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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Afi Ogoubi,
Petitioner,

vs. No. 14 WC 13338

18IWCC0729

Tyson Foods, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses and prospective care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).*

Petitioner testified via a French interpreter that on March 27, 2013, she worked as a "fat picker" for Respondent Tyson Foods. Her duties included monitoring conveyor lines moving pieces of meat from which she removed fat and bones. That day, a machine had broken down. When it came back on line, a lot of meat came out. Petitioner stopped the meat with her right hand, while pulling back with her left hand, "using her neck." She felt a sudden pain in the right side of her neck. Petitioner stopped the machine and called her supervisor.

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Petitioner testified she felt pain from the right side of her neck to her shoulder, down her arm, and into her right ribs and back. Her supervisor referred her to the company nurse, who gave her ice and pain pills. Although Petitioner claimed she or her employer filled out an incident report which indicated that she had radiating pain, no such report was offered into evidence. Respondent referred Petitioner to the company's doctors, who prescribed medication and four weeks of physical therapy. During this time, Petitioner continued working light duty.

Following a 7-month gap in treatment, Petitioner, who lives in Moline, IL, commenced medical treatment with doctors at Michigan Avenue Associates in Chicago. Dr. David Schafer examined her and ordered an MRI. Dr. Neeraj Jain examined her and prescribed medication. Petitioner testified that two of her doctors suggested surgery, which she now wishes to undergo. Petitioner testified she has pain in her neck which radiates to her right shoulder, goes down her arm and to her right side and back. She still works for Tyson, but experiences pain every day.

On cross-examination, Petitioner admitted she had not seen any other doctors for her condition since late 2014 or early 2015. She had no appointments scheduled for cervical spine or shoulder treatment. She was not taking prescription pain medications; only occasional ibuprofen. She admitted that the job she was performing at the time of her injury was considered a light duty position.

Petitioner expressly denied having any neck injuries, pain or treatment prior to March 27, 2013. After being shown medical records indicating she had, Petitioner admitted involvement in a 2007 car accident and acknowledged reporting cervical pain to treaters at Genesis Health Systems. However, Petitioner specifically denied being involved in a second car accident in 2008, even after being shown an EMS report which documented her complaints of neck and shoulder pain following a 30 mph rear-end accident on October 24, 2008. Petitioner was also shown a medical record showing that a cervical CT scan was ordered for her following a, "MVA, c/o posterior neck pain/stiffness." Petitioner admitted that she neglected to tell Drs. Erickson, Jain or Schafer that she had received prior treatment to her neck and shoulders.

Petitioner denied receiving a settlement from State Farm for an October 24, 2008 injury, even after being shown documents suggesting she did. Only when the Arbitrator offered Petitioner's counsel the opportunity to go off the record to talk to Petitioner, did Petitioner finally admit she had been involved in a 2008 car accident, for which she received treatment to her cervical spine and shoulder. Respondent's Exhibit D documented the treatment Petitioner received following that 2008 car accident, and included a letter from State Farm Insurance addressed to Petitioner, confirming a personal injury settlement she purportedly entered into.

The Commission finds the only injuries Petitioner proved to be causally related to her March 27, 2013 work accident were cervical, right trapezius and right shoulder sprains. In so finding, the Commission relies on the reports and conclusions of Petitioner's treaters at Respondent's Health Service Department. Those providers treated Petitioner for six months following her work accident, through September 16, 2013. Dr. Clem's diagnoses were a right trapezius and shoulder sprain. Although Petitioner did complain of cervical pain on May 6, 2013, her cervical spine range of motion on that date was normal and most of her tenderness was over her trapezius/right scapular area. Notably, Petitioner had no complaints of radiating arm pain until

she saw Dr. Schafer in April 2014, over one year after her accident. During that period and through arbitration, Petitioner missed no time from work.

