unlimited – Murphysboro were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent occupational therapy for the timeframe of August 5, 2016 through September 16, 2016. (PX7).

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Illinois Form 45: Employer's First Report of Injury was dated September 22, 2015 and noted a date of accident of August 23, 2015. It was noted that the accident occurred with "repetitive motion: carrying carpenters box w/syringes and medications in it; carrying it around with 3 fingers usually because also carrying around envelopes; strain on wrist; pulling medical files; pushing meds out of blister packets." The Workers' Compensation Employee's Notice of Injury was dated September 22, 2015 and noted that Petitioner reported the accident to his supervisor, Gail Walls, on August 23, 2016 [*sic*]. It was noted that the duties Petitioner was performing at the time of injury was that of repetitive use of the right hand, wrist and arm performing setting up of medications and carrying medication caddy. When asked to describe how the injury occurred, Petitioner indicated popping out pills to set up offender medications and carrying medication caddy in cell houses, as well as pulling medical files for 2-3 hours every night. The Supervisor's Report of Injury or Illness completed by Gail Walls on September 22, 2015 noted that Petitioner gave written notice on that date and that Petitioner's description of accident/incident was that of repetitive use of the right hand and wrist/arm while setting up medications and carrying the medication caddy. (PX8).

The Work History Timeline was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Timeline reflects that Petitioner indicated that on a shift the three areas that he may be assigned to included infirmary, medication pass in the cell houses and first aid. The Detailed Job Description references that Petitioner lifts 7-8 pounds daily for 2-3 hours, and that he pulls and refiles medical file folders for approximately 2 hours per shift. The Detailed Job Description also indicates that Petitioner carries the medication tote for 2-3 hours per shift, pulls medical files for 2 hours per shift and grips medication blister cards for 2 hours per shift. (PX9).

The Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The Client's Written Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The Job Duties description was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The description as prepared by Petitioner referenced, among other things, the tasks of routinely reviewing records to assure that they were complete in detail and scope and ensuring medications were properly charted and records of nursing care and patient treatment and observations were maintained, as well as providing direct patient care as needed such as treatment and administering DOT medications and performing patient assessments, assisting physicians and transcribing orders and making infirmary and cell house rounds. (PX12).

The Corrections Nurse Class Specifications were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The March 23, 2006 Position Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The March 29, 2011 Position Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The February 18, 2011 Demands of the Job was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The May 13, 2011 Demands of the Job was entered into evidence at the time of arbitration as Petitioner's Exhibit 17.

The December 2, 2009 and December 22, 2009 Settlement Contract was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The Settlement Contract Lump Sum Petition and Order for Case Numbers 09 WC 52610 and 10 WC 3193 alleged dates of accident of December 2, 2009 and December 22, 2009 involving the right and left hands, wrists, elbows shoulders, neck and thumb as a result of repetitive trauma/pushing on side of lancet. The Settlement Contract Lump Sum Petition and Order further referenced a settlement of 7.5% loss of use of the left thumb and 17.5% loss of use of the left hand. (PX18).

The transcript of the deposition of Dr. Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Dr. Mall testified that he is an orthopedic surgeon and that he first saw Petitioner on September 30, 2015 and that the various documentation he had in his file pertaining to Petitioner included a 2009 nerve conduction study which referenced mild to moderate severe median entrapment neuropathy at the left carpal tunnel and no evidence of right median or right or left ulnar neuropathy. (PX19).

Dr. Mall testified that Dr. Peeples' October 29, 2015 note referenced that Tinel's and Phalen's were negative, and that the impression of the diagnosis of the electrodiagnostic study was that of median nerve entrapment at the right carpal tunnel as well as some entrapment at the left carpal tunnel as well, but no evidence that he found for right or left ulnar neuropathy. He testified that Dr. Peeples did not compare the current findings to those of the prior values given the fact that Petitioner had had a left carpal tunnel release, but typically there could be some residual findings that would then need to be compared back to the initial study to make sure there was improvement in the nerve conduction. He testified that in comparing the two studies, the latency was the same on the left side as it was pre-operatively, and that the latency on the median nerve on the right side had increased which meant that the nerve was slower across the carpal tunnel which crossed the threshold into being significant. (PX19).

Dr. Mall testified that activities that cause and contribute to the development of carpal tunnel syndrome typically include gripping, and that it can be especially worse if one was gripping in a poor position. He testified that any sort of repetitive maneuvering of the wrist with poor position, such as flexion-extension of the wrist, was a risk factor as was heavy gripping and heavy loading. He testified that there are some non-work-related risk factors as well, but that Petitioner did not have any. He testified that his diagnoses were that of right-sided carpal and carpal tunnel syndrome, which were both clinical diagnoses. He testified that nerve conduction studies can help confirm the diagnosis, but did not

oftentimes have to be present to get a good outcome from either conservative or operative treatment. (PX19).

Dr. Mall testified that his recommendation for treatment initially was that of an ulnar nerve night brace but that failed, so he recommended surgical intervention for carpal tunnel release and cubital tunnel release with possible transposition. He testified that he reviewed Dr. Sudekum's deposition transcript, and that he had a few things that he disagreed with. He testified that Petitioner was not overweight. He testified that it had not been proven that smoking had anything to do with carpal tunnel syndrome. (PX19).

Dr. Mall testified that he believed that the job duties as a Correctional Nurse I and/or II would cause and contribute to the development of carpal and carpal tunnel syndrome on the right. He testified that Petitioner had to carry his tote which typically required a little bit of elbow flexion, and that he was placing force through the upper extremity with his elbow flexed. He testified that Petitioner was also having to manipulate things with his left hand and trying to keep the tote in hand, and that he had to flex and extend the wrist to do so. He testified that Petitioner also had to lock and unlock the cell doors and dispense medications, and that he was also sorting through medications and envelopes so he performed a lot of wrist and hand-intensive activities. He testified that for those things and his lack of other risk factors, he felt that Petitioner's job duties at Menard were contributing factors to the development of his carpal and cubital tunnel syndrome. (PX19).

Dr. Mall testified that Petitioner popped medications out of bubble packs, and that he has seen those in his practice and at his house as well. He testified that he imagined that this would contribute to the development of carpal tunnel syndrome if you were doing them frequently. He testified that he did not think it was one specific activity necessarily, but more so the combination of all of the activities that Petitioner was doing. He testified that he did not believe that Petitioner had any outside activities or hobbies that would cause and contribute to the condition, and that he did some hunting, fishing and gardening, as well as beekeeping. (PX19).

When asked about how examinations can be different on the same day as indicated by Dr. Sudekum, Dr. Mall responded that part of it may be the point of how Dr. Peeples did his examination and typically if it was different days of the week, you can have different exams based on how irritated the nerve may be. (PX19).

On cross examination, Dr. Mall admitted that he did not see the actual bubble packs, but that it sounded like Petitioner spent a fair amount of time at the beginning of the day getting those ready and popping the medications out. He testified that he had not done a force analysis on the bubble wraps. He testified that Petitioner demonstrated the elbow flexion to him in his office. He testified that carrying the container was maybe 30-40 degrees of flexion, but if he had to get a medicine out he would flex it up more to about 90 degrees so that he could see and pull out the other medication with his left hand and dispense it. He testified that he did not have the exact number of minutes that Petitioner carried the tote back and forth, but he knew he had to dispense medications for a fair amount of his day. (PX19).

On cross examination, Dr. Mall agreed that he made the statement that the literature did not demonstrate that smoking had an effect or was a cause in the etiology of carpal tunnel syndrome. He then testified that there may be some relationship, but it was not one that was typically pointed out as a major risk factor for carpal tunnel syndrome. He agreed that nicotine constricted the blood vessels. He testified that he could see how it could potentially cause some lack of blood supply to the nerve, but it was not necessarily going to cause the compression of the nerve. (PX19).

The Appearance of Representative was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records were effectively duplicative of those as contained in Petitioner's Exhibit 8. (RX2; PX8).

The IME report of Dr. Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report noted that Dr. Sudekum had the opportunity to perform the medication dispensing activity himself using bubble pack med cards to push out pills, and that the foil on the backside of the bubble pack was quite thin and perforated and released the pill relatively easily with little manual or digital force applied to the bubble side of the pack required to push the pill through the foil on the back side of the card. The report reflects that Dr. Sudekum noted that the majority of the digital/manual force involved when pushing pills out of the bubble pack was concentrated in the thumb tip and there was no direct pressure to the palm, wrist, carpal tunnel region, medial elbow or cubital tunnel region. (RX3).

The transcript of the deposition of Dr. Sudekum was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Sudekum testified that he is board-certified in plastic and reconstructive surgery and also holds a separate board certification in surgery of the upper extremity. He testified that he performed an IME of Petitioner on December 15, 2015, at which time he was complaining of right upper extremity symptoms, including pain and paresthesias of his right wrist, elbow, hand, shoulder and the right side of his neck. (RX4).

Dr. Sudekum testified that some work factors that can create or lead to the development of carpal tunnel syndrome include situations where an employee has a sustained flexed posture for a long time, but that this was highly unusual for most employment activities since usually there was movement. He testified that if the patient held onto a vibrating instrument or tool or was swinging a hammer that was associated with vibration and impact, these types of activities can potentially contribute to the development of at least carpal tunnel symptoms if not carpal tunnel syndrome. He testified that heavy pinching, gripping and grasping, impact and vibration were some of the things that they knew contributed to the symptomatology. As to cubital tunnel syndrome, Dr. Sudekum testified that if an individual was in a work situation where there was sustained hyperflexion of the elbow, it could cause symptoms. (RX4).

Dr. Sudekum testified that co-morbid factors that can also lead to cubital tunnel syndrome include increasing age, arthritis, or tendinitis in and around the elbow joint, diabetes, obesity and smoking. He testified that what you were looking for would be anything that could cause increased pressure in and around the cubital tunnel region. He testified that you can also have direct metabolic conditions, like diabetes and hypothyroidism, which can cause cubital tunnel symptoms as well as carpal tunnel symptoms and syndrome as well. He also testified that you can have a sustained hyperglycemic situation cause direct neurotoxicity to the nerves, which was more of a direct metabolic effect that can contribute to those conditions. (RX4).

Dr. Sudekum testified that some of the co-morbid factors specifically for carpal tunnel syndrome would include increasing age, female sex, conditions such as arthritis, anything that causes edema or fluid to collect in the distal extremities, pregnancy, hypertension, hypothyroidism and diabetes. He testified that any type of condition that could lead to vasculopathy, such as smoking, hypertension or primary vascular disease can contribute to either of those conditions. (RX4).

Dr. Sudekum testified that Petitioner reported to him that he had a 2-3 year history of pain of the right volar wrist, medial elbow, right shoulder and right side of his neck, and that he also complained of numbness and tingling in the entire right hand at night and throughout the day as well as intermittent cramping of the right thenar eminence. He testified that Petitioner denied any weakness of his right upper extremity and denied any symptoms involving his left upper extremity. He testified that the physical examination performed revealed that Petitioner was in the overweight body morphology category and that

he had a well-healed surgical incision from his previous left carpal tunnel operation. He testified that Petitioner had subjective responses to his wrists, and that Tinel's and Phalen's signs on the right were positive on the right and negative on the left. He testified that Petitioner also had a positive right elbow Phalen's test and negative elbow Tinel's test on the right, and that his grip strength was reduced on the right side compared to the left. He testified that Petitioner had mild right lateral elbow pain with resisted wrist and middle finger extension, but he did not have any medial elbow pain. (RX4).

Dr. Sudekum testified that in reviewing Dr. Mall's note of September 30, 2015 which noted that any movement of Petitioner's wrist out of neutral produced significant discomfort was significant because it was not the type of symptoms that you would expect from carpal tunnel syndrome. He testified that typically with carpal tunnel syndrome, movement of the wrist relieved the symptoms. He testified that unless Petitioner had a very significant arthritis, that would be unusual. (RX4).

Dr. Sudekum further testified that his review of the medical records indicated that Petitioner saw Dr. Peeoples on October 20, 2015, and that on physical examination Dr. Peeples found that the wrist Tinel's and Phalen's signs were negative and elbow flexion test was also negative bilaterally. He testified that the records he reviewed indicated that on the same day Petitioner was seen by Dr. Mall, and that the physical examination findings by Dr. Mall were significantly different than those found by Dr. Peeples. He testified that Dr. Mall's records indicated that the wrist and elbow Tinel's and Phalen's signs were positive, while Dr. Peeples' the same day did not find them to be positive. He testified that at that time where was no objective evidence of any ulnar neuropathy or cubital tunnel syndrome, which he thought was significant. (RX4).

Dr. Sudekum testified that Petitioner's subjective symptoms were in his opinion out of proportion of the findings on the physical examination. He testified that Petitioner did not have any neurologic evidence on nerve conduction studies of any kind of an ulnar neuropathy or any kind of a cervical radiculopathy that was identified on nerve conduction studies that might explain the symptoms he was having. He testified that Dr. Mall made statements that any movement of Petitioner's hand or outer wrist caused significant discomfort, which in the absence of any kind of an arthritic condition, would certainly be unusual and may be an indication of symptom magnification. He testified that the x-rays performed revealed an incidental finding of bone cysts in the proximal phalanx of the right middle finger and evidence of calcific tendinitis of both elbows, which was just an indication of chronic tendinitis that may have occurred in those areas, but that there was no evidence of significant arthropathy or arthritis. (RX4).

Dr. Sudekum testified that nerve conduction studies performed at his office revealed normal distal motor and sensory latencies for the bilateral median and ulnar nerves, and that there was no evidence of significant neuropathy, carpal tunnel syndrome or cubital tunnel syndrome on either side. He testified that there was a minor abnormality of the right median nerve in the median ulnar differential, which by itself was a relatively minor and certainly non-diagnostic finding. (RX4).

Dr. Sudekum testified that Petitioner indicated that his job consisted of delivering medications to inmates, writing progress notes, locking and unlocking doors approximately 30 times a shift and occasionally using a computer to check his e-mail. He testified that Petitioner also indicated that he did Accu-Checks (*i.e.*, blood sugar checks) and that he would then give insulin shots as needed, and that he would do this for approximately 24-30 patients per shift. He testified that Petitioner reported that he was also required at times to push a cart with supplies and at times carry a tote with supplies, which were used to help carry the materials he needed to give medications and injections and do wound care. (RX4).

Dr. Sudekum testified that Petitioner's constellation of symptoms involving his right upper extremity would be classified as generalized subjective right upper extremity neuromuscoskeletal symptoms. He testified that the nerve conduction study that he performed had no objective evidence of significant upper extremity peripheral neuropathy, and that there was a minimal abnormality

electrodiagnostically of the right median nerve. He testified that he felt that Petitioner's whole constellation of neuromusculoskeletal symptoms was out of proportion to the objective findings on the physical examination, and that Petitioner's records and his examination of Petitioner revealed inconsistent bilateral upper extremity clinical examinations as compared to those of Dr. Mall and Dr. Peeples. He testified that he could not rule out symptom magnification as a confounding factor in his presentation. He testified that Petitioner did not have any objective evidence of carpal tunnel syndrome, and that it was his opinion that Petitioner did not suffer from cubital tunnel syndrome. (RX4).

On cross examination, Dr. Sudekum agreed that he performed a NeuroMetrix test on Petitioner's hands and arms, and that he and his nurse performed the test. He testified that his nurse was not a neurologist nor was she a physiatrist. He testified that he did not know who performed Dr. Peeples' test. (RX4).

On cross examination, Dr. Sudekum testified that he was not provided with any medical records after the date of the IME on December 15, 2015. He testified that he was not made aware that Petitioner sustained another injury on December 30, 2015. (RX4).

On cross examination, Dr. Sudekum testified that Petitioner indicated to him that there were three levels of medical providers at Menard and that as he rose through the ranks, he did not have to do the same job specifically that the lower level employees did but he performed all of those same jobs as needed depending on staffing. He testified that there were more administrative tasks from a higher level medical officer in that situation. He testified that Petitioner stated that he performed all of the same tasks, but not as frequently would he do many of those jobs depending on staffing. He testified that Petitioner made a statement when he saw him that he had in the recent past (although he admitted that he did not know specifically what that time period was) not been working overtime, but in the distant past he had worked overtime to a more significant degree. (RX4).

On cross examination, Dr. Sudekum testified that Petitioner was overweight but not obese. He testified that he was not aware that Petitioner had diabetes, hyperthyroidism or hypertension. He agreed that Petitioner was not a female. He testified that Petitioner told him that he did not have a smoking history but that he told Dr. Peeples that he had a smoking history, so it was his assumption that he had smoked in the past. (RX4).