On July 31, 2013, Dr. Clem found Petitioner to be at MMI; he wrote that he expected her to have no disability as a result of her work accident. Dr. Brower also found Petitioner to be at MMI when he examined her on September 16, 2013.

The Commission find the opinions of Dr. Erickson unpersuasive. At his first exam of Petitioner on June 27, 2014, Dr. Erickson recommended she undergo an anterior cervical discectomy and fusion, reporting that she suffered from bilateral C6 radiculopathy caused by a herniated cervical disc. Although Dr. Erickson opined Petitioner's radiculopathy and cervical disc were caused by her work activities, he admitted he had not reviewed or considered any of Petitioner's medical records from before or after her work accident. Instead, Dr. Erickson relied upon the history Petitioner gave to him, which omitted mention of her 2007 and 2008 auto accidents and treatment. Dr. Erickson believed Petitioner's right arm pain began suddenly after her work accident, based upon her history to him that "soon after" it, she began experiencing pain in her right arm and right-hand weakness.

Dr. Erickson's opinions were inconsistent with those of Dr. Jain. Dr. Jain did not recommend fusion surgery; only medications, physical therapy and cervical injections. And even though Dr. Erickson acknowledged an injury date of March 27, 2013, he seemed to attribute Petitioner's cervical radiculopathy to her repetitive work activities, even testifying Petitioner, "did not have a distinct accident."

The Commission finds Dr. Jain's opinions unpersuasive for similar reasons. Dr. Jain did not review Petitioner's job description or any of her medical records prior to Dr. Schafer's April 9, 2014 report. He was not made aware of Petitioner's prior cervical and shoulder injuries. He did not recommend surgery to Petitioner, and following both of his exams, he agreed with Petitioner's request to be released to full duty work. Dr. Jain's opinions are not reliable because he based them on Petitioner's incomplete and inaccurate medical history.

The Commission finds Dr. Goldberg's opinions, following his July 14, 2014 Section 12 examination support the Commission's findings that there is no causal connection between Petitioner's work accident and her radiating right arm pain, because it did not develop until over one year after her accident.

Dr. Goldberg personally reviewed Petitioner's April 9, 2014 cervical MRI and found it to be normal, with only a minimal bulge at C5-6 and no evidence of stenosis, herniation or nerve compression. Dr. Goldberg explained why he considered Petitioner's bulging C5-6 disc to be a normal variant and not pathological: it did not result in any narrowing of the neuro elements. He also explained why he did not believe Petitioner was a candidate for spine surgery: because she reported no cervical pain at his exam and because her MRI showed no neurocompression. He diagnosed Petitioner with a cervical strain.

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Because the Commission finds Petitioner's cervical, right trapezius and right shoulder strains caused by her March 27, 2013 accident were completely resolved in 2013, and that her cervical problems for which she received treatment commencing in 2014 were not causally related to her work injury, the Commission reverses the Arbitrator's award of all medical expenses in 2014 and thereafter. The Commission also reverses the award of prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of medical expenses and prospective medical care are reversed.

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

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

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

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: NOV 30 2018

o-10/03/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OGOUBI, AFI
Employee/Petitioner

Case# **14WC013338**

TYSON FOODS INC
Employer/Respondent

18IWCC0729

On 3/20/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% 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:

5271 LEADERS LAW CENTER
OWOLABI ALABA
30 E ADAMS ST SUITE 400
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
MAITAL B SAVIN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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

Afi Ogoubi
Employee/Petitioner

v.

Tyson Foods, Inc.
Employer/Respondent

18IWCC0729

Case # 14 WC 13338

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 **4/5/16**. 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 **Is Petitioner entitled to prospective medical care?**

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FINDINGS

On **3/27/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,830.05**; the average weekly wage was **$551.78**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$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 $20,558.76, as set forth in PX 5, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Erickson and Dr. Jain, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

3/10/17
Date

ICArbDec p. 2

MAR 20 2017

At the outset the Arbitrator notes that the request for hearing form indicates that nature and extent of the injury is in dispute and does not indicate that Petitioner is seeking prospective medical care. During the course of the hearing, however it became apparent that additional medical care has been recommended and that Petitioner wishes to undergo that additional treatment. The Arbitrator notes that Petitioner speaks French and testified through an interpreter.