On cross examination, Dr. Sudekum denied telling Petitioner that he had carpal tunnel syndrome but he would not have surgery if he was him. He testified that he might have told Petitioner that he had the symptoms which could be consistent with carpal tunnel syndrome, but because of the fact that his nerve conduction studies were normal he would not recommend carpal tunnel surgery. He testified that he did not recall if Petitioner asked him if he would do his surgery. (RX4).

On cross examination, Dr. Sudekum testified that there was no indication in the notes that Petitioner had taken any medications. He testified that there was no indication in the medical records or what he stated that he did any home exercises. He testified that he did not know how much conservative treatment Petitioner had prior to his left carpal tunnel release. He admitted that he did not know specifically how the job duties of a Nurse II changed when a facility was on lockdown. He testified that on physical examination, there was no objective evidence of carpal tunnel syndrome but that Petitioner had subjective symptoms which could be consistent with carpal tunnel syndrome but also could be consistent with a cervical radiculopathy, thoracic outlet syndrome or many other conditions like diabetes. (RX4).

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on August 23, 2015, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator finds the opinions of Dr. Sudekum to be more persuasive than the opinions provided by Dr. Mall. The Arbitrator finds to be highly significant the fact that Dr. Sudekum testified that Petitioner's subjective symptoms were in his opinion out of proportion of the findings on the physical examination and that Petitioner did not have any neurologic evidence on nerve conduction studies of any kind of an ulnar neuropathy or any kind of a cervical radiculopathy that was identified on nerve conduction studies that might explain the symptoms he was having. The Arbitrator further finds to be significant that Dr. Sudekum further testified that Dr. Mall made statements that any movement of Petitioner's hand or outer wrist caused significant discomfort, which in the absence of any kind of an arthritic condition, would certainly be unusual and may be an indication of symptom magnification. (RX4). The Arbitrator is troubled by Dr. Sudekum's testimony that his review of the medical records indicated that Petitioner saw Dr. Peeoples on October 20, 2015, and that on physical examination Dr. Peeples found that the wrist Tinel's and Phalen's signs were negative and elbow flexion test was also negative bilaterally, yet on the same day Petitioner was seen by Dr. Mall whose records indicated the wrist and elbow Tinel's and Phalen's signs were positive. (RX4). The totality of this evidence, then, thereby causes the Arbitrator to place greater reliance upon the opinions of Dr. Sudekum rather than Dr. Mall in this matter. Having reviewed the entirety of the evidence, the Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on August 23, 2015, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of notice, medical bills and nature and extent are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Jones,
Petitioner,

17IWCC0581

vs.

NO: 15 WC 36883

Illinois Department of Employment Security,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, statute of limitations and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 12, 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: SEP 25 2017
KWL/vf
9/12/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0581

JONES, CYNTHIA
Employee/Petitioner

Case# **15WC036883**

IL DEPT OF EMPLOYMENT SECURITY
Employer/Respondent

On 10/12/2016, 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 0.49% 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:

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
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
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 12 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0581

Cynthia Jones
Employee/Petitioner

v.

Illinois Department of Employment Security
Employer/Respondent

Case # **15** WC **36883**

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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, 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. ☒ 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 _____

17IWCC0581

FINDINGS

On the date of accident, **8/20/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$70,755.65**; the average weekly wage was **$1,360.69**.

On the date of accident, Petitioner was **61** 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 **$94.80** under Section 8(j) of the Act.

ORDER

Petitioner's claim is barred by the Statute of Limitations.

Petitioner did not sustain an accident that arose out of and in the course of her employment.

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.

David A. Kane
Signature of Arbitrator

October 11, 2016
Date

ICArbDec19(b)

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia Jones,
Employee/Petitioner,

v.

Illinois Department of Employment Security,
Employer/Respondent.

17IWCC0581

Case # **15** WC **36883**

I. FINDINGS OF FACT

Cynthia Jones (the "Petitioner") seeks relief from the Respondent-Employer, the State of Illinois, Illinois Department of Employment Security (the "Respondent"), for the Petitioner's alleged work-related accident on August 31, 2015, pursuant to the Illinois Workers' Compensation Act (the "Act"). On September 27, 2016, a hearing on the disputed issues was held before Arbitrator David Kane in Chicago, Illinois. The disputed issues are: accident, notice, causation, medical expenses, prospective medical care, and statute of limitations. [Arb. Ex. 1].

The parties stipulated that on August 31, 2015, the culmination of the alleged work-related accident, the Petitioner was 61 years old and single with no dependent children. [Id.].

The Petitioner testified she worked for the State of Illinois at the Department of Employment Security as an adjudicator. She worked in that capacity for 14 years. Petitioner is currently working full duty. Petitioner

testified that she works seven and a half hours per day with two fifteen minute breaks. Petitioner testified her duties require her to take back to back client interviews and consistently type on her specialized keyboard. Petitioner's keyboard has been modified to accommodate previous injuries sustained to her right hand.

Prior to the accident, on August 11, 2003, Petitioner presented to Midland Orthopedic Associates, where she was diagnosed with bilateral carpal tunnel syndrome and given steroid injections for the pain. [Pet. Ex. 1]. Subsequently, on May 7, 2007, Petitioner returned to Midland and was treated for the reoccurring pain with steroid injections. [Id.]. On June 21, 2007, Petitioner returned to Dr. Sonnenberg with complaints of numbness in her left fourth and fifth fingers at which point he recommended an EMG. [Id.]. On September 27, 2007, the EMG results did not show evidence of cubital tunnel syndrome, rather significant carpal tunnel syndrome. [Id.]. At that time, Petitioner was given a steroid injection in her left carpal tunnel.

Petitioner returned with bilateral wrist pain on May 5, 2011. [Id.]. She was diagnosed with a right first dorsal compartment tenosynovitis and examination findings were consistent with left carpal tunnel. [Id.]. Injections were administered to her right carpal tunnel and first dorsal compartment. [Id.]. Petitioner followed up with Dr. Sonnenberg on May 26, 2011 and stated that she received good pain relief from the injections and no longer had triggering and carpal tunnel syndrome. [Id.]. On July 11, 2011, Dr. Sonnenberg determined Petitioner had recurrent de Quervain's of the right wrist and that her carpal tunnel symptoms had resolved. [Id.]. On July 26, 2011, Petitioner underwent surgery on her first dorsal compartment of the right wrist, which was deemed successful. [Id.]. Petitioner followed up with Dr. Sonnenberg on September 12, 2011, stating that she was

having right trigger point over the right dorsal aspect of the wrist. [Id.]. On November 14, 2011, Petitioner was not improving in therapy due to persistent de Quervain's and recurrent carpal tunnel syndrome. [Id.]. On December 15, 2011, a positive EMG was performed, finding that Petitioner had right carpal tunnel syndrome, left cubital tunnel syndrome, and evidence of thoracic outlet syndrome. [Id.]. Petitioner underwent a right carpal tunnel injection on December 15, 2011. [Id.]. Petitioner received substantial relief; however, she then began to have complaints of pain in the ulnar nerve distribution along with numbness of the ring and fifth finger. [Id.]. Petitioner was started on an exercise program and told to follow up with Dr. Sonnenberg. [Id.].

On January 12, 2012, Petitioner was making progress in her exercise program as her motion was improving and her pain was less. [Id.]. Petitioner was given a return to light duty. [Id.]. On January 26, 2012, Petitioner stated that she was making much more progress and that her range of motion and grip strength was good. [Id.]. Petitioner was given approval to return to full duty on January 30, 2012.

On February 21, 2013, Petitioner returned to Dr. Sonnenberg with complaints of pain in her left wrist and elbow. At that time, she was diagnosed with left lateral epicondylitis and de Quervain's of the left wrist. [Id.]. Petitioner followed up on May 12, 2013 with vague elbow complaints on the left that radiated to the anterior portion of the elbow. [Id.]. Petitioner had full range of motion and no tenderness over the lateral or medial epicondyle and minor tenderness over the ulnar nerve. [Id.]. On June 14, 2013, Petitioner underwent an MRI of the elbow. Petitioner followed up with Dr. Sonnenberg on August 1, 2013 where the MRI was interpreted to

show only mild thickening of the common extensor, no evidence of tearing, and tenderness along the ulnar nerve. [Id.].

On October 30, 2013, Dr. Vitello performed an IME, concluding the left elbow cubital tunnel syndrome, left elbow medial and lateral epicondylitis were unrelated. [Id.]. Dr. Vitello opined that the Petitioner has a sedentary job that is repetitious, but not a combination of heavy forceful and repetitive work. [Id.] Further, Dr. Vitello stated that he believed Petitioner was capable of working without work restrictions. [Id.]. Thus, he did not believe that Petitioner's injuries were related to her work.

On August 13, 2015, Petitioner presented to Dr. Sonnenberg with complaints of bilateral carpal tunnel syndrome. [Pet. Ex. 1.]. At that time, Petitioner underwent injections into her carpal tunnels. [Id.]. Petitioner followed up with Dr. Sonnenberg on October 1, 2015 with continued complaints of bilateral carpal tunnel syndrome as well as a small Dupuytren's nodule on the fourth and fifth digits on the palm. [Id.]. Dr. Sonnenberg recommended surgery for the release of both the right and left carpal tunnels. [Id.]

Petitioner filed her Application for Adjustment of Claim on November 13, 2015.

On May 9, 2016, Petitioner underwent a repeat IME with Dr. Vitello. [Res. Ex. 5]. Dr. Vitello found Petitioner's current condition to not be causally connected to an alleged repetitive work injury as she has a sedentary job, which does not require any forceful and repetitive gripping, grasping, or lifting with the hands. [Id.]. Additionally, Dr. Vitello found Petitioner can return to work full duty without limitation. [Id.].

CONCLUSIONS OF LAW

With regard to issue "C", whether Petitioner's accident arose out of and in the course of her employment, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's accident did not arise out of her employment. The Arbitrator relies on Dr. Vitello's two IME reports. Petitioner's job does not involve any heavy or forceful lifting, pushing, or pulling. There is no repetitive gripping, grasping or lifting with her hands. Thus, the Arbitrator finds no work accident.

With regard to issue "F", whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds the Petitioner's current condition of ill-being is not causally related to the injury. On October 30, 2013, Dr. Vitello found in his IME that Petitioner's current condition is not work related. Rather, Dr. Vitello finds Petitioner has a sedentary job that is repetitious but is not a combination of heavy forceful and repetitive work. Further, he believes Petitioner's subjective complaints are greater than her objective findings. Dr. Vitello finds Petitioner is capable of working without restrictions given the nature of her sedentary job.

With regard to issue "E", whether Petitioner gave proper notice of the alleged accident, the Arbitrator finds as follows:

The Arbitrator finds the Petitioner did not give proper notice of her alleged work accident. Petitioner alleges proper notice to her supervisor Jerene Meier on April 12, 2011 and August 31, 2015. However,

Petitioner's medical records show her pain complaints arose as early as 2003 when she presented to Dr. Sonnenberg and received treatment. It appears Petitioner's condition of ill-being arose far before notice was given to her employer. Thus, the Arbitrator finds Petitioner did not give proper notice of the alleged work accident.

With regard to issue "J", whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator finds that Respondent is not responsible for unpaid bills as no accident or causal connection were found. Therefore, Respondent shall not pay the outstanding bills.

With regard to issue "K", whether Petitioner is entitled to prospective medical care, the Arbitrator finds as follows:

Given the Arbitrator's findings on accident, causation, and the statute of limitations, no medical care is ordered.

With regard to issue "O", whether this claim was filed with the statute of limitations, the Arbitrator finds as follows:

The Arbitrator finds Petitioner did not file her claim within the statute of limitations. The statute of limitations to file in the state of Illinois is three years from the date of accident and two years from the date the injured employee last received Workers' Compensation benefits, whichever is later. Petitioner's medical records show symptoms of an injury manifesting in 2003. Petitioner gave written notice to her supervisor of

work related carpal tunnel syndrome on April 12, 2011. This is the date that Petitioner knew of her carpal tunnel syndrome and first alleged that it was work related. *See Durand v. Industrial Commission,* 224 Ill.2d 53 (2006) (Limitations period runs when both the injury and its causal link to the employee's work becomes plainly apparent to a reasonable person). The application of claim was filed on November 13, 2015. The application was not filed within three years.

Additionally, even if the statute was tolled while TTD was paid, the application was still not timely filed.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mario Sanchez,

Petitioner,

vs. NO: 16 WC 7545

Freight Car Services,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan on Petitioner's Petition to Correct Clerical Error, which was filed on July 5, 2017, and presented to Commissioner Brennan on August 18, 2017. After due consideration, the Commission finds as follows:

1) Petitioner filed two Applications for Adjustment of Claim against Respondent, namely Claim Nos. 16 WC 7544 and 16 WC 7545. The claims were not consolidated for purposes of trial.

2) Arbitration was held on the 16 WC 7544 claim on June 23, 2016 and June 28, 2016; this claim involved a left arm injury. No arbitration hearing was held on 16 WC 7545, a claim which pertained to an alleged injury to both ears.

3) Respondent subsequently filed its Petition for Review; however, both claim numbers were incorrectly noted on said Petition. Any Review before this Commission, and any subsequent Decision and Orders pertained only to 16 WC 7544.

4) Notwithstanding the above, Petitioner's second claim, Claim No. 16 WC 7545, was inadvertently recorded on the Commission's computer system as under review pending orals, and removed from the Call.

5) Petitioner requests that this Commission correct the error, so that this matter may

proceed before the Arbitrator.

Therefore, it is the Order of the Commission:

1) That Petitioner's Petition to Correct Clerical Error is hereby granted;

2) That the Petition for Review is hereby amended *sua sponte* to remove Claim No. 16 WC 7545 as listed on said Petition; and,

3) That Petitioner's Claim No. 16 WC 7545 is hereby remanded to the Arbitrator for further proceedings.

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

DATED: SEP 1 - 2017
MJB/pm
8/18/17

Michael J. Brennan

16 WC 12495
Page 1

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

Justin Johnson,

Petitioner,

vs. NO: 16WC 12495

Safelite Fulfillment Inc.,

17IWCC0557

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical care, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2017 is hereby affirmed and adopted.

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

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

DATED: SEP 8 - 2017
SJM/sj
o-7/13/2017
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

JOHNSON, JUSTIN
Employee/Petitioner

Case# **16WC012495**

15WC008935

SAFELITE FULFILLMENT INC
Employer/Respondent

17IWCC0557

On 2/2/2017, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701-9531

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0557

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
19(b)

Justin Johnson
Employee/Petitioner

Case # 16 WC 12495

v.

Consolidated cases: 15 WC 08935

Safelite Fulfillment, 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 Bloomington , on December 28, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 2, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $31,200.00; the average weekly wage was $600.00.

On the date of accident, Petitioner was 28 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's conclusions of law attached hereto, all benefits are awarded in case number 15 WC 08935.

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)

January 30, 2017
Date

FEB 2 - 2017

17IWCC0557

Preliminary Ruling

These two cases were tried in Bloomington on December 28, 2016, in a 19(b) proceeding. At the conclusion of the trial, the Arbitrator closed proofs. On January 11, 2017, counsel for Petitioner filed a Motion to Reopen Proofs wherein he sought to introduce additional evidence which consisted of an e-mail from Petitioner to an agent of Respondent, and an e-mail response from the agent of Respondent to Petitioner.

Respondent's counsel filed a Response to Petitioner's Motion to Reopen Proofs on January 12, 2017. In that response, Respondent's counsel objected to Petitioner's Motion to Reopen Proofs. Copies of both Petitioner's Motion and Respondent's Response are included with the record the Arbitrator filed with the Commission.

On January 25, 2017, counsel for Petitioner and Respondent had an oral argument on the Motion to Reopen Proofs via conference call before the Arbitrator. At that time, the Arbitrator denied Petitioner's Motion to Reopen Proofs on the basis that there was no good cause for the reopening of proofs because the e-mails were available and could have been tendered into evidence at the time the case was tried.

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 15 WC 08935, Petitioner alleged that on April 29, 2014, he "...was injured while working for Respondent" and sustained an injury to the "low back, both legs." In case number 16 WC 12495, Petitioner alleged that on December 2, 2015, he "...sustained injuries to his low back/legs from his work activities." (Arbitrator's Exhibits 3 and 4).

These cases were consolidated and tried in a 19(b) proceeding wherein Petitioner sought payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In case number 15 WC 08935, Respondent stipulated that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship and specifically disputed liability for all medical services incurred after May 20, 2015. In case number 16 WC 12495, Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2).

Petitioner started working for Respondent in June, 2005, as a glass technician. Most of Petitioner's work consisted of replacing windshields on cars and trucks. At trial, Petitioner testified that on April 29, 2014, he was in the process of lifting a windshield when he felt a "pop" and an electrical type shock in his low back as well as pain in his right hip. Petitioner estimated the weight of the windshield to be 30 to 50 pounds.

The accident was reported in a timely manner to Respondent and Petitioner initially sought medical treatment on April 30, 2014, at Advocate Medical Group (AMG). Petitioner was diagnosed as having sustained a back strain and was prescribed some medication and released to return to work with restrictions (Petitioner's Exhibit 3).

Petitioner continued his medical treatment at AMG in May and June, 2014. On May 2, 2014, the diagnosis was lumbar spine strain. Petitioner's work restrictions were no lifting over 10 pounds, no overhead lifting and no bending. During May and June, 2014, Petitioner received some physical therapy and the work restrictions remained in place (Petitioner's Exhibits 4 and 9). Petitioner continued to work for Respondent during that time as Respondent provided work to Petitioner consistent with his restrictions.

When Petitioner was seen at AMG on June 17, 2014, an MRI of the lumbar spine was ordered. The MRI was performed on July 8, 2014, and it revealed right paracentral disc herniations at L4-L5 and L5-S1. When seen at AMG on July 16, 2014, Petitioner was referred to an orthopedic surgeon (Petitioner's Exhibits 5 and 9).

On August 14, 2014, Petitioner was evaluated by Dr. Craig Carmichael, a physical medicine/rehabilitation specialist associated with McLean County Orthopedics. Dr. Carmichael examined Petitioner and reviewed the MRI scan. At that time, Dr. Carmichael recommended Petitioner undergo an epidural injection (Petitioner's Exhibit 7).

Dr. Carmichael administered epidural injections at the L5 level on September 5, and November 21, 2014. Dr. Carmichael saw Petitioner on November 24, and December 9, 2014. On those occasions, Petitioner still complained of low back pain with occasional pain down the legs. Dr. Carmichael suggested work conditioning or possible surgical consultation (Petitioner's Exhibit 10).

When Dr. Carmichael saw Petitioner on January 20, 2015, he reaffirmed his recommendation Petitioner undergo work conditioning. Petitioner was in work conditioning from February 3, 2015, through March 6, 2015. When seen on March 6, 2015, it was noted Petitioner had made good progress and was able to lift 60 to 65 pounds, but still had limitations with prolonged standing, kneeling, crouching and forward bending (Petitioner's Exhibit 10).

Dr. Carmichael saw Petitioner on March 12, 2015. At that time, Petitioner still had complaints of low back pain aggravated by increased lifting/activity. Dr. Carmichael recommended Petitioner undergo a functional capacity evaluation (FCE) which might determine whether Petitioner was at MMI (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was examined by Dr. Andrew Zelby, a neurosurgeon, on May 20, 2015. In connection with his examination of Petitioner, Dr. Zelby reviewed medical records provided to him by Respondent. When seen by Dr. Zelby, Petitioner complained of pressure and pain in the low back with some symptoms in the right leg. Dr. Zelby opined that the MRI revealed disc abnormalities at L4-L5 and L5-S1; however, he did not note any radicular findings on examination. He opined that all of the medical treatment Petitioner had received was reasonable and necessary and related to the accident of April 29, 2014. He further opined

Petitioner was at MMI and could return to work with a lifting restriction of 60 to 65 pounds and no further medical treatment or diagnostic studies were indicated. He also stated that the onset of Petitioner's symptoms was in greater part due to the injury, but the perpetuation of the symptoms was, in greater part due to Petitioner's morbid obesity (Respondent's Exhibit 5). Based upon Dr. Zelby's opinions, Respondent disputed liability for medical expenses incurred subsequent to the examination of Petitioner by Dr. Zelby.

Petitioner continued to work for Respondent with restrictions until December 2, 2015 (the date of accident alleged in 16 WC 12495). At that time, Petitioner was at his girlfriend's house and bent over to tie his shoelaces when he experienced a sharp pain in his low back. Petitioner attempted to go to work afterward; however, his pain worsened and he went to the ER of Advocate Bromann Medical Center. Petitioner was diagnosed with a low back strain and was discharged (Petitioner's Exhibit 13).

The following day, December 3, 2015, Petitioner was evaluated by Dr. Carmichael who diagnosed Petitioner with lumbosacral radiculopathy. He ordered another MRI of the lumbar spine (Petitioner's Exhibit 12).

On January 4, 2016, Dr. Carmichael prepared a narrative report directed to Petitioner's counsel. In this report, Dr. Carmichael referenced both the accident of April, 2014, and the recent onset of pain in December, 2015. In regard to causality, Dr. Carmichael opined that the mechanism of injury of April, 2014, was consistent with his diagnosis of L4-L5 and L5-S1 disc herniations and there was a causal relationship between the injury of April, 2014, and the diagnosis. He further stated that Petitioner was off work and additional treatment recommendations would depend upon the results of the MRI (Petitioner's Exhibit 11).

Dr. Zelby was deposed on February 8, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Zelby's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He specifically stated Petitioner was at MMI and there was no reasonable expectation that further treatment would improve Petitioner's condition (Respondent's Exhibit 1; p 13).

Dr. Carmichael was deposed on February 25, 2016, and his deposition testimony was received into evidence at trial. Dr. Carmichael's testimony regarding his treatment of Petitioner was consistent with his medical records. In regard to the FCE he recommended, Dr. Carmichael testified that authorization for the FCE was denied by Respondent. Dr. Carmichael reaffirmed his opinion that the disc herniations at L4-L5 and L5-S1 were related to the accident of April, 2014, and further medical treatment, including an MRI, was indicated. He also stated that Petitioner should remain off work until the MRI was performed (Petitioner's Exhibit 1; pp 13, 15-17).

On cross-examination, Dr. Carmichael stated that Petitioner's morbid obesity contributed to his back condition; however, not to the extent the accident of April, 2014, contributed to Petitioner's two herniated discs. Dr. Carmichael also stated that because the FCE was not performed, he could not opine whether Petitioner had reached MMI between March and December, 2015 (Petitioner's Exhibit 1; pp 24, 28-31).

Dr. Carmichael saw Petitioner on April 5, 2016, and Petitioner still had lumbosacral radiculopathy. He noted he previously ordered an MRI, but was awaiting insurance approval (Petitioner's Exhibit 15). Petitioner had an MRI performed in April, 2016; however, the radiologist's report was not tendered into evidence at trial. Dr. Carmichael again saw Petitioner on April 29, 2016, and performed an epidural injection at L5-S1 on the right side (Petitioner's Exhibit 18).

Dr. Carmichael subsequently saw Petitioner on May 13, 2016, and Petitioner advised that following the epidural injection and some additional physical therapy, his condition was better, but he still had pain in the lumbosacral junction as well as the right buttock and thigh. Dr. Carmichael noted that the MRI revealed a very large right L5-S1 herniation and a moderate L4-L5 herniation. Dr. Carmichael noted that the L5-S1 herniation was much larger than it was on the prior MRI (because Dr. Carmichael compared the findings of two MRIs, it is the Arbitrator's belief that he had reviewed the more recent MRI of April, 2016, as previously stated, a copy of said report was not tendered). Dr. Carmichael ordered Petitioner continue physical therapy and then attempt to return to work on moderate duty (Petitioner's Exhibit 16).

On June 10, 2016, Dr. Carmichael performed an epidural steroid injection at L5-S1 on the right side. Following that injection, Petitioner received additional physical therapy through June 24, 2016. According to the physical therapy record of that date, Petitioner was able to lift up to 70 pounds; however, Petitioner stated he was fearful of returning to work and lifting because of his pain symptoms. It was noted Petitioner had participated in work conditioning, but with little success. It was suggested Petitioner discuss options with Dr. Carmichael, but the likely scenario was a change in profession. Petitioner was seen by Dr. Carmichael on June 24, 2016. Dr. Carmichael's diagnosis remained the same and he recommended Petitioner continue light duty restrictions and a home exercise program (Petitioner's Exhibits 17 and 18).

At trial, Petitioner testified he had not been able to work for Respondent since December 2, 2015, because Respondent would not accommodate his lifting restriction. Petitioner testified he was able to work from April, 2014, through December 2, 2015, because Respondent accommodated his light duty work restrictions, but Respondent did not accommodate his work restrictions subsequent to December 2, 2015.

Petitioner testified the windshields he worked with varied in weight with automobile windshields weighing 25 to 50 pounds and semi truck windshields weighing 75 pounds. When Petitioner was released to return to work to light duty with restrictions in the Spring of 2016, he stated that Respondent would not accommodate his restrictions. Petitioner testified he informed Jerod Grubner, the shop manager, of his work restrictions in April, 2016.

Jerod Grubner testified on behalf of Respondent when this case was tried. Grubner confirmed he was Respondent's shop manager. Grubner initially stated that the windshields Petitioner worked with would usually weigh approximately 45 pounds and the heaviest one Petitioner would have worked with would be about 60 pounds. Grubner also testified Petitioner never provided to him a release to work light duty in April, 2016, and he was not aware that Petitioner had been released to work light duty until the day of trial.

Petitioner testified in rebuttal and stated that the semi truck windshields weigh 75 pounds and some of the automobile windshields were made of thicker glass and weighed more as well. He also stated that he contacted Sade Woods, Respondent's HR director, in April, 2016, and informed her of his work restrictions. Woods did not testify when this case was tried.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on December 2, 2015, and Petitioner's current condition of ill-being is causally related to the accident of April 29, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner was not at work on December 2, 2015, and his testimony was that he bent over to tie his shoelaces when he experienced a sharp pain in his back.

At the time of the incident of December 2, 2015, Petitioner still had back symptoms related to the accident of April 29, 2014.

Dr. Carmichael opined that Petitioner's back condition was related to the accident of April 29, 2014.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Curry,
Petitioner,
vs.

NO: 16WC 13682

Big Muddy Correctional Center,
Respondent.

17IWCC0537

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 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.

DATED: SEP 6 - 2017
MJB/bm
o-8/22/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CURRY, DANIEL
Employee/Petitioner

Case# **16WC013682**

BIG MUDDY CORRECTIONAL CENTER
Employer/Respondent

17IWCC0537

On 3/8/2017, 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 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4377 MICHAEL MILES
3200 FISHBACK RD
PO BOX 907
CARBONDALE, IL 62903

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
RISK MANAGEMENT SERVICES
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 8 - 2017

DONALD A. PASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Daniel Curry
Employee/Petitioner
v.

Big Muddy Correctional Center
Employer/Respondent

Case # **16** WC **13682**

Consolidated cases: **N/A**

17IWCC0537

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 **Mt. Vernon**, on **January 6, 2017**. By stipulation, the parties agree:

On the date of accident, **October 12, 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 **$66,785.68**, and the average weekly wage was **$1,284.34**.

At the time of injury, Petitioner was **52** 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.**

Respondent is entitled to a credit for all medical bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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 **$755.22/week** for a further period of **32.25** weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **15% loss of use of the left 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.

Melinda M. Pope Gallivan
Signature of Arbitrator

3/3/17
Date

MAR 8 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Daniel Curry
Employee/Petitioner

Case # **16** WC **13682**

v.

Consolidated cases: **N/A**

Big Muddy Correctional Center
Employer/Respondent

17IWCC0537

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he works for Respondent in security as a correctional officer. He testified that on October 12, 2015, he injured his left knee at work. He testified that he was conducting a count and was inside dietary. He testified that they were mixing up mashed potatoes right before he went through and that some had spilled on floor. He testified that they tried to wipe up the floor but did not tell him that they had been spilled. He testified that when he walked past, he slid and pulled ligaments on the inside of his left knee.

Petitioner testified that he saw Dr. Brown at Orthopaedic Institute of Southern Illinois and that his diagnosis was that of a complex posterior horn meniscal tear. He testified that Dr. Brown recommended surgery and that it was performed on February 22, 2016. He testified that he underwent physical therapy following surgery and that he was off work for about a month or so. He testified that when he last saw Dr. Brown in May of 2016, he went back to work. He testified that he then went back to Dr. Brown in August of 2016 as he had been having problems through the summer because his knee was still painful and he was not able to get up on his knee without support. He testified that today he cannot get to a kneeling position to fire a weapon and that he did his last qualification standing up.

Petitioner testified that in August, he had an injection in his knee and that this was his last office visit with Dr. Brown. He testified that he did not return to him with his knee issues. He testified that he can do his duties now with the exception of kneeling down.

Petitioner testified that he currently has issues kneeling down and shooting in a kneeling position. He testified that he has to go into a high kneeling position and does not squat down. He testified that he stabilizes his weapon whenever he fires it. He testified that he is otherwise able to work full duty. He testified that his knee hurts every once in a while with weather changes, but thought this was typical of old age. He testified that he continues to be employed by Respondent.

On cross examination, Petitioner confirmed that he is open relief and can work towers, dietary patrol and any job assignment as needed as a correctional officer. He testified that he has difficulty kneeling while qualifying and that he has to qualify on the range once a year. He testified that if he was in the tower and had to use weapon, he would not need to kneel and could get a foundation with the window configuration.

On cross examination, Petitioner testified that his hobbies include being a photographer. He agreed that he is currently working full duty with no restrictions. He agreed that he went back to work

full duty in the spring of 2016. He confirmed that he does not have any appointments to return to see Dr. Brown. He agreed that he has no need to wear his knee brace. He confirmed that he was not taking any medications. He testified that he does, however, ice and elevate the knee on average twice per month.

On cross examination, Petitioner testified that he has not had any performance reviews since he returned to work. He denied having received any complaints from his supervisors regarding his work duties.

The medical records of Logan Primary Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on October 12, 2015 with complaints of left knee pain. It was noted that Petitioner slipped on mashed potatoes on the floor and twisted his knee. It was noted that Petitioner had good range of motion, no joint effusion, mild medial joint line tenderness and no collateral ligament tenderness or instability. The assessment was noted to be that of pain in the left knee. At the time of the October 19, 2015 visit, it was noted that Petitioner was given a Medrol dose pack and knee brace to wear but it had not helped. It was noted that Petitioner stated that walking up and down steps and sitting for any period of time made his pain worse in his left knee, and that the more he moved it the better. It was noted that Petitioner could hardly stand on it that morning, and if he drove anywhere it just ached. The assessment was noted to be that of pain in left knee and strain of knee. Petitioner was recommended to take Tylenol and avoid NSAIDs. It was noted that Petitioner had no work restrictions and that as long as he was doing ok and not worsening, he could continue to work without restrictions. (PX1).

The records of Logan Primary Care reflect that Petitioner was seen on November 2, 2015, at which time it was noted that he had been wearing a knee brace for the past two weeks and that it had helped some. It was noted that Petitioner was able to walk better with it, and that he stated that if he sat for very long he still had pain when he got up. It was noted that Petitioner could not move side to side without increased pain, and that it was not swollen but sore if he laid on his right side and tried to move it. The assessment was that of pain in left knee, strain of knee and questionable meniscus tear. It was noted that the mild click with testing could be a sign of a meniscal tear but the history of the knee feeling better the more he was on it was more suggestive of a tendon or knee strain. Petitioner was recommended a Medrol dose pack and if he was not improved in two weeks, consider referral vs. MRI of the knee. At the time of the November 16, 2015 visit, it was noted that Petitioner stated that the medications did not help much and that he did not have the constant throbbing pain he had been having but it was still painful if he sat too long. It was noted that Petitioner would occasionally have a burning sensation behind his kneecap after being on it for a while, but it had gone away. The assessment was that of pain in left knee, strain of knee and meniscal tear. Petitioner was recommended to undergo x-rays of the knee to rule out underlying arthritis and spurs. It was noted that Petitioner could continue his work duties with the exception of wearing the knee brace. Petitioner was given a home exercise program. (PX1).

The records of Logan Primary Care reflect that Petitioner was seen on December 7, 2015, at which time it was noted that he was supposed to have had an MRI but it had not yet been scheduled. It was noted that Petitioner stated that his left knee was still bothering him going up and down steps and when he turned over in bed, and that he was using Biofreeze but it did not help. Petitioner was recommended to continue to wear the knee brace for comfort, undergo the MRI and avoid excess time going up and down stairs to prevent worsening injury. At the time of the December 24, 2015 visit, it was noted that Petitioner stated his knee was the same, that there were days that it hurt and that there days that it did not. It was noted that Petitioner had undergone an MRI, which showed a meniscal tear with flap formation and was most likely the cause of his continued pain. Petitioner was referred to an orthopedic physician and recommended to avoid stairs or hills and to avoid twisting motions. (PX1).