FINDINGS OF FACT

On 3/27/13, Petitioner was employed by Respondent as a Fat Picker. Her job duties entailed removing fat from meat. There are two conveyor belts which Petitioner had to monitor. One of the conveyor belts is higher than the other. The conveyor belts carry the meat to Petitioner from her left to her right. She will pull the fat and bone from the meat and discard it to her left, as the meat continues to the right. Petitioner must simultaneously monitor the two conveyor belts. Petitioner testified she has to constantly turn her head from left to right and back to monitor the meat coming and going on the belts. This movement is done continuously during her entire shift, with the exception of lunch and break periods. If meat begins to come to her too quickly Petitioner must use her arms to hold the meat back.

On 3/27/13, a machine had been broken and was down for repair. Once the machine began working, a lot of meat came through the conveyer belt. While trying to stop the meat which was coming from her left with her hands she suddenly began experiencing pain. The pain began in her right neck and shoulder. She ultimately began experiencing symptoms down her arm as well as into her thorax, back and abdomen. There is no dispute that Petitioner reported the accident to her supervisor, who referred her to Respondent's Health Services Department.

The Arbitrator notes that Petitioner denied having any neck injuries or treatment prior to 3/27/13. However Respondent produced Records from Genesis Health System which indicate Petitioner was involved in an 11/22/07 motor vehicle accident resulting in neck pain, among other complaints as well as a 10/24/08 motor vehicle accident which resulted in neck and shoulder pain. Diagnostic studies done following those accidents were all negative. While Petitioner was somewhat evasive in testifying regarding the motor vehicle accidents it also appeared there was some degree of confusion resulting from the translation process. Significantly, there is no evidence to indicate any ongoing neck or shoulder symptoms or treatment between October of 2008 and the date of accident.

On the day of the accident Petitioner presented to Respondent's Health Services Department (HSD), complaining of right neck, trapezius and rib pain. She followed up with Dr. Gregory E. Clem in Respondent's Clinic on 4/29/13, reporting right shoulder pain. Dr. Clem assessed a right trapezius and shoulder strain, recommended medication and provided work restrictions. On 5/6/13, Petitioner presented to Dr. Jeff Brower in Respondent's Clinic, pain in the right lateral neck and trapezius. Petitioner reported pain with cervical rotation. Dr. Brower recommended medication and ordered Petitioner to begin physical therapy. Dr. Brower continued to provide the same work restrictions. On 6/17/13 Petitioner returned to Dr. Clem with complaints over the right trapezius, right scapular area and cervical spine. Dr. Clem recommended medication, physical therapy and x-rays of the cervical spine. Dr. Clem continued to provide the same work restrictions of no pulling lean off fat.

On 6/19/13 w-rays of the cervical spine and shoulder were taken and read as negative. On 7/1/13, Petitioner returned to Dr. Clem. Tenderness over the right scapular area was noted. Dr. Clem assessed right trapezius shoulder pain, much improved. Dr. Clem found Petitioner to be at MMI and did not provide work restrictions. Petitioner returned to Dr. Clem on 7/19/13 after completing a course of physical therapy and reporting right trapezius discomfort. Dr. Clem noted that Petitioner was tender over the right scapula and trapezius. Dr. Clem prescribed medication and again noted that Petitioner was at MMI.

On 8/23/13, Petitioner returned to Dr. Brower for follow up of neck and trapezius pain. Petitioner did not tolerate even moderate touch of the right paravertebral musculature or trapezius. Dr. Brower assessed chronic trapezius pain and recommended medication.