The records of Logan Primary Care reflect that Petitioner was seen on January 25, 2016, at which time it was noted that he stated that his left knee was still bothering him going up and down steps and

when he turned over in bed. It was noted that Petitioner stated that he was scheduled for surgery. Petitioner was recommended to keep his follow-up appointment with orthopedics and to avoid excess stairs and pivoting on the knee. It was noted that Petitioner could continue to work while wearing his left knee brace. At the time of the February 9, 2016 visit, it was noted that Petitioner stated the last week or so his left knee pain had been worse. It was noted that Petitioner was scheduled for surgery and that he wanted to see if he could be off work until the surgery to see if this helped the pain some. It was noted that Petitioner was on his feet all day long at work and this did not help his knee. Petitioner was taken off work and suggested to use a crutch or cane if he had to be up on his feet. Petitioner underwent pre-operative clearance on February 17, 2016. (PX1).

Included within the records of Logan Primary Care was the interpretive report for x-rays of the left knee performed on November 16, 2015, which were interpreted as revealing no acute osseous abnormality and no significant degenerative joint disease. An MRI of the left knee was performed on December 18, 2015, which was interpreted as revealing (1) medial meniscal tear with flap formation; (2) medial and patellofemoral compartment osteoarthrosis; minimal joint effusion; slit-like popliteal cyst; (3) scarring related to a chronic sprain medial collateral ligament; mucoid degeneration versus minimal sprain of the ACL with intact fibers identified; (4) minimal patellar/quadriceps tendinosis without a tendon tear. (PX1).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen for a consultation on January 19, 2016, at which time it was noted that he had a left knee injury on October 12, 2015 when he slipped in the kitchen area and injured the knee. It was noted that Petitioner's pain had persisted since that time and that he attempted wearing a brace without any significant improvement. It was noted that Petitioner stated he had no previous problems with the knee. The impression was noted to be that of acute traumatic medial meniscus tear, left knee. Petitioner was recommended to undergo arthroscopic partial medial meniscectomy. Petitioner was allowed to continue to work full duty. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on March 15, 2016 for follow-up of a complex posterior horn, medial meniscus tear which was traumatic in nature as well as a primary osteoarthritis of the medial compartment and a medial plica. It was noted that Petitioner was doing fairly well other than having continued pain in the left knee which he stated could be 6-7/10 depending on activity levels. It was noted that Petitioner was going to physical therapy and had had a fairly good improvement of his range of motion. Petitioner was recommended a sedentary job restriction with no inmate contact and was recommended to continue physical therapy. At the time of the April 12, 2016 visit, it was noted that Petitioner was doing well and that he stated that he had occasional popping in the knee and occasional swelling. It was noted that Petitioner was finishing his physical therapy and felt he was ready to return to work full duty. Petitioner was returned to full work duty status and instructed to return in six weeks. (PX2).

Included within the records of Orthopaedic Institute of Southern Illinois was the Operative Report dated February 22, 2016, which noted that Petitioner underwent (1) arthroscopic partial medial meniscectomy; (2) arthroscopic plica excision; (3) cortisone injection of the knee for a pre-operative diagnosis of left knee complex posterior horn medial meniscus tear, traumatic and post-operative diagnoses of (1) left knee complex posterior horn medial meniscus tear, traumatic; (2) medial plica; (3) primary osteoarthritis medial compartment. (PX2).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on May 24, 2016, at which time it was noted that he was doing well and not having difficulties and that he stated that overall he was doing fine. It was noted that Petitioner was already back to work full duty and was not having any difficulties with this activity level. Petitioner was released and placed at maximum medical improvement. At the time of the August 30, 2016 visit, it was noted that Petitioner stated he was having

pain in the left knee again and was unable to kneel on the left knee. It was noted that Petitioner described a burning pain in the anterior aspect of the knee which was worse in the morning when first getting up and for the first few hours of the day. It was noted that Petitioner stated he had to qualify with a gun in a kneeling position and was unable to do that, that he stated his symptoms were moderate and that he also had an occasional popping in the knee on the left side. It was noted that Dr. Brown believed that Petitioner had a moderate patella tendinitis and fat pad impingement/Hoffa syndrome of the left knee. Petitioner was recommended to undergo a corticosteroid injection. Petitioner was returned to work full duty and instructed to return in six weeks. It was noted that if he was no better at that point, Dr. Brown would consider the possibility of hyaluronic acid injections to determine whether or not it was his underlying osteoarthritis that was bothering him. (PX2).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The Work Slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 4.

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

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 was a correctional officer at the time of the accident and that he returned to his position with Respondent upon completion of his treatment. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 52 years old on his date of accident. Given the relatively advanced age of Petitioner and the fact that the medical records lack any reference to Petitioner having been placed under any restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his position as a correctional officer 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 he has issues kneeling down and shooting in a kneeling position. He testified that he has to go into a high kneeling position and does not squat down. He testified that he stabilizes his weapon whenever he fires it. He testified that he is otherwise able to work full duty. He testified that his knee hurts every once in a while with weather changes, but thought this was typical of old age. At the time of the most recent office

visit on August 30, 2016, it was noted that Petitioner stated he was having pain in the left knee again and was unable to kneel on the left knee, and that he described a burning pain in the anterior aspect of the knee which was worse in the morning when first getting up and for the first few hours of the day. (PX2). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were corroborated by his treating records at the conclusion of his treatment based on the medical records submitted into evidence at the time of arbitration. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **15% loss of use of the left leg** as provided in Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Shepard,

Petitioner,

vs. NO: 16 WC 34944

17IWCC0582

State of Illinois/IYC-St. Charles,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 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.

DATED: SEP 26 2017
TJT:yl
o 9/18/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHEPARD, SCOTT
Employee/Petitioner

Case# **16WC034944**

STATE OF ILLINOIS/IYC-ST CHARLES
Employer/Respondent

17IWCC0582

On 3/16/2017, 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 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 SHEPARD, SCOTT
64 WILLEY LANE
BATAVIA, IL 60510

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 DEPT OF CENTRAL MGMT SYSTEMS
RISK MANAGEMENT SERVICES
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

MAR 16 2017

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

17IWCC0582

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

Scott Shepard
Employee/Petitioner

v.

State of Illinois / IYC-St. Charles
Employer/Respondent

Case # **16** WC **34944**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **March 8, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 18, 2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned wages resulting in an average weekly wage of $1,275.19.

On the date of accident, Petitioner was 52 years of age, *married* with no dependent children.

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

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $2,626.10 for other benefits (i.e., payments made by the workers' compensation insurance carrier), for a total credit of $2,626.10. *See* AX1.

Respondent is entitled to a credit of for any and all payments made by the group insurance carrier under Section 8(j) of the Act. *See* AX1.

ORDER

Permanent Partial Disability: Schedule Injury

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 15 weeks, because the injuries sustained caused the 3% 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

March 8, 2017
Date

MAR 16 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Scott Shepard
Employee/Petitioner

v.

State of Illinois / IYC-St. Charles
Employer/Respondent

Case # **16** WC **34944**

Consolidated cases: **N/A**

FINDINGS OF FACT

The parties submitted a completed Request for Hearing form indicating two issues in dispute including causal connection and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Scott Shepard (Petitioner) testified that he was injured while working for the State of Illinois IYC in St. Charles (Respondent) on January 18, 2016 while supervising a cell house or cell block and breaking up a fight between two rival gang members. He explained that the two youths were fighting extensively during a 4-5 minute event. During the fight, Petitioner testified that he went over a table, onto the floor, back up again, into a wall, and back down to the floor before he was relieved by roving security patrolperson who intervened. Petitioner testified that he reported the injury and was seen the next day at Dryer Medical Clinic per Respondent's workers' compensation protocol.

The medical records confirm that Petitioner presented at the Dreyer Medical Clinic on January 19, 2016. PX1 at 1-5, 272-274. He reported that he was breaking up an inmate fight injuring his left shoulder and cervical area. Id. Specifically, the Physician's Assistant, Mariah Hilby, PA-C (Ms. Hilby), noted Petitioner's report of pain on the left side of the neck, in the left upper back area, and soreness. Id. On physical examination, Ms. Hilby noted that Petitioner had tenderness to palpation of the left trapezius muscle. Id. Ms. Hilby diagnosed Petitioner with a left trapezius strain, prescribed Ibuprofen 600, and released Petitioner to modified duty work through January 25, 2016. Id.

Petitioner returned to Ms. Hilby at the Dreyer Medical Clinic on January 29, 2016. PX1 at 20-23, 274-276. Ms. Hilby noted Petitioner's report that he was previously discharged because he thought the injury was minor and it would subside quickly, but "[i]t did not and so he has returned to additional care." Id. Petitioner reported that he was not doing better and that his pain was located in the left side of the neck with inability to fully move the neck from side to side without pain. Id. Petitioner also reported that the Ibuprofen was only providing minimal relief. Id. On physical examination, Ms. Hilby noted tenderness to palpation of the left trapezius muscle. Id. She instructed Petitioner to apply heat or ice to the neck area as needed, perform gentle range of motion exercises, and continue with his medication. Id. Petitioner was also provided with a referral for physical therapy. Id.

Petitioner returned to see Ms. Hilby or Dr. Christofersen on February 12, 23, 26, 2016, March 10, 2016 during which time additional physical therapy was recommended and, while awaiting insurance approval, Petitioner

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" with a corresponding number as identified.

continued to report neck or left trapezius pain and inability to move his neck without pain from side to side. Id. PX1 at 66-68, 83-85, 97-104, 110-112, 121-123, 276-286.

On March 22, 2016, Petitioner reported that he was doing much worse and his physical therapy had not been approved. PX1 at 286-287. He also reported pain in the left neck as well as pain and tingling down the left arm to the third and fourth digits. Id. On physical examination, Petitioner had tenderness to palpation of the left trapezius muscle. Id. Ms. Hilby prescribed additional Flexeril and noted that Petitioner was still waiting for approval of the additional physical therapy. Id. She also ordered a cervical MRI to rule out any discogenic etiology given that Petitioner's symptoms were worsening. Id.

On April 1, 2016, Petitioner underwent the recommended cervical MRI. PX1 at 264-265. The interpreting radiologist noted the following: (1) multilevel nerve root impingement predominantly at C4-C6; (2) multilevel disc bulges causing neural foraminal narrowing; (3) straightening of the cervical spine that may be due to muscle spasm and should be clinically correlated; and (4) multilevel spondylosis causing neural foraminal narrowing. Id. Petitioner ultimately underwent the recommended physical therapy at the Dreyer Medical Clinic beginning on February 3, 2016 and continuing over 12 visits through March 31, 2016. PX1-PX2.

On April 18, 2016, Jon Christofersen, M.D. (Dr. Christofersen) noted Petitioner's presentation for a re-check of neck, left shoulder and arm pain. PX1 at 148-150. On physical examination, Dr. Christofersen noted somewhat limited range of motion, Petitioner's complaints of pain particularly with turning or tipping to the left, and tenderness to palpation in the posterior left shoulder. Id. Dr. Christofersen also noted his review of Petitioner's MRI results which showed primarily degenerative changes, diffuse bulging, and neuroforaminal protrusions at the C4-C5 level. Id. He diagnosed Petitioner with a cervical strain with some radicular symptoms and kept Petitioner released to full duty work. Id. Dr. Christofersen also ordered a course of Prednisone and referred Petitioner to a spine specialist for a consultation. Id.

On April 18, 2016, Petitioner saw Dennis Wen, M.D. (Dr. Wen) at Elgin Barrington Neurosurgery. PX1 at 163-164. Petitioner testified that he was referred to Dr. Wen through the workers' compensation carrier. Dr. Wen noted that Petitioner was a corrections officer involved in an altercation with an inmate with an initially mild neck-ache that worsened with radiation into the left shoulder and upper arm with occasional paresthesias into the left middle and ring finger. Id. He also noted that the course of prednisone had little if any effect. Id. Dr. Wen noted his review of Petitioner's cervical MRI showing mild disc disease at C4-C5 and C5-C6, and a questionable small lateral left herniated nucleus pulposus/spur. Id.

Petitioner returned to Dr. Wen on June 1, 2016. PX1 at 183. He diagnosed Petitioner with cervical spondylosis at C4-C5 and C5-C6 though the radicular symptoms were more at C7. Id. Dr. Wen indicated that Petitioner was able to live with the symptoms for the time being and he instructed Petitioner to return as needed. Id. Petitioner testified that Dr. Wen indicated that any surgery would be aggressive and he would not perform or recommend surgery.

Regarding his current condition of ill-being, Petitioner testified that he did not have the pain in his neck and left shoulder like he has today. He described the pain like a toothache; it is not acute, as when he sleeps "wrong" on his neck, but it is present and affects activities such as exercise. Petitioner testified that he takes Motrin and over-the-counter medications to assist with inflammation.

Petitioner also testified that he basically resigned from his position as a Sworn Correctional Officer as a result of the culture and climate of the facility. He explained that he does not have the ability to do the type of work

required of a correctional officer any longer and he took an administrative position, which has a considerable difference in pay. Petitioner testified that he earns less in his position as the Facility Control Review Officer and cannot work overtime in this position. Petitioner explained that his current duties are completely administrative and he has no contact with inmates whereas in his prior position he always had contact with inmates.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's claimed current condition of ill-being in the left trapezius and neck is causally related to the injury sustained at work on January 18, 2016. In so finding, the Arbitrator finds Petitioner's testimony to be credible as it is corroborated by the medical records submitted into evidence. Petitioner's testimony is also uncontroverted.

Petitioner's accident occurred while breaking up a fight between two juvenile detainees and lasted several minutes. Petitioner immediately reported the incident and symptoms as a result of the incident. He received treatment at Dreyer Medical Clinic as referred by Respondent and was diagnosed with a left trapezius strain and cervical strain from the date of accident through approximately June of 2016. Petitioner was evaluated by a spine specialist, Dr. Wen, who more specifically diagnosed Petitioner with cervical spondylosis at C4-C5 and C5-C6 with radicular symptoms localized at C7. Petitioner underwent eight weeks of physical therapy and conservative medication management.

~~Petitioner testified that he did not have the symptoms in the left shoulder or neck before his accident at work.~~ While Petitioner's MRI and treatment records reveal degenerative changes in the cervical spine, no evidence was submitted that Petitioner's post-accident symptoms or medical treatment resulted solely from any pre-existing degenerative condition or non-occupational source. Respondent did not require Petitioner to submit to any medical examination pursuant to Section 12 and no medical opinion was offered in contravention of Petitioner's testimony or his medical records.

Based on all of the foregoing, the Arbitrator finds that Petitioner's claimed current condition of ill-being is causally related to the injury sustained at work on January 18, 2016 as claimed.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injuries, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);
(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. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial 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 by either party. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner testified that he was a Sworn Correctional Officer at the time of his accident. This evidence is uncontroverted. As a result, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 52 years old at the time of the accident. The medical records corroborate Petitioner's testimony. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner testified that his physical capacity was diminished as a result of his injury at work and that he resigned the position and took a new position that required no inmate contact. However, the medical records reflect that Petitioner was released to return to work full duty one week after his accident and Petitioner testified that he returned to full duty work in his position as a Sworn Correctional Officer before obtaining the position the currently holds as an administrator. As a result, the Arbitrator finds no evidence that Petitioner's earning capacity was impaired as a result of the accident and gives significant 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 a left trapezius strain and cervical strain that required two months

of physical therapy, conservative medication management, and evaluation by a spine specialist who ultimately diagnosed Petitioner with cervical spondylosis at C4-C5 and C5-C6 with radicular symptoms. As a result, the Arbitrator gives significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 3% loss of use of the 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alita Jones-Richard,
Petitioner,

vs. No. 97 WC 39437

Chicago Board of Education,
Respondent.

16IWCC0230

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 reinstatement of claim, causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner filed an Application for Adjustment of Claim alleging injuries following a 6/4/97 work accident. On 12/5/13 when Petitioner did not appear for specially set trial, Arbitrator Carlson dismissed her claim for want of prosecution, with prejudice. On 12/17/13 Petitioner filed a timely pro-se motion to reinstate which was heard by Arbitrator Cronin, who reinstated the claim following a hearing in which Petitioner explained that her failure to appear for trial on 12/5/13 was due to her not having a caregiver for her ill mother, who needed Petitioner to administer chemotherapy that day.

The Commission affirms and adopts the reinstatement of this claim on the basis that Arbitrators have sound discretion to do so, and not because Arbitrators are without authority to dismiss claims for want of prosecution with prejudice, as suggested in the 2/27/14 reinstatement order.

This claim was subsequently tried on all issues on 7/3/14 before Arbitrator Cronin. Petitioner, a 40-year old physical education teacher with Associates, Bachelors and Masters degrees and an administrative teaching certificate, testified that on 6/4/97, she was pushed down six stairs by a 3rd grade student, causing her to strike her knees and feet on each stair as she fell. Before this accident, Petitioner had received treatment for heel spurs and plantar fasciitis from Dr. Nanette Gormley as well as a podiatrist in 1992. Petitioner also was treated for prior injuries to her neck, spine and other body parts following a 1996 vehicle collision, and for a fractured right ring finger April 1997.

Following the instant accident, Petitioner treated with Dr. Gormley for general and specific complaints of pain to her left knee, right finger and back. A 6/5/97 x-ray was negative for acute fracture or dislocation of her right 4th digit, left knee, left ankle, and left foot, though it did show small plantar & posterior calcaneal spurs. A year later, follow up x-rays reported no change to her left foot, and documented only a small left-sided and tiny right-sided plantar calcaneal spur.

On 6/10/97, Petitioner began treatment with Dr. Herbert White. On 10/31/97, she began treatment for her knees with Dr. James Hill; he performed arthroscopic surgery on her left knee on 1/27/98 and right knee on 2/23/01. She also treated with podiatrist Dr. Dominic Andriacchi, Dr. Churl-Soo Suk, Dr. Robert Miller, Dr. Ann Ryan and Dr. Michael McDermott. Currently, Petitioner still sees Drs. Hill, White and Andriacchi, but has not returned to work; she testified that no doctors ever released her. Petitioner last underwent physical therapy in 2005.

In 1999 or 2000, Petitioner applied for two administrative positions but never received any offers in response. She also met with vocational rehabilitation counselor, Susan Rosenberg.

Dr. Herbert White, Jr., MD, testified at his 9/30/09 deposition that he never examined Petitioner's heels before 5/27/98 and he did not treat her knees or feet. His 3/25/03 diagnosis of plantar fasciitis was based on other doctors' diagnoses, and his diagnosis of left foot neuroma came from Petitioner. He deferred opinions regarding her knees and feet to her orthopedic doctor. Dr. White released Petitioner to work on 7/6/00 with the only restriction being that she should avoid stress. He then took her off work on 10/30/00 even though her condition and complaints were almost identical to those of 7/6/00. Since 9/7/04, Dr. White periodically examines Petitioner but has not provided her with any treatment or physical therapy.

Orthopedic surgeon James Hill, MD, testified at his 8/20/09 deposition that he first saw Petitioner on 10/27/97 for her left knee and that the totality of his treatment was to her knees only. He reviewed no diagnostic tests of her feet. Petitioner's left knee problems were causally related to her work accident and he performed a left knee arthroscopy on 1/27/98. Petitioner never complained of right knee pain before her 1/27/98 surgery or for 4 or 5 visits thereafter. Her first right knee complaints were on 8/12/98. He opined at that time that Petitioner's right knee condition could have been aggravated by her gait problems following her left knee surgery because that is what Petitioner told him. His records, however, documented that Petitioner had a normal gait and full ROM on several visits following her left knee surgery. On 11/30/98 he reported Petitioner could return to work with permanent work restrictions of no prolonged standing, walking, kneeling or lifting over 25 lbs. Six months after her 2/23/01 right knee surgery on 9/4/01, Petitioner's gait was normal and her knee ROM was full. Her main problems

were with her feet, though the plantar fasciotomy surgery she had been scheduled for was not related to her accident.

Podiatrist Dominic Andriacchi testified at his 8/4/09 deposition that before Petitioner's accident she sought and received treatment for her heels with an associate in his office. After Petitioner's accident, she did not seek foot treatment until August 1998. Dr. Andriacchi himself did not examine Petitioner at any time before 1999, contrary to his 12/8/11 letter stating she had been under his care since 1997. His opinion that her heel pain was from possible trauma to her heels – hitting, bruising and hurting them during her fall – was based on Petitioner's statement, not from his exam or diagnostic testing. Dr. Andriacchi agreed that if Petitioner's history to him was incorrect, that could affect his conclusions.

Dr. Andriacchi believed Petitioner's right foot pain on 7/21/99 was related to her accident, though she hadn't reported injuring her right foot in that fall. On 1/27/00, he found Petitioner able to work light duty while seated. In 2004, he performed a left endoscopic plantar fascia release. On 2/29/06 Petitioner developed a left forefoot neuroma.

Vocational reports from Rehabilitation Works dated 11/25/98 and 11/4/99 documented that Petitioner's multiple academic degrees and Type 75 certificate qualified her for administrative positions such as principal and assistant principal. Vocational specialist Susan Rosenberg scheduled and notified Petitioner of an interview for a sedentary position as a Special Services Coordinator with IIT, administering tests to students, on 11/10/99. However, Petitioner cancelled that interview, explaining why she couldn't do that job. Ms. Rosenberg questioned Petitioner's motivation to return to any type of work.

Petitioner's 9/3/98 functional capacity evaluation documented high subjective complaints of pain with all activities as well as symptom magnification behavior. There were validity issues with the FCE report; it stated Petitioner's current physical demand level was unknown because the FCE did not reflect her maximum physical performance.

On 6/8/98, orthopedic doctor, Mitchell Krieger, MD, performed a Section 12 exam of Petitioner's knees; he documented many normal findings. Dr. Krieger diagnosed bilateral chondromalacia of patella and recommended a spine exam and right knee MRI.

Orthopedic doctor, Edward Goldberg, MD, performed a Section 12 examination of Petitioner's spine on 7/13/98 and opined Petitioner would be at MMI for her spine after a month of physical therapy, and could then return to her prior job from a lumbar spine point of view.

For Respondent, orthopedic surgeon Ira Kornblatt, MD, testified at his 3/24/10 deposition that he examined Petitioner on 11/25/2009 and took x-rays which revealed minor changes to her knees, a small left calcaneus spur and a normal right foot. He reported Petitioner walked with a normal gait. He reviewed Petitioner's 9/3/98 FCE, noting its significant inconsistencies between subjective complaints and objective findings, which he believed made that evaluation invalid. He thought it likely that Petitioner has behaved like that for many years. Dr. Kornblatt opined: Petitioner had no significant objective findings; her ongoing foot complaints were not related to her injury; there was no evidence of significant disability to her knees, and her subjective complaints were far in excess of the findings on x-rays and physical examination. Dr. Kornblatt

further opined that Petitioner needed no additional medical treatment for her feet as a result of her work injury, and was capable of carrying out her normal job activities as a gym teacher.

Dr. Kornblatt testified Petitioner's 1/27/98 left knee surgery was related to her accident but her 2/23/01 right knee surgery was not. Her right knee surgery was likely required for a degenerative process and the right knee was not compromised by the left knee injury. Her right knee findings were very minimal and her patellar chondromalacia and plica were basically normal findings in persons of Petitioner's age. If her right knee was aggravated by her accident, it would at most be a temporary aggravation that likely resolved in 3 or 4 months. Petitioner had no direct injury to her feet on 6/4/97. Dr. Kornblatt found no objective evidence of a left foot neuroma, and he "absolutely" disagreed that Petitioner was disabled and unable to return to work. Finally, Dr. Kornblatt opined that Petitioner's plantar fasciitis and spurs were pre-existing; she was MMI, and she had no significant permanent partial impairment.

The Commission finds that Petitioner proved the condition of her left knee is related to her accident, but that she failed to prove her current conditions of her right knee, feet, and back are causally related. In so holding, the Commission finds more credible the opinions of Respondent's Section 12 doctors than those of Petitioner's treating physicians, who based their opinions on incomplete, inaccurate or unsubstantiated histories provided them by Petitioner.

Petitioner's testimony, statements to her doctors and motivation to return to work are questionable. At trial, Petitioner denied that any of her doctors ever released her to work, yet at various times, Drs. Andriacchi, Hill and White each had released her with restrictions. On 8/27/98, Petitioner sought a letter from Dr. Andriacchi's office stating that her heel pain was due to her work accident; the treating podiatrist had to tell her attorney that her heel pain was pre-existing. According to Dr. Krieger, Petitioner magnified her alleged accident symptoms as early as 6/8/98; he documented her significant subjective complaints and minimal objective findings. Petitioner's 9/3/98 FCE also noted considerable validity issues making it unreliable. Dr. Kornblatt reported, following his 11/25/2009 exam, that Petitioner's subjective complaints were far in excess of her x-ray and exam findings. Petitioner implicitly acknowledged her ability to work by seeking administrative jobs with the Board of Education, but then refused to attend a an interview for a sedentary job set up by a vocational rehabilitation counselor, who reported her motivation to return to any type of work was questionable. Prior to arbitration, Petitioner was working as a caregiver for her ill mother, showing her ability to perform gainful employment.

In finding the Petitioner's foot problems unrelated, the Commission notes they were pre-existing; that Petitioner was wearing orthotics at the time of her accident, and that immediately following, she had few specific foot complaints. Dr. Hill agreed that Petitioner's plantar fasciotomy surgery was unrelated to her accident. In finding Petitioner's right knee condition not causally related, the Commission notes that Petitioner received little treatment to her right knee after her fall, and it adopts Dr. Kornblatt's opinions that Petitioner's right knee findings were very minimal, most likely age related, and that any need for the right knee surgery performed over 3½ years following her accident was related to a degenerative condition.

The Commission finds that Petitioner attained MMI on 11/30/98, when Dr. Hill first released her to work. Consequently, the Commission modifies the Arbitrator's award of temporary total disability benefits to 23-2/7 weeks, for the periods of 7/1/97 through 9/4/97, 7/1/98 through 9/4/98, and 10/31/98 to 11/30/98.

The Commission reverses the Arbitrator's award of prospective medical care. That care was awarded for Petitioner's foot problems, which the Commission finds not causally related to her accident.

For medical services, the Arbitrator awarded Petitioner the following amounts:

1.	The 6/29/08 (sic, should be 6/29/98) right knee MRI bill:	$ 950.00
2.	Physical therapy bill (2/10/98 – 11/30/98):	$4,112.00
3.	Various office visit bills of Dr. White (dates not specified):	$1,152.25
4.	Stroger Hospital bill, 6/1/06:	$2,407.00
5.	Balance of Dr. Andriacchi bill (dates not specified):	$1,910.00

The Commission agrees with the Arbitrator that the physical therapy bill (No. 2, above, in the amount of $4,112.00) was appropriately awarded to Petitioner for treatment related to her accident, and adopts and affirms that $4,112.00 award. The therapy was within 6 months of Petitioner's accident and was reasonable and necessary. The Commission finds the Arbitrator erred in awarding the other bills for medical treatment for the above items numbered 1, 3, 4, and 5. For the reasons stated above, the Commission finds that Petitioner has not proven those to be causally related to her work accident. The Commission therefore reverses the Arbitrator's decision and award as to those bills.

Finally, the Commission finds the Arbitrator erred in converting the decision to a §19(b) award and not awarding permanency. The parties stipulated at arbitration that all issues, including nature and extent, were at issue. As noted, the Commission finds that Petitioner reached MMI for her work injuries on 11/30/98, and therefore it now considers the nature and extent of Petitioner's disability. Taking into consideration her left knee injury and treatment including surgery, as well as all her other relatively minor injuries, bruises, contusions and sprains and strains, the Commission awards Petitioner 20% loss of person as a whole under §8(d)2 of the Act, for all of her injuries combined.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2015, is 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 to Petitioner the sum of $695.20/week, commencing July 1, 1997 through September 4, 1997, and from July 1, 1998 through September 4, 1998, and from October 31, 1998 through November 30, 1998, totaling 23-2/7 weeks, those being the periods of temporary total incapacity from work under §8(b) of the Act.

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IT IS FURTHER ORDERED BY THE COMMISSION that the award of the award of prospective medical care is reversed, and the award of medical expenses Respondent is to pay Petitioner is modified; Respondent shall pay Petitioner only the sum of $4112.00 as reasonable and necessary medical expenses as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $421.59 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 permanent partial disability to Petitioner to the extent of 20% loss of use of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury, including but not limited to $396,247.20 in TTD benefits heretofore paid, as reflected by the stipulation of the parties, and $15,148.55 which Respondent paid for Petitioner's foot surgery.

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: MAR 2 8 2016

o-02/24/16
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES-RICHARD, ALITA
Employee/Petitioner

Case# **97WC039437**

CHICAGO BOARD OF EDUCATION
Employer/Respondent

16IWCC0230

On 2/13/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1218 LAW OFFICES OF MARK SCHAFFNER
205 N MICHIGAN AVE
SUITE 2560
CHICAGO, IL 60601

0559 CHICAGO BOARD OF RDUCATION
RACHEL M GARCIA
125 S CLARK ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ALITA JONES-RICHARD,
Employee/Petitioner

v.

CHICAGO BOARD OF EDUCATION,
Employer/Respondent

Case # **97** WC **39437**

Consolidated cases: **N/A**

16IWCC0230

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 3, 2014 and August 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 (1) **Prospective Medical Care**
(2) **Dismissal/Reinstatement of Claim**

FINDINGS

On **June 4, 1997**, Respondent *was* operating under and subject 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 **$54,225.60**; the average weekly wage was **$1,042.80**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$396,247.20** for TTD benefits, **$0** for maintenance benefits, and **$0** for other benefits, for a total credit of **$396,247.20**.

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

ORDER

Temporary total disability benefits

Respondent shall pay Petitioner temporary total disability benefits of **$695.20**/week for **836-3/7** weeks, commencing **7/1/1997** through **9/4/97**, **7/1/1998** through **9/4/1998**, and **10/31/1998** through **7/3/2014**, as provided in Section 8(b) of the Act.

Credit

Respondent shall be given a credit of **$396,247.20** for temporary total disability benefits that have been paid.

Medical Bills

Respondent shall pay reasonable and necessary medical services of **$10,531.25**, as provided in Section 8(a) and subject to Section 8.2 of the Act, as applicable.

Prospective Medical Care

Respondent shall authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

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

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

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

Signature of Arbitrator

February 11, 2015
Date

FEB 13 2015

ILLINOIS WORKER'S COMPENSATION COMMISSION

ALITA JONES-RICHARDS,	)	
	)	
Petitioner,	)	
vs.	)	No. 97 WC 39347
	)	
CHICAGO BOARD OF EDUCATION,	)	
	)	16IWCC0230
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter having come before the Arbitrator for hearing on July 3, 2014 and August 5, 2014, the Arbitrator, having heard the testimony of the parties and considered the exhibits admitted into evidence, makes the following findings in support of his award:

I. Findings of Fact

Petitioner filed an Application for Adjustment of Claim alleging she sustained injuries in the course of her employment with the Chicago Board of Education on June 4, 1997. At the time of the accident, Petitioner was 40 years of age and was employed as a physical education instructor.

Petitioner testified that she holds a Bachelor of Science Degree in physical education and health as well as a Masters Degree in school administration. She has never been employed in the area of school administration, but has worked many years as a physical education instructor. Petitioner's Illinois teaching certificate was received into evidence as Petitioner's Exhibit 38. The certification confirms the Petitioner's certificate was valid for special K-12 teaching, physical education. The subsequent teaching certificate, which was issued in June 1995, indicates it was valid for administrative K-12.

Petitioner testified that her position as physical education instructor requires her to be on her feet the entire day, requires her to demonstrate the various physical education activities to her students and requires lifting and pulling for such items as wrestling mats. Petitioner testified she was able to perform all these duties prior to the accident of June 4, 1997. Immediately prior to that date, she was not under the care of a doctor nor did she have treatment for any knee complaints. Petitioner did testify she had seen a foot doctor prior to the date of her accident, but that her foot condition was in good control for at least a year prior to the accident.

Petitioner testified that on June 4, 1997, as she was descending a flight of stairs in the school where she taught, a student pushed her, which caused her to fall forward and strike the floor after she went down approximately six steps. Petitioner described the steps as being of a hard material. A picture of the stair steps was admitted as Petitioner's

Exhibit 20. As Petitioner lay where she fell, the same student descended the stairs and stomped on her left thigh, which caused her leg "to move."

Petitioner testified that immediately following the assault, she noticed pain in her left thigh as well as pain in her neck, shoulders, arm and generally everywhere. Another employee of the Board of Education assisted Petitioner following the accident.

Petitioner completed an Employee Accident Report in which she identified the parts of the body that she injured: "BOTH ARMS, LEGS, KNEES, + BACK, BOTH ELBOWS, + NECK." She also wrote that she had a bruise on the following body parts: "ARMS, LEGS, BOTH KNEE (sic) + ?". She wrote that she had a sprain of her LEFT ANKLE and scratches to BOTH KNEES. She wrote that she had a fracture of her FINGER RGT, but also indicated that she had a broken finger prior to being pushed. *PX 1*

Following the accident, Petitioner underwent extensive medical treatment, particularly for pain in her ring finger, her left and right knees and her left and right feet. Petitioner was initially seen by her doctors at Advocate Meyer Medical. *PX 4* X-rays were ordered and were taken of her right fourth finger, left knee and left ankle and foot on June 4, 1997. *PX 4*

Petitioner then followed up with Dr. Herbert White on June 10, 1997. Petitioner testified she went to Dr. White because a relative had received treatment from him and had recommended him. Petitioner treated with Dr. White for, among other body parts, her ankles and feet. Petitioner has continued to treat with Dr. White to the present. During his treatment, Dr. White ordered a number of diagnostic studies, which included a September 26, 1997 MRI of the right knee, a June 26, 1998 order for an MRI of the right knee, a June 19, 2006 order for an MRI of the lumbar spine and left knee and a June 30, 2005 order for a MRI of the left foot. The primary treatment rendered by Dr. White has been medication for pain and swelling as well as multiple courses of physical therapy. Such therapy has included, at various times, swim therapy, massage therapy and acupuncture. *PX 6B*

The deposition of Dr. Herbert White was taken on September 30, 2009 and was admitted into evidence as Petitioner's Exhibit 6.