Petitioner next returned to Dr. Brower on 9/9/13 to follow up on her chronic pain. Dr. Brower noted that Petitioner had decreased cervical rotation to the left and right and that Petitioner was moderately tender over the trapezius bilaterally. Dr. Brower declared Petitioner to be at MMI and did not provide work restrictions.

On 4/9/14 Petitioner exercised her first choice of physician and presented to an Orthopedist, Dr. David Schafer of Michigan Avenue Medical Associates. Petitioner complained of pain primarily in the low neck and cervical thoracic junction. Dr. Schafer noted radiation in the trapezius and occasionally down her right arm and occasional numbness down the arm. Petitioner complained of difficulty turning her head. Dr. Schafer noted tenderness in the paraspinals. Range of motion was decreased. Spurling's sign was positive for right arm pain. Dr. Schafer assessed cervical radiculopathy and pain. Dr. Schafer recommended topical pain lotion and a cervical spine MRI and referred Petitioner to a pain specialist for a possible epidural injection series.

A 4/9/14 cervical spine MRI as read by the radiologist revealed mild multilevel degenerative bulging discs accompanied by marginal spurs; there was a "broad-based posterior disc extension greatest in the midline partially effacing ventral CSF with mild central canal narrowing" at C5-6; multilevel minor foraminal narrowing; bilobed bulging disc and marginal spurs at T1-2 with mild foraminal narrowing. (PX1 at 53-54).

On 4/17/14, Petitioner presented to Dr. Neeraj Jain of Michigan Avenue Medical Associates, reporting neck and upper back pain that radiated into her right arm. She denied any prior such complaints. Spurling's sign was positive on the right. Dr. Jain interpreted the MRI as revealing herniations at C5-6 and T1-2. Dr. Jain assessed cervical facet syndrome, cervical discogenic pain and cervical radiculopathy. Dr. Jain ordered an SSEP study as well as bilateral C3-4, C4-5 and C5-6 facet joint injections, physical therapy and pain medication. He opined that Petitioner's symptoms were directly related to the injury and that treatment had been reasonable and necessary. (PX1 at 35-38). Dr. Jain warned that delay in authorizing the prescribed treatments adversely affects outcome in terms of habituation to medication, psychological decline and affliction and decreases likelihood of symptoms resolution.

On 2/29/14 Petitioner returned to Dr. Jain for follow-up. She was not improved. She was noted to have neck and upper extremity pain, greater on the right than left. The pain was increased with any overhead activity, prolonged lifting, sitting and standing. Dr. Jain noted Petitioner has a poor sleep pattern because of pain. She had not yet started physical therapy or obtained the SSEP of the upper extremity because of an approval problem. (*Id.*, at 28)

On 6/27/14, Petitioner presented to Dr. Erickson, neurosurgeon, reporting that she experienced pain in the neck and shoulder as well as pain between the shoulder blades immediately after the accident. Shortly thereafter, she experienced pain in the right arm and weakened right grip strength. Petitioner denied significant antecedent injuries other than a 2009 work-related upper back strain. Dr. Erickson noted positive neurologic findings in the right upper extremity on exam. Dr. Erickson interpreted the MRI to show a broad central disc herniation at C5-6. SSEP testing of the upper extremity conducted that day revealed bilateral C6 radiculopathy. Dr. Erickson assessed C6 radiculopathy secondary to C5-6 disc herniation which he attributed to her work accident. Dr. Erickson prescribed continued physical therapy and anti-inflammatory medication as well as analgesic medication. Dr. Erickson felt that if Petitioner did not respond well to conservative treatments, she would undergo anterior cervical discectomy and fusion at C6-C6. (*Id.* at 22)

On 7/14/14, Petitioner was examined by Dr. Edward Goldberg pursuant to section 12 of the Act. Petitioner reported injuring her neck and shoulder on 3/27/13. She complained of neck pain and bilateral shoulder pain towards the interscapular region. He notes she denied any radicular pain in the upper extremities. Petitioner described her job duties to Dr. Goldberg and he reviewed her written job description. Dr. Goldberg also reviewed Petitioner's treatment records. Dr. Goldberg conducted a physical examination, although it does not appear he conducted a Spurling's test. (T. at 35). Dr. Goldberg deferred his diagnosis pending receipt of the cervical MRI, but tentatively diagnosed a cervical strain, which he related to the 3/27/13 alleged accident. Dr. Goldberg opined that Petitioner's treatment had been reasonable. Dr. Goldberg opined that Petitioner could return to work full duty. (RXA at 26-28).