At the request of Respondent and pursuant to Section 12 of the Act, on June 8, 1998, Dr. Mitchell I. Krieger examined Petitioner's knees. Upon examination, the doctor found, *inter alia*, ½ inch atrophy of Petitioner's left calf when compared with her right calf. He diagnosed chondromalacia of the patella bilaterally, ordered an MRI of the right knee. If such MRI were negative, he would declare Petitioner to be at MMI. He would then order an FCE to determine whether she could return to work as a physical education teacher. Dr. Krieger further opined: "There does appear to be a significant amount of subjective complaints with minimal objective findings." *RX 9*

At the request of Respondent and pursuant to Section 12 of the Act, on July 13, 1998, Dr. Edward J. Goldberg examined Petitioner's lumbar spine. Dr. Goldberg did not find any focal neurological change to indicate that the slight atrophy in Petitioner's left calf is from her lumbar spine. Dr. Goldberg opined: "It is possible that she has been

favoring the left lower extremity due to the fact that she did have the arthroscopic surgery and had the injury to that knee." He recommended one month of formal physical therapy for her low back while she receives PT for her left knee. After that, he would find her to be at MMI for her lumbar spine and capable of returning to work as a physical education teacher. In that regard, Dr. Goldberg continued, he would defer to Dr. James Hill, who performed the arthroscopy on Petitioner's left knee. *RX 10*

The records of Meyer Medical reflect that on June 19, 1998, Petitioner complained of heel pain. On July 24, 1998, Petitioner returned to Meyer Medical. Among her subjective complaints, the physician wrote the following:

> "Hx Heel spurs – Using orthotics x 11 YR. C/O heel pain x 4 mos. - Notes Trauma 1/98 to Lt Knees 1 YR ago - Jan 98 had arthroscopy – Notes cartilage damage – Walking differently." *PX 4*

Upon examination, the physician noted bilateral tenderness to the heels, but no edema. The physician assessed Petitioner with heels spurs and ordered x-rays of bilateral heels with copies of the x-rays to be given to Petitioner. He also referred Petitioner to a podiatrist. *PX 4*

On August 12, 1998, Petitioner visited the offices of Dr. Dominic Andriacchi DPM. The Progress Note for this date indicates: "Pt. is picking up X-rays – she says she is taking them to another Dr. who did surgery on her knee." *PX 19, Resp. Dep. Ex. #3* Just above the August 12, 1998 Progress Note is a July 31, 1995 Progress Note that states:

> "Pt has x-rays – Pt had "knot" on left foot for approx. 3 mos. – has disappeared. Primary doctor stated pt. has heel spurs. Sensitivity on heels. Plantar Fasciitis. X-rays show heel spurs. Pt. to have ort's made. RTO PRN." *PX 19, Resp. Dep. Ex. #3*

After Petitioner's visit to the offices of Dr. Andriacchi on August 12, 1998, she returned to him on August 27, 1998. The Progress Note for this date indicates:

> "Pt. here to pick-up letter w/Diagnosis. Letter is for work. Also, here to inquire about Orthotics.
> S/ Pt. wants letter stating that states her heel pain is from accident.
> P/ Spoke c̄ Pt's lawyer – advised him that she had heel pain in '95 before the accident. She's to cont. c̄ current tx. RTC PRN
> *PX 19, Resp. Dep. Ex. #3*

Although Dr. Andriacchi did not personally treat Petitioner until sometime in 1999, he and his colleagues have treated Petitioner for her foot problems from August 1998 to the present. The records reflect that following Petitioner's accident, Dr. Andriacchi provided various forms of treatment, including left ankle bracing, orthotics, biofreeze, cortisone injections on multiple occasions, diagnostic ultrasound examinations and surgery. Following his evaluation of Petitioner, Dr. Andriacchi diagnosed her with aggravation of her bilateral heel spurs, plantar fasciitis and a neuroma. *PX 14, PX 18, PX 19, Resp. Dep. Ex.#1, #3 and #4*

The deposition of Dr. Dominic Andriacchi was taken on August 4, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 19.

Dr. White referred Petitioner to Dr. James Hill for treatment of her knee complaints. Dr. Hill performed left knee arthroscopic surgery on Petitioner on January 27, 1998. He found Grade III chondromalacia of the patella and Grade II changes to the lateral tibial plateau. The doctor's treatment did not resolve Petitioner's problems and she remained on work restrictions from Dr. Hill. Dr. Hill then proceeded to perform right knee arthroscopic on Petitioner on February 23, 2001, at which time he found Grade II chondromalacia of the patella. *PX 15, Deposition Exhibits*

The records reflect that on March 12, 2007, Dr. Hill offered to perform a second surgery on Petitioner's left knee, but Petitioner declined additional surgery at that time. *PX 15, Deposition Exhibits*

Petitioner testified that Dr. Hill, on various occasions, recommended she proceed with foot surgery to help her with her knee pain. Such recommendations appear in his records, including April 16, 2004. In addition to the surgical treatment to the knees, Dr. Hill prescribed various periods of physical therapy, home exercise and activity restrictions.

The deposition of Dr. James Hill was taken on August 20, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 15. At this deposition, Dr. Hill opined that if Respondent could find a job for Petitioner that is within the restrictions Dr. Hill had imposed on her, she could probably perform such job. *PX 15, pp. 31-32*

Petitioner received physical therapy from Health South from October 6, 1998 through October 14, 1998, but had to transfer to another facility due to an allergy to pool chemicals used at that facility. Petitioner received additional physical therapy at Health South from August 5, 1999 through August 21, 1999 for treatment of her foot pain and received more physical therapy from Health South in Palos Heights in August of 2001 for treatment of her knee pain. *PX 40*

On June 1, 2006, Petitioner presented to the emergency room of John Stroger Hospital with complaints of foot and knee pain. She followed up with injections to the left knee and with an offer of left knee surgery, which Petitioner again declined. *PX 30*

Petitioner testified she continued to complain of pain and has had continuous pain from the date of accident to present. The pain is most notable in her knees and feet. As a result, she uses a cane if she has to walk any significant distance. She also notes that she moves more slowly and is unable to participate in any of the sports she used to do, which previously included running, basketball and racquetball. Petitioner has not returned to work since the date of her accident.

Petitioner testified she has not received any offers of employment within the limitations imposed by her doctors. Petitioner did receive a notice to return, admitted into evidence as Petitioner's Exhibit 37. The notice to return to work was dated September 14, 2009, but erroneously referred to her medical release to return to work from her physician. As her doctors have testified, she was not released to return to work at that

time. Even if she had a release to return to work, Respondent informed her, through the notice, that her prior position had been closed and no other positions were offered to her.

Petitioner looked for work in school administration. Documentation of the Petitioner's attempt to look for administrator positions are reflected, not only in her testimony but in Petitioner's Exhibit 46, which documents an application for a position advertised in the Board of Education personnel bulletin.

The records reflect Petitioner was assigned to vocational rehabilitation with Rehabilitation Works, Inc. Petitioner testified that she only recalls one meeting with the vocational rehabilitation specialist. The reports of Susan J. Rosenberg, the vocational rehabilitation consultant hired by Respondent, were admitted as Petitioner's Exhibit 17. Ms. Rosenberg performed an initial vocational assessment in November 1998, with a recommendation to Respondent to conduct a Labor Market Survey and to work with Petitioner to develop job skills. In January 1999, Ms. Rosenberg completed a Labor Market Survey with a plan to meet with Petitioner to discuss transferable skills and to develop a rehabilitation plan. However, following the development of the Labor Market Survey, the vocational rehabilitation consultant was instructed to put a hold on additional vocational services. *PX 17*

In September of 1999, Respondent restarted vocational services, with two meetings between the vocational specialist and Petitioner. The vocational rehabilitation consultant, Ms. Rosenberg, noted that the jobs identified for Petitioner would pay her in the range of $6.50 to $10.00 per hour. Per the records of Rehabilitation Works, Inc., Petitioner refused to attend a job interview with a prospective employer. Such job was within her restrictions. Respondent then terminated rehabilitation services. *PX 17*

Rehabilitation Works, Inc., reopened the file on April 22, 2000, but then closed it on June 2, 2000 in order to seek clarification of Dr. White's off-work opinion. *PX 17*

On November 25, 2009, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner submitted to an examination by Dr. Ira Kornblatt. Dr. Kornblatt specifically examined Petitioner's knees and feet. Following the examination, Dr. Kornblatt provided the following answers to specific questions:

1. Diagnosis of the patient's current condition is early degenerative arthritis, patellofemoral region, bilateral knees. With respect to her feet, she has complaints of foot pain without evidence of significant objective findings to substantiate her ongoing subjective complaints. With respect to her knees, on exam, there is no evidence of significant disability, and her subjective complaints are far in excess of the findings of the x-ray and on physical exam.

2. With respect to the question regarding whether the diagnosis of her feet is related to the work injury, it is my opinion that there is no relationship at all between her foot symptoms and the injury as described. It is my opinion that she did have documented plantar fascial symptoms and spurs prior to the injury, which she admitted to, and it is my opinion that it is not likely that the injury

as described resulted in any aggravation of her pre-existing foot problem.

3. Is any further treatment required to cure the injuries/conditions caused by the work-related injury? No.

4. Has the employee reached maximum medical improvement from this injury? With respect to permanent partial impairment, I find no evidence of significant permanent partial impairment.

5. Not applicable.

6. Does the employee have any permanent work restrictions? No.

7. Do you believe all the medical treatment to date has been necessary and directly related to the injury? No, I do not. I believe that the claimant likely reached maximum medical improvement approximately 6 months following the surgery of the left knee. It is my opinion that the surgery which was carried out of the right knee was not related to the work injury, and it is my opinion that she likely could have returned to work back in 1998. *RX 11, Dep, Ex. 2*

The deposition of Dr. Ira Kornblatt was taken on March 24, 2010 and was admitted into evidence as Respondent's Exhibit 11.

Petitioner's Exhibit (Group) 16 is a compilation of off-work slips from June 5, 1997 through February 14, 2014.

II. Conclusions of Law

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (F) "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?", THE ARBITRATOR FINDS:

Petitioner described the June 4, 1997 accidental injury. She described walking down a flight of stairs, with a group of students, at the school where she worked as a physical education instructor. As she was descending the stairs, she was pushed by a student, which caused her to fall forward down half a flight of stairs. As she lay at the bottom of the stairs, the same student that pushed her descended the stairs and stomped on Petitioner's left leg.

Petitioner has had an extensive history of medical treatment, primarily from her occupational medicine physician, Dr. Herbert White; from her orthopedic surgeon, Dr. James Hill; and from her podiatrist, Dr. Dominic Andriacchi. Throughout the records of these doctors, Petitioner consistently relates her pain as starting from the date of her accident and further describes fairly constant and consistent reports of pain in her bilateral knees and bilateral feet. Given the nature of the accident, her complaints of pain are consistent with the description of the accident.

As to Petitioner's bilateral knee complaints, the Arbitrator notes that she was seen by Dr. Herbert White on June 10, 1997, which was within one week of the accident. At that time, she was complaining of pain in her ankles, knees, elbows, shoulder, neck, back, ribs and hand. *PX 6, p. 13.* Dr. White treated Petitioner after the initial visit, made various referrals to specialists and ordered an MRI of the left knee. He reported a working diagnosis as of September 26, 1997 of left knee torn cartilage and right knee pain, among other diagnosis. He therefore referred Petitioner to Dr. James Hill, an orthopedic surgeon. *PX 6, p. 19; PX 15, p. 7.*

Dr. Hill initially examined Petitioner on August 26, 1997, and offered a causal connection opinion between Petitioner's left knee condition and the June 4, 1997 accident. *PX 15, p. 12.* He performed surgery on the left knee and gave a post-operative diagnosis of chondromalacia of the patella and the lateral tibial plateau. The operation did not alter Dr. Hill's opinion that the left knee condition was causally related to the accident. Dr. Hill also treated Petitioner for her complaints of right knee pain. As of August 12, 1998, Dr. Hill diagnosed her with chondromalacia of the right knee. This treating orthopedic surgeon opined that the right knee pain was also causally related to the accident as Petitioner had an altered gait and favored her left knee. *PX 15, p. 16.* Dr. Hill continued to treat Petitioner for bilateral knee pain and ordered an MRI in 2000 that showed patella tendinitis and chondromalacia. *PX 15, p. 19.* The doctor subsequently performed arthroscopic surgery on Petitioner's right knee Petitioner on February 23, 2001. At that time, he excised the medial plica. *PX 15, p. 20.* Dr. Hill testified that since he initially evaluated Petitioner in August 1997, he has seen Petitioner regularly for her ongoing complaints of bilateral knee pain, left greater than right.

Dr. Hill offered no causation opinion with regard to Petitioner's feet.

Dr. Herbert White, who continued to treat Petitioner on a non-surgical basis, causally related Petitioner's complaints of left and right knee pain to the accident of June 4, 1997. *PX 6, pp. 19, 22, 26 and 29.*

To the extent that Respondent's Section 12 physicians have expressed differing opinions, this Arbitrator finds the explanations and foundation for opinions expressed by Dr. Hill to be more persuasive. In addition, the treating doctors have had the benefit of years of treatment and frequent contact with Petitioner to evaluate her condition and form opinions. It is therefore the finding of the Arbitrator that Petitioner's current condition of ill-being related to her right and left knees is causally related to the accident of June 4, 1997.

At trial, Petitioner continued to complain of bilateral foot pain. The record reflects she had complaints of left heel pain prior to her accident of June 4, 1997 and was seen by a podiatrist at Dr. Andriacchi's office on July 31, 1995. At that time she was diagnosed with heel spurs. She was only seen on one occasion. She did not return to Dr. Andriacchi's office for treatment until approximately 1 year after the accident.

Post-accident, Petitioner voiced complaints of foot pain to Dr. White. On May 27, 1998, Dr. White recorded complaints of worsening bilateral heel pain. Dr. White testified that Petitioner sustained an aggravation of her heel spurs. *PX 6, pp. 68-69* Dr. White further opined that Petitioner had an abnormal gait due to knee pain and back pain

that caused an aggravation of her foot pain resulting in plantar fasciitis. *PX 6, pp. 36-37* The Arbitrator accepts these opinions given the minimal treatment Petitioner received for heel pain in 1995 and the nearly two-year period prior to the accident during which she did not seek medical attention for heel or foot pain.

Petitioner returned to see Dr. Andriacchi, a podiatrist, who noted ongoing complaints of heel pain from August 1998, when his office first saw her, to the date he testified by deposition. He treated her with multiple injections, medications, orthotics and a heel brace. Dr. Andriacchi opined that this condition is causally related to the accident. *PX 19, pp. 22, 27-28*

In March 1999, Dr. Andriacchi further found the onset of plantar fasciitis, which he noted was secondary to heel trauma. *PX 19, pp. 25-6.* On September 24, 2004 Dr. Andriacchi performed surgery for treatment of the left foot plantar fasciitis. The left foot pain continued, even after surgery, and resulted in an additional diagnosis of a neuroma, which he measured to be approximately 1 cm.

Dr. Andriacchi concluded that the left and right foot conditions, for which he treated Petitioner, were causally related to the accident, and continue to be causally related as of the date he testified. *PX 19, p. 46.*

In 2009 and 2010, Dr. Kornblatt opined that neither the condition of Petitioner's right knee nor her feet are causally related to the accident of June 4, 1997. Moreover, Dr. Kornblatt opined that Petitioner was capable of returning to her job of physical education teacher.

The Arbitrator recognizes that payment of TTD benefits is no admission of liability. Yet, after Respondent had paid nearly 12-1/2 years of TTD benefits, Dr. Kornblatt examined Petitioner on one occasion, did not review all of Petitioner's treating records and rendered a 2-1/2-page report.

The Arbitrator finds the opinions of the treating physicians, in particular, Dr. Hill, to be more persuasive than those of Dr. Kornblatt. Dr. Hill is a Professor of Orthopedic Surgery at Northwestern University Feinberg School of Medicine and has a 13-1/2 page curriculum vitae. Dr. Hill performed surgery on each of Petitioner's knees.