7/25/14, Petitioner returned to Dr. Erickson, reporting continued neck pain and some paresthetic sensations in her right arm "which seem[ed] new to her." (PX1 at 17). There was mild generalized weakness of the right arm most prominent in the elbow extension. There was some lessening of pinprick acuity in the C6, C7 and C8 distributions on the right side. (*Id.*) Dr. Erickson refilled medication prescribed by Dr. Jain and planned to follow petitioner for conservative treatments pending authorization for surgery. (*Id.*, at 18)

On 7/30/14, Dr. Goldberg authored an addendum report after reviewing the 4/9/14 cervical spine MRI. Dr. Goldberg opined that the MRI was normal. He noted a minimal bulge at C5-6. He noted no evidence of stenosis, herniation or nerve compression. Dr. Goldberg diagnosed a cervical strain as a result of the 3/27/13 accident. Dr. Goldberg did not believe that Petitioner had cervical facet syndrome, discogenic pain or cervical radiculopathy. Dr. Goldberg found that the treatment up to that point had been reasonable and necessary. Dr. Goldberg opined that Petitioner did not require any further treatment. Dr. Goldberg opined that Petitioner could return to work full duty and placed her at MMI. (RXA at 29-30). The Arbitrator finds it significant that Dr. Goldberg does not mention the SSEP testing or having conducted Spurling's testing, but appears to rule out cervical radiculopathy based upon the MRI findings.

On 09/26/14, Petitioner again followed up with Dr. Erickson. Dr. Erickson noted that Petitioner "has certainly not improved during the period of time that she has been waiting to undergo surgical treatment." (PX1, at 12). Dr. Erickson concluded that "[Petitioner] remains an excellent surgical candidate who unfortunately has no good therapeutic alternatives at this point. Conservative treatment is unlikely to reverse this situation." (*Id.*)

On 10/3/14, Dr. Erickson authored a letter to Petitioner's counsel after reviewing Dr. Goldberg's report and addendum. Dr. Erickson disagrees with Dr. Goldberg's assertion that Petitioner does not have evidence of stenosis and herniation. Dr. Erickson points out the radiologist report which suggests extrusions of disc material with findings being most prominent at C5-C6 level. (PX1 at 10) He further indicates that the broad diffuse disc herniation at C5-6 correlates perfectly with neurophysiological findings on SSEP testing. While agreeing with Dr. Goldberg's notion that there was no definite evidence of clear nerve compression with MRI viewed by itself, Dr. Erickson states that it was simply misleading to imply there was no evidence of stenosis or herniation. (*Id.*, at 11) Dr. Erickson then reaffirmed Petitioner's diagnoses as cervical radiculopathy at C6 on the right side. He cited the continuous and chronic nature of Petitioner's pain which is prominently axial in nature and confined to the neck and shoulder, which he felt was a consequence of the disc herniation at C5-C6; her continued feeling of tightness around the right wrist, abnormal sensations and diminished grip on the right side; and her biceps reflex asymmetry as well as biceps weaknesses noted on her recent examinations as supportive of his diagnosis. (*Id.*, at 11) Dr. Erickson further suggested Petitioner may also be suffering from component of facet disease, facet injury, and facet change which could account for the predominance of shoulder and paraspinal neck pain. Distinguishing facet syndrome from radicular pain, Dr. Erickson stated facet syndrome does not explain Petitioner's grip weakness, reflex symmetry, or neurophysiological findings on SSEP testing. (*Id.*) He reiterated that he would not recommend further conservative treatment or injections therapy based upon the number of times that had passed since Petitioner's injury on 03/27/13. He confirmed that Petitioner had not reached maximum medical improvement and continued to recommend anterior cervical discectomy and fusion at C5-6. (*Id.*)

On 1/18/16, Dr. Goldberg authored a second addendum report after reviewing Petitioner's updated records from Michigan Avenue Medical Associates, Dr. Erickson and Dr. Jain's deposition transcripts and Petitioner's medical records from Genesis Health System relative to a motor vehicle accident. Dr. Goldberg continued to opine that Petitioner had a cervical strain from a work related accident. He noted that Petitioner's first mention of any radicular pain came over a year after Petitioner's alleged accident date. Dr. Goldberg opined that Petitioner did not require a cervical discectomy and fusion or injections. Dr. Goldberg opined that Petitioner could continue to work full duty and was at MMI as of 7/30/14. (RXA at 5)

As of the date of hearing Petitioner had not undergone surgery nor had she received any injections due to the failure of Respondent to authorize same.

At trial, Petitioner described her pain as starting at the neck, radiating to her right shoulder, down the arm and in the lower back. She testified that she is unable to bathe her kids or bend without pain. Despite Dr. Erickson's recommendation that Petitioner work only light duty, with the caveat that a light duty job itself may not be dangerous but might be impaired by Petitioner's poor grip, Petitioner has continued to work full duty. She credibly testified that as a single mother of two children she must continue to work to provide for her family.

Dr. Erickson testified via evidence deposition (PX2) He is a board certified d neurosurgeon. (*Id.* at 5) He testified consistent with his records and reports discussed above. Dr. Erickson diagnosed a cervical disc herniation at C5-6 with cervical radiculopathy affecting the C6 nerve root, which he opined was causally connected to Petitioner's accident. (*Id.* at 10-11) Dr. Erickson relied on his exam findings, diagnostic studies

and Petitioner's reports in coming to his opinion regarding causation. (*Id.* at 24) Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6. (*Id.* at 13) Dr. Erickson opined that Petitioner's treatment had been reasonable and necessary. (*Id.* at 17)

Dr. Jain testified via evidence deposition. (PX3) He is a doctor specializing in anesthesia and pain management. (*Id.* at 5) He also testified consistent with his records and reports. He diagnosed cervical facet syndrome, cervical discogenic pain and cervical radiculopathy. (*Id.* at 8,10) Dr. Jain based his diagnoses and opinion regarding causation on the history and physical examination. (*Id.* at 11) Dr. Jain reviewed Dr. Schafer's report and the MRI. (*Id.* at 18) Dr. Jain opined that Petitioner's treatment was necessary and appropriate. (*Id.* at 13). When he last saw Petitioner Dr. Jain recommended C3-4, C4-5 facet injections, medication, physical therapy and an SSEP. (*Id.* at 15)

Dr. Goldberg testified via evidence deposition. (RXA) Dr. Goldberg is a board certified orthopedic surgeon. (*Id.* at 2) Dr. Goldberg too testified consistent with his records and reports. Dr. Goldberg testified that his review of Petitioner's cervical MRI revealed a minimal bulge—not a herniation—at C5-6. He explained that he did not observe any evidence of stenosis, herniation or nerve compression. (*Id.* at 4, 11) Dr. Goldberg explained that a bulge is a normal finding. (*Id.* at 4) Dr. Goldberg diagnosed a cervical strain. (*Id.* at 4-5, 11) Dr. Goldberg opined that there was a causal connection between the cervical strain and the accident. (*Id.* at 4) Dr. Goldberg opined treatment had been reasonable and necessary through 7/14/14. (*Id.* at 5, 11) Dr. Goldberg opined that Petitioner required no further treatment, could work full duty and had reached MMI without any permanent impairment. (*Id.* at 4-6) Dr. Goldberg explained that Petitioner was not a surgical candidate because the MRI did not reveal a herniation or nerve compression and she did not report any right arm radicular arm pain until over a year after the alleged accident. (*Id.* at 5) The Arbitrator notes he again did not address the positive SSEP results.