As the Arbitrator finds Dr. Kornblatt's opinions unpersuasive with regard to Petitioner's right knee and her ability to return to her job of physical education instructor, he gives little weight to his causation opinions with regard to Petitioner's feet.

The Arbitrator puts great weight on the opinions of Dr. Hill.

Given the mechanism of injury, Petitioner's altered gait, the consistency of her complaints and the opinions of Doctors Andriacchi and White, the Arbitrator finds Petitioner's current condition of ill-being of her feet to be causally related to the accident of June 4, 1997.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (J) "WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY? HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICE?", THE ARBITRATOR FINDS:

The Arbitrator has found Petitioner's bilateral knee complaints and bilateral foot complaints causally related to the accident of June 4, 1997. She received diagnostic and therapeutic services for her bilateral knee condition at St. James Hospital and Health Center, underwent an MRI on June 29, 2008, participated in physical therapy and visited Dr. White. These services fall within reasonably and necessarily prescribed services as follows:

1. June 29, 2008 MRI billed in the amount of $ 950.00;
2. February 10, 1998 through November 30, 1998 physical therapy billed in the amount of $4,112.00;
3. Various office visits with Dr. White billed in the amounts of $24.00, $262.50, $131.25, $370.50 and two visits of $182.00.

Petitioner presented to the emergency room of John Stroger Hospital on June 1, 2006 with complaints of foot and knee pain. She received an injection to her left knee from the hospital. This complaint and treatment is consistent with her complaints to Dr. James Hill and are reasonable and necessary in the billed amount of $2,407.00.

In addition to the treatment for her knee injury, Petitioner saw Dr. Dominic Andriacchi for care of her bilateral foot pain, which the Arbitrator has found to be causally related to her accident of June 4, 1997. The Arbitrator finds the unpaid balance of $1,910.00 was for reasonable and necessary treatment.

The Arbitrator orders the above medical bills to be paid, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Finally, while Respondent paid for the surgery to Petitioner's foot, they claim a credit for their payments, which is addressed below. The Arbitrator finds the surgery, as described by Dr. Andriacchi in his deposition, to be reasonable, necessary and related treatment.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (K) "WHAT TEMPORARY BENEFITS ARE IN DISPUTE? (TTD)", THE ARBITRATOR FINDS:

Petitioner testified she was off work following the accident of June 4, 1997 through the date she testified. She testified that Respondent employed her as a physical education instructor. She found this to be a physically demanding job. Petitioner testified that she is required to demonstrate physical education activities to her students, which include basketball, volleyball, running and other physically demanding activities. In addition, she is responsible for setting up the facilities for the students, which would include pulling and placing wrestling mats.

All three of Petitioner's treating physicians following this accident, Drs. Hill, White and Andriacchi, testified she could not return to work as a physical education instructor. The Arbitrator finds this is significant as the opinion of inability to perform work as a physical education instructor comes from three, independent doctors.

Dr. James Hill, the orthopedic surgeon, testified that he took Petitioner to surgery on January 27, 1998 for her left knee. As of March 28, 1998, he kept her off work to help build her leg muscle. *PX 15, p. 15.* He continued Petitioner's treatment and testified that as of December 10, 1998, he still had not released her to work duties. *PX 15, p. 18.* Dr. Hill continued his treatment plan, including home exercise program and a second surgery, this time to the right knee, on February 23, 2001. The doctor testified that as of March 21, 2007, he continued her off work as a physical education instructor and imposed permanent restrictions of no prolonged standing, walking, kneeling, squatting, bending and no lifting over 25 pounds. *PX 15, p. 23.* The doctor reiterated these permanent restrictions as of November 3, 2008. *PX 15, p. 24.* Given the physical nature of Petitioner's job, these restrictions rule out her ability to perform her occupational duties from the date of her accident until the date this case was tried.

Dr. White, who followed Petitioner on a non-surgical basis, also limited Petitioner from returning to her occupational duties. When Dr. White saw Petitioner in June 1997, he certified her off work. *PX 6, p. 16.* He continued her off work through June 26, 1998. *PX 6, p. 26.* He further confirmed he held Petitioner off work continuously from June 10, 1997 through February 23, 2001. *PX 6, p. 33.* The doctor testified the off work status continued through July 2009, with the exception of one unsuccessful attempt to return to work. *PX 6, pp. 38-39.* On the date of his deposition, Dr. White concluded Petitioner continued to be unable to return to work as a physical education instructor. *PX 6, p. 41.*

Dr. Dominic Andriacchi also opined Petitioner could not work as a physical education instructor. His medical records reflect ongoing off-work certifications confirmed by his testimony. His treatment recommendations include the use of orthotics, rest, elevation of the feet and the use of compression stocking. *PX 19, p. 44.*

Since Dr. Hill, Dr. White and Dr. Andriacchi testified to their opinions in 2009, each of them has issued numerous "off work" slips. There are no "light-duty" work releases in this exhibit. *PX (Group)16*

Based on the complaints of pain in both her knees and feet, and on these off-work slips, the Arbitrator finds that has been temporarily, totally disabled from the date of her accident to the present.

The parties stipulated to payments received for full salary and TTD benefits. Based on contractual obligations, Respondent paid Petitioner her full salary for the periods of June 5, 1997 through June 30, 1997; September 5, 1997 through June 30, 1998; and September 5, 1998 through October 30, 1998. Petitioner was disabled and did not work during this period, but was entitled to full salary pursuant to the collective bargaining agreement. Petitioner is entitled to payment of TTD benefits from July 1, 1997 through September 4, 1997; from July 1, 1998 through September 4, 1998; and October 31, 1998 through July 3, 2014, the date Petitioner testified, representing a period

of 836-3/7 weeks. Respondent is entitled to a credit for TTD benefits they have paid in the amount of $396,247.20.

IN SUPPORT OF HIS DECISIONS WTH REGARD TO ISSUES (L) "WHAT IS THE NATURE AND EXTENT OF THE INJURY?", AND (O) "OTHER: PROSPECTIVE MEDICAL CARE", THE ARBITRATOR FINDS:

Based on the testimony of Petitioner and the deposition testimony of Drs. Hill and White, Petitioner sustained a traumatic injury to her left knee resulting in an aggravation of a degenerative knee condition. Dr. Hill further found Petitioner sustained an aggravation of her right knee degenerative condition as a result of an altered gait resulting from her left knee pain.

Both Dr. White and Dr. Andriacchi causally related the condition of Petitioner's feet to the accident of June 4, 1997.

The accident also resulted in the sprain of Petitioner's left fourth finger. While Dr. White felt there was a fracture, Dr. Suk found a sprain, which Petitioner reported continues to bother her.

As a result of the knee injuries, Dr. Hill, on March 21, 2007, imposed activity restrictions on Petitioner that limit her standing, walking, stooping, kneeling and lifting (to 25 lbs.). Dr. White testified in 2009 that if Petitioner were allowed undergo surgery for the neuroma on her foot, she might be able to return to some work. The later off-work slips of Doctors White and Andriacchi have simply limited Petitioner to no return to work. *PX 16 (Group)*

The Arbitrator finds that Petitioner failed to prove that she is an "odd-lot" permanent total. No doctor or vocational rehabilitation counselor has specifically opined that Petitioner is permanently and totally disabled. Moreover, Petitioner did not introduce evidence of a job search or any evidence to show that no stable job market exists for any of her services and thus failed to meet her burden that she was not capable of obtaining gainful employment.

The Arbitrator notes that Petitioner is well educated. Petitioner is not taking prescription pain medication. Under Dr. Hill's March 21, 2007 restrictions, to which he referred at the August 20, 2009 deposition, Petitioner was capable of performing, at the very least, sedentary work. At the February 11, 2014 hearing of the motion to reinstate, Petitioner stated that she has been looking after her mother during her mother's long illness.

Petitioner has also failed to prove that she is entitled to a wage differential award. Although Respondent provided vocational rehabilitation services from November 25, 1998 through May 23, 2000, the vocational consultant questioned Petitioner's motivation to return to work. Furthermore, Petitioner refused to attend an interview with a prospective employer that the consultant had arranged on November 10, 1999. The Labor Market Survey conducted in early 1999 indicated that Petitioner would likely suffer a wage loss. However, such data is 15 years old. No recent Labor Market Survey

or recent opinion of a vocational specialist was offered into evidence. No evidence was introduced to show the amount Petitioner is able to earn in some suitable employment or business. No evidence was introduced to show what Petitioner would be able to earn in the full performance of her duties in the occupation in which she was engaged at the time of the accident.

On August 20, 2009, Dr. Hill opined that if Respondent could find a job for Petitioner within the restrictions he had imposed on her, that Petitioner could probably perform such job. Thereafter, he issued no return to work slips and recommended further treatment for her foot. Petitioner's Exhibit (Group) #16 is a compilation of off-work slips, produced by Dr. Hill, Dr. White, Dr. Andriacchi, and Dr. Gormley. The first off-work slip was authored by Dr. Gormley and dated June 5, 1997. The rest of the off-work slips are authored by the other three treating physicians, which begin on February 13, 2008 and end on February 15, 2014.

Dr. Hill continues to keep Petitioner off work and has recommended that Petitioner seek a surgical consultation regarding her left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

Based on Dr. Hill's recommendation, the Arbitrator finds that Petitioner has not yet reached MMI. Consequently, a determination as to Petitioner's permanent disability is not appropriate at this time.

Therefore, the Arbitrator orders Respondent to authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (M) "SHOULD PENALTIES AND FEES BE IMPOSED ON RESPONDENT?", THE ARBITRATOR FINDS:

Respondent introduced reports of physicians hired by them to perform Section 12 examinations. Respondent was entitled to rely on the opinions of their physicians, even though the Arbitrator has found the opinions of the treating doctors, to the extent they conflict with those rendered by Doctors Krieger and Kornblatt, to be more persuasive. No penalties are due Petitioner on this record.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (N) "IS RESPONDENT DUE ANY CREDIT?", THE ARBITRATOR FINDS:

Respondent claims a credit for the payment of Petitioner's foot surgery. However, the Arbitrator finds that both Dr. Herbert White and Dr. Dominic Andriacchi opined that Petitioner's foot condition was causally related to the accident. In this regard, the Arbitrator adopts his findings of fact and conclusions of law as to the issue of causation. Respondent was liable for the foot surgery pursuant to Section 8(a) of the Act and is not entitled to a credit against the award herein.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (O) "OTHER: DISMISSAL/REINSTATEMENT OF CLAIM", THE ARBITRATOR FINDS:

The Arbitrator made detailed findings and entered a written Order for the reinstatement of the instant case. The Arbitrator finds no reason to disturb his findings and Order. The reinstatement of this case shall stand.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Lenington,
Petitioner,

vs.
Menards, Inc.,
Respondent,

NO: 98 WC 47272

17IWCC0567

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 expenses, prospective medical expenses, and whether or not there is a causal connection between the left hip condition and the work accident, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 12, 2016 is hereby affirmed and adopted.

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

DATED: SEP 18 2017

Kevin W. Lamborn

Charles J. DeVriendt

Joshua D. Luskin

KL/mas
o:8/30/17
43

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

LENINGTON, ERIC
Employee/Petitioner

Case# **98WC047272**

MENARDS INC
Employer/Respondent

17IWCC0567

On 9/12/2016, 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 0.47% 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:

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

1109 GAROFALO SCHREIBER HART ETAL
MATTHEW NOVAK
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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)

ERIC LENINGTON,
Employee/Petitioner

v.

MENARDS, INC.
Employer/Respondent

Case # **98** WC **47272**

Consolidated cases: _____

17IWCC0567

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **8/11/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/27/98**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to his left hip *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$16,900.00**; the average weekly wage was **$325.00**.

On the date of accident, Petitioner was 29 years of age, ***married*** with 1 dependent children.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services for the total left hip arthroplasty and total right knee arthroplasty as recommended by Dr. Mitzelfelt, 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.

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

8/30/16
Date

ICArbDec19(b)

SEP 12 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 29 year old worker at Menards, sustained an accidental injury to his right knee that arose out of and in the course of his employment by respondent on 3/27/98. This matter came up for trial before Arbitrator Holland on 4/22/08. The issues in dispute were causal connection, medical services, temporary total disability and prospective medical. The arbitrator awarded no temporary total disability benefits, and no unpaid medical. However, the arbitrator did find the petitioner's right knee meniscus tear and ACL re-injury causally related to the accident and found causal connection. The arbitrator also found the recommended ACL reconstructive surgery of the right knee was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 3/27/98. This decision was issued on 5/12/08. Respondent appealed the decision to the Commission. On 4/2/09 the Commission affirmed and adopted the Decision of the Arbitrator. No further appeals were taken. As of the hearing on 8/11/16 no surgery has been performed on petitioner's right knee.

The parties stipulated that this hearing will only address the issues of causal connection and medical issues as they relate to the left hip. The parties have deferred any issues as the related to the right knee, except the need for the total right knee arthroplasty, which respondent stipulated that it has agreed to authorize. Any other outstanding issues as they relate to the right knee are deferred to a later date.

Since 2008 petitioner testified that the only work he performed was at American Rental. He testified that in 2012-2013 he worked a light duty job at American Rental. He testified that he was the supervisor in the warehouse. He stated that his wife works two jobs to support the family.

Petitioner testified that the original brace with the hinges he was given for his right knee wore out and now he wears two braces that he picked up at Walmart. Petitioner was unaware that respondent may have offered to buy him a new brace at some point.

Petitioner testified that since 2008 his right knee has gotten worse. He stated that it swells up, pops out, clicks, and hinges. He stated that it hurts 24/7, and the pain never goes away. He stated that because of all these symptoms he has been putting all his weight on his left leg. As a result, he began experiencing problems with his left hip in 2009. He stated that his gait is off and he waddles.

Petitioner testified that between 2008 and 2015, while waiting for authorization for the ACL reconstructive surgery approved by the Arbitrator in 2008, and the Commission in 2009, his right knee worsened and he began over compensating with his left leg until the point where his left hip hurt as bad or worse than the right knee.

Following the Commission Decision in 2009, petitioner presented to Mitzelfelt on 7/9/09 for his left hip and hands. With respect to his left hip petitioner complained of increasing pain in the left hip with ambulation. Petitioner complained of pain over the left buttock and left anterior hip region with some pain radiating down the leg with certain motions. An examination revealed decreased range of motion of the left hip with pain on internal or external rotation, as well as abduction. X-rays of the left hip showed moderate to severe degenerative arthritis of the left hip. Dr. Mitzelfelt assessed moderate to severe degenerative arthritis of the left hip. He discussed a left total hip arthroplasty versus left hip resurfacing versus injection. Dr. Mitzelfelt performed an injection into petitioner's left hip.

Petitioner returned to Dr. Mitzelfelt on 8/7/09. Petitioner reported that his pain and instability had continued to worsen to the point where he was having near chronic swelling of the right knee with catching and giving way. He reported that on attempted flexion and extension when going to stand, his right knee will sometimes lock to where he cannot extend the knee. Then it subsequently pops and he can extend it. Petitioner reported that he tries to stay mobile. Dr. Mitzelfelt reviewed an x-ray of petitioner's knees dated 7/16/09 that showed moderate right knee arthritis with mild left knee arthritis. He believed the x-rays showed severe degenerative arthritis of the right knee with large periarticular osteophytes. He noted that with the right knee bent the x-ray showed the femur was actually located posteriorly on the tibia and there was very little space between the femur and the tibia signifying bone-on-bone arthritis, especially posteriorly. On the standing x-rays he saw large periarticular osteophytes. He noted hardware remnants from his ACL reconstructive were present, as well as severe patellofemoral joint arthritis with large periarticular osteophytes.

Following an examination, Dr. Mitzelfelt assessed severe posttraumatic arthritis of the right knee, status post work injury, status post ACL reconstruction in the knee, which at this point, is ACL insufficient. He was of the opinion that the ACL reconstruction discussed in the past, would at this time do him no good. The only surgical option was a right total knee arthroplasty. He recommended a right total knee arthroplasty when petitioner's symptoms warrant. He recommended conservative treatment, bracing and intermittent injections until that time.

On 3/3/15 petitioner returned to Dr. Mitzelfelt for evaluation of the right knee and left hip pain, and possible surgical evaluation. Petitioner last saw Dr. Mitzelfelt in 2009. Petitioner complained of a worsening right knee. He reported recurrent pain, catching, giving way, and swelling, which had gotten worse. Petitioner had intermittent aspirations, injections, anti-inflammatories, pain medicines, and various anti-inflammatory gels over time. Dr. Mitzelfelt was of the opinion that petitioner's pain and

instability had worsened to the point where he was having chronic swelling of the right knee with catching and giving way. Petitioner reported that with flexion and extension, and standing, sometimes, the right knee will lock and he cannot extend it. He stated that it subsequently pops and he can then extend it. Petitioner reported that he has tried to stay mobile. He reported that he utilizes braces and has been having increasing pain in the left hip to the point where the left hip is giving him more pain than the right knee. Dr Mitzelfelt was of the opinion that petitioner's right knee symptoms have continued to worsen and his left hip has continued to get worse with increased pain.

Dr. Mitzelfelt took x-rays of the right knee and left hip. The right knee x-rays showed severe degenerative arthritis of the right knee with periarticular osteophytes and bone on bone arthritis. X-rays of the left hip showed severe degenerative arthritis with deformity. Following an examination, Dr. Mitzelfelt's plan included discussions regarding a right total knee arthroplasty. He also noted that the left hip was more symptomatic than the right knee because the petitioner had been limping on the right leg for a prolonged period of time. Dr. Mitzelfelt was of the opinion that petitioner had some degenerative changes on the right hip, but significantly less than on the left, and though the arthritic changes on the left hip were most likely not caused by the injury and the prolonged limping, these conditions had definitely exacerbated it and worsened it to the point where he required treatment on the left hip now. As a result, Dr. Mitzelfelt was of the opinion that petitioner was in the need of a left total hip arthroplasty. Dr. Mitzelfelt wanted to address the left hip first, before addressing the right knee, because he believed patients do much better. After the left hip arthroplasty, Dr. Mitzelfelt wanted to proceed with a total right knee arthroplasty.

On 8/3/15 petitioner underwent a Section 12 examination performed by Dr. Joshua Jacobs, at the request of the respondent. In addition to obtaining a history and performing a physical examination, Dr. Jacobs reviewed medical records relevant to the condition of the left hip from 7/9/09 through 3/3/15. Petitioner stated that the pain in his left hip started in 2010 when he began to have burning pain. He stated that the pain had increased and was now in the groin and lateral hip region. He stated that his left hip gives out, and the pain occasionally radiates to the knee. He reported that the pain was constant and on different occasions is sharp or dull. He stated that the pain is exacerbated by walking, sitting and standing, and will keep him awake at night. He rated his pain at a 5 on a scale of 10. He reported associated stiffness and weakness with the pain. Petitioner stated that he has a moderate limp, and when he walks 2 steps he begins experiencing pain and he can only walk up to half a block at the present time.

Petitioner reported difficulty ascending and descending stairs and must use a banister. Petitioner denied any left hip pain prior to the work injury of 3/27/98.

Following an examination, Dr. Jacobs diagnosed osteoarthritis of his left hip secondary to femoroacetabular impingement. He opined that the osteoarthritis in petitioner's left hip is secondary to femoroacetabular impingement, He opined that it is unrelated to the injury of 3/27/98, and any ongoing treatment for the left hip would not be related to the injury on 3/27/98.

On 1/29/16 the evidence deposition of Dr. Mitzelfelt, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Mitzelfelt testified that in 2013 he opined that petitioner was then in need of a total right knee arthroplasty instead of a right ACL reconstruction. He opined that this change in surgical recommendation was still causally related to the injury petitioner sustained to his right knee on 3/27/98. Dr. Mitzelfelt testified that his diagnosis of petitioner in 2009 had not changed, just the progressive worsening of his right knee condition. He opined that petitioner now needed a right total knee arthroplasty rather than the original recommendation in 2009 for a right knee ACL reconstruction. Dr. Mitzelfelt opined that even if another doctor recommended a lifting brace, or a further ACL reconstruction, a brace would be okay, but would not fix his knee. He opined that petitioner would still need a right total knee replacement. He stated that bracing it would get him a little bit more time, but not eliminate the need for a total knee arthroplasty. Dr. Mitzelfelt testified that he has not been authorized by workers' comp to provide any of his recommended treatments. He opined that the casual connection between petitioner's current condition of ill-being as it relates to his right knee remains related to the injury on 3/27/98. He opined that it has been a continuing event.

Dr. Mitzelfelt opined that given the fact that petitioner has been favoring the right knee/leg for the past 5 years his left hip has been destroyed to the point where the left hip does not move and is actually becoming the more symptomatic issue. He noted that petitioner has severe degenerative arthritis of the left hip. Dr. Mitzelfelt opined that the left hip should be addressed before the right knee, because the total knee arthroplasty rehab is intensive. He stated that rehab for the knee would require the ability to ambulate, walk with a straight leg, and right now the left hip cannot do that because it is fairly fixed in position and that would limit petitioner's ability to rehab his right knee and get a good outcome. So for this reason he was of the opinion that the left hip needs to be addressed first, followed by the right total knee arthroplasty 2-3 months later.

Dr. Mitzelfelt opined that petitioner's current condition of ill-being as it relates to his left hip was significantly contributed to by the condition of the right knee that has not been addressed over the years,

causing petitioner to ambulate differently over the years, by placing all his weight over the left hip. He was of the opinion that because petitioner has had a severe antalgic gait for years after the ACL reconstruction was recommended and not authorized, the limping on the right knee since then has caused all the brunt force to be on the left hip. Dr. Mitzelfelt was of the opinion that petitioner was putting his weight on the left leg because the right leg was unstable. He stated that it was significant in determining the causation between the left hip and right knee that the right hip did not really have a lot going on as far as arthritis and he had good cartilage, and the left hip had significant arthritis. Dr. Mitzelfelt opined that petitioner's left hip had a deformity over the superolateral femoral head and neck most probably from the way he had to ambulate over the years from some lateral impingement which had gradually gotten worse to the point where the hip joint is basically socked in and petitioner has very little motion.

Dr. Mitzelfelt opined that if the ACL reconstruction originally recommended in 1999 had been done when recommended, it would have significantly alleviated the symptoms petitioner would have had with the left hip. He opined that that it would have hopefully straightened his gait and taken care of the knee, and the limp.

On cross examination Dr. Mitzelfelt agreed that hip arthritis can develop idiopathically. However, he opined that if he had been able to perform the ACL reconstruction of the right knee when recommended petitioner would not have been limping and had such severe antalgic gait for the last 16-17 years, and the recommended left total hip arthroplasty would have been much less likely. He did not believe that even if petitioner had undergo the recommended ACL reconstruction in 2009 that it would have prevented the worsening of his left hip arthritis because by then petitioner already had quite a bit of arthritic changes because it had been already 10 years since the recommended surgery on the right knee. He opined that had the surgery been performed in 2009, it would not have helped his knee because of the arthritic changes that had developed over the last 12-14 years. He opined that by 2009, when the ACL reconstruction had been approved by the Commission, it would not have done the petitioner any good, given that it was recommended 10 years earlier. He further opined that had some surgery been performed in 2009 that could have prevented the worsening of his left hip to its current state. Dr. Mitzelfelt was of the opinion that by doing surgery on the right knee in 2009, it is most likely that petitioner's gait would have straightened out and that could have slowed to where the next 6 years would not have caused so much increased deformity and damage to the left hip. He opined that the abnormality of petitioner's gait caused petitioner's problems, not his increased weight.

On redirect examination Dr. Mitzelfelt was of the opinion that if petitioner does not undergo the recommended surgeries to his left hip and right knee he will have more difficulty getting around. He was of the opinion that the left hip is going to fuse completely, and the right knee will worsen and he will lose range of motion in extension and flexion, and it will start to affect other areas of his body. He opined it will definitely get to the point where it will affect his mobility and he would need a cane.

On 2/4/16 the evidence deposition of Dr. Joshua Jacobs, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Jacobs testified that he is an adult reconstructive orthopedic surgeon. He stated that it means he deals with degenerative arthritis of the hip and knee. Dr. Jacobs was of the opinion that there is not a lot of literature evidence to support that gait abnormalities would lead to severe osteoarthritis of the left hip. He was also of the opinion that there is increasing evidence that show femoroacetabular impingement can lead to osteoarthritis later in life, but could not cite any specific papers, such as his journals that he relies on in the course of his practice. Dr. Jacobs was of the opinion that petitioner had bilateral cam deformities in his hips that were probably developmental. He was also of the opinion that it was worse on the left hip. Dr. Jacobs was of the opinion that the femoroacetabular impingement petitioner has affects the chances of petitioner developing arthritis in his hips. He did not think it would be unusual for a person to develop symptomatic osteoarthritis at 41 years of age with femoroacetabular impingement. Petitioner was 41 when he first complained to Dr. Mitzelfelt of left hip pain. Dr. Jacobs agreed that an antalgic gait, favoring the right leg, could aggravate or accelerate osteoarthritis in the left hip because you are putting more weight on one extremity versus the other, and the mechanical forces can potentially aggravate an existing arthritic problem in the joint on that side of the body. Dr. Jacobs believed it is not uncommon for it to be at different stages in one hip versus the other. Dr. Jacob opined that any ongoing treatment for petitioner's left hip would be causally related to his femoroacetabular impingement, as a result of his cam deformity.

On cross examination, Dr. Jacobs did not agree that an abnormal gait and limping had caused petitioner's severe osteoarthritis of the left hip. However, he did agree that femoroacetabular impingement syndrome can cause osteoarthritis in the hips. Dr. Jacobs agreed that the arthritis in petitioner's right hip was mild and was not significant. He also agreed that the left hip was more symptomatic and should be taken care of before the right knee.

Petitioner testified that all he does now is sit in his chair at home. He denied any prior problems with his left hip before overcompensating with his left leg because of his right knee problems and the failure of the respondent to authorize the ACL reconstructive surgery awarded by the Arbitrator and

Commission from 2009 to 2015. Petitioner denied that he is currently part of the Morton JFL board, a youth football league. He stated that he has not been part of it since 2013. While on the board he was the coaching supervisor, and his duties were to take the high school playbook and convert it for the younger players. He stated that at times he was on the field working with a youth at the request of a parent. He testified that he never coached.

Petitioner also testified that he has a Honda Gold Wing Motorcycle that his father gave him. He stated that he does not ride it now, but did ride it this summer. He testified that he gets his leg over by sitting and pulling it over. He testified that he does not kick his leg over the seat to get on the bike. Petitioner denied that he purchased a Harley motorcycle in 2013. However, he admitted that he may have road a Harley in 2013.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The parties have stipulated that the petitioner's current condition of ill-being as it relates to his right knee is causally related to the injury he sustained on 3/27/98. The parties further stipulated that respondent has agreed to authorize the total arthroplasty of the right knee recommended by Dr. Mitzelfelt. The parties stipulated that the sole issue to be determined here is the causal connection between the petitioner's left hip condition and the injury on 3/27/98.

In 1999 Dr. Mitzelfelt recommended an ACL reconstruction of the petitioner's right knee as a result of the accident on 3/27/98. However, for whatever reason, this issue was not tried until 2008. The arbitrator awarded the ACL reconstruction. In 2009 the Workers' Compensation Commission affirmed and adopted the Arbitrator's decision regarding the surgery recommended by Dr. Mitzelfelt.

When petitioner presented to Dr. Mitzelfelt in July of 2009 petitioner complained of increasing pain in his left hip with ambulation. X-rays of the left hip showed moderate to severe degenerative arthritis of the left hip. Dr. Mitzelfelt recommended a left total hip arthroplasty. In August of 2009 petitioner told Dr. Mitzelfelt that his pain and instability have continued to where he was having near chronic swelling of the right knee with catching and giving way. He reported that his right knee sometimes locks to the point where he cannot extend it, and then it pops and he can extend it. X-rays were taken of the right knee that Dr. Mitzelfelt was of the opinion showed severe degenerative arthritis of the right knee with large periarticular osteophytes. He also noted severe patellofemoral joint arthritis. Based on these findings of severe posttraumatic arthritis of the right knee, Dr. Mitzelfelt was of the opinion that the ACL reconstruction he recommended in 1999 was no longer possible due to the worsening condition of the

right knee based on the 16 years that had passed since he recommended the ACL reconstruction. He opined that only a total right knee arthroplasty should be done.

Petitioner reported to Dr. Mitelfelt that with the worsening condition of his right knee over the years, his gait has worsened. He reported that since before 2009 he has been overcompensating with his left leg to the point where he has been experiencing increasing pain in the left hip to the point where the left hip began hurting him more than the right knee.

Dr. Mitzelfelt took x-rays of petitioner's hips. X-rays of the left hip showed severe degenerative arthritis with deformity. He noted that petitioner's left hip was more symptomatic than the right knee because the petitioner had been limping on the right leg for a very prolonged period of time. Dr. Mitzelfelt found it significant that x-rays of the right hip showed some degenerative changes, but significantly less than the left. Dr. Mitzelfelt was of the opinion that although the arthritic changes on the left hip were most likely not caused by the injury and prolonged limping, the injury and prolonged limping definitely exacerbated the left hip condition and worsened it to a point where petitioner needed the treatment to his left hip now.

Dr. Mitzelfelt opined that since petitioner had been favoring his right knee/leg for at least the past 5 years, his left hip had been destroyed to the point where the left hip does not move and is actually becoming the more symptomatic issue. He opined that the left hip total arthroplasty should be performed before the total right knee arthroplasty, because the total knee replacement rehab is intensive. Dr. Mitzelfelt opined that petitioner's condition as it relates to his left hip was significantly contributed to by the condition of the right knee that had not been addressed since his surgical recommendation in 1999. He opined that the failure to authorize the recommended surgery in 1999 resulted in petitioner developing a severe antalgic gait for years, and the limping on the right knee caused all the brunt force to be on the left hip. Dr. Mitzelfelt found it significant that the arthritis in the left hip is so much more worse than in the right hip, and opined that this was due to the limping caused by the antalgic gait. He opined that had the ACL reconstruction he recommended in 1999 been done at that time, it would have greatly alleviated petitioner's symptoms in the left hip, because it would have hopefully straightened out petitioner's gait and taken care of his knee. He opined that it would have made the need for the left hip total arthroplasty less likely.

Respondent had petitioner examined by Dr. Jacobs. Dr. Jacobs diagnosed osteoarthritis of the left hip secondary to femoroacetabular impingement, unrelated to the injury on 3/27/98. Dr. Jacobs opined that there is not a lot of literature to support that gait abnormalities would lead to severe osteoarthritis of

the left hip. He opined that femoroacetabular impingement can lead to osteoarthritis later in life. Dr. Jacobs opined that petitioner has bilateral cam deformities in his hips that are probably developmental. However, Dr. Jacobs also agreed that an antalgic gait, favoring the right leg, could aggravate or accelerate osteoarthritis in the left hip because you are putting more weight on one extremity versus the other, and mechanical forces can potentially aggravate an existing arthritic problem in the joint on that side of the body. He was of the opinion that the arthritis in one hip can be different than the other. Dr. Jacobs agreed that the arthritis in petitioner's right hip was mild and not significant.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Mitzelfelt more persuasive that those of Dr. Jacobs and finds the petitioner's current condition of ill-being as it relates to his left hip is causally connected to the injury petitioner sustained to his right knee on 3/27/98. The arbitrator finds it significant that petitioner had no prior problems with his left hip prior to 3/27/98. The arbitrator also finds it significant that despite a surgical recommendation in 1999 for an ACL reconstruction, no surgery has was performed to petitioner's right knee for 17 years, and during these 17 years petitioner's right knee condition has worsened and he has had an antalgic gait and limping for at least the past 7 years. This altered gait and limping has required petitioner to put more force on his left leg and this resulted in increased pain in his left hip and very severe arthritis in his left hip. Although Dr. Jacobs opined that petitioner has bilateral cam deformities in both his hips, the arbitrator finds it significant that the condition of petitioner's hip are not the same or slightly different. In fact that left hip arthritis is severe and very significant, and the right hip arthritis is only mild and not significant. Based, on this, as well as Dr. Mitzelfelt's other opinions with the respect to the left hip, the arbitrator adopts the findings and opinions of Dr. Mitzelfelt and finds petitioner's left hip condition causally related to the injury petitioner sustained on 3/27/98.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner's current condition of ill-being as it relates to petitioner's left hip causally related to the injury he sustained on 3/27/98, the arbitrator adopts the opinions of both Dr. Mitzelfelt and Dr. Jacobs, who both agree that petitioner's left hip condition must be addressed before petitioner's right knee condition. Both agreed the left hip is more symptomatic and should be taken care of first.

The arbitrator finds the respondent shall authorize the total left hip arthroplasty recommended by Dr. Mitzelfelt and shall pay for this treatment pursuant to Sections 8(a) and 8.2 of the Act. Following the total left hip arthroscopy recommended by Dr. Mitzelfelt, the parties stipulated that the respondent shall

pay, pursuant to Sections 8(a) and 8.2 of the Act, for the total right knee arthroscopy, also recommended by Dr. Mitzelfelt.

Respondent shall pay all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 for the total left hip arthroscopy and total right knee arthroscopy recommended by Dr. Mitzelfelt.