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?

On 3/27/13 Petitioner sustained an injury while trying to hold back meat which was moving past her on a conveyor belt by using her arms and hands. The injury was reported immediately and she was provided treatment at Respondent's medical facility the same day. She treated consistently thereafter until Respondent ceased paying for medical treatment based upon the opinions of the section 12 examiner.

As time went by, Petitioner began experiencing worsening symptoms, including symptoms radiating into the upper extremities. Dr. Goldberg agreed that Petitioner sustained injuries at the time of the accident, but found that she sustained only a cervical strain and was at MMI as of 7/14/14. Petitioner's treating physicians opined that Petitioner had not yet reached MMI and required further treatment. Dr. Erickson diagnosed a cervical disc herniation at C5-6 with cervical radiculopathy affecting the C6 nerve root, which he opined was causally connected to Petitioner's accident. Dr. Erickson relied on his exam findings, diagnostic studies and Petitioner's reports in coming to his opinion regarding causation. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6. Dr. Jain diagnosed cervical facet syndrome, cervical discogenic pain

and cervical radiculopathy. The Arbitrator finds the opinions of Dr. Erickson and Dr. Jain more persuasive than those of Dr. Goldberg.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds did sustain an accident which arose out of and in the course of her employment with Respondent on 3/27/13 and that her current condition of ill-being is causally related to the accident.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (O) Is Petitioner entitled to any prospective medical care?

The treating physicians as well as Dr. Gold berg agree that the treatment received up to 7/14/14 was reasonable and necessary. Dr. Goldberg, however felt Petitioner required no treatment thereafter. Petitioner's treating physicians have opined that all of the treatment received through the date of hearing was reasonable and necessary. When he last saw Petitioner Dr. Jain recommended C3-4, C4-5 facet injections, medication, physical therapy and an SSEP. The recommended treatment was never provided because Respondent would not approve the care. Petitioner then saw Dr. Erickson on 6/27/14. An SSEP was performed that same day which revealed bilateral C6 radiculopathy. Dr. Erickson recommended an anterior cervical discectomy and fusion at C5-6.

Based upon the foregoing and the record taken as a whole, and having previously found the opinions of Dr. Erickson and Dr. Jain more persuasive than those of Dr. Goldberg, the Arbitrator finds that Petitioner's treatment through the date of hearing has been reasonable and necessary. The Arbitrator further finds Petitioner is entitled to prospective medical treatment.

Respondent shall pay reasonable and necessary medical services of $20,558.76, as set forth in PX 5, 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 further authorize and pay for prospective medical care as recommended by Dr. Erickson and Dr. Jain, as provided in Sections 8(a) and 8.2 of the Act.

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

Petitioner has not yet reached MMI therefore this issue is not yet ripe for resolution.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Filimon Chama,

Petitioner,

18IWCC0730

vs.

NO: 16 WC 19876

Elite Staffing-Bollingbrook,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of permanent disability, medical, prospective medical and other evidence 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 21, 2018, is hereby affirmed and adopted.

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

18IWCC0730

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: NOV 30 2018
o10/25/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0730

CHAMA, FILIMON
Employee/Petitioner

Case# **16WC019876**

ELITE STAFFING-BOLINGBROOK
Employer/Respondent

On 2/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5755 COSTA IVONE LLC
JULIO COSTA
6847 W CERMAK RD
BERWYN, IL 60402

66020 GOLDBERG SEGALLA LLC
JENNIFER B SANTORO
311 S WACKER DR SUITE 2450
CHICAGO, IL 60606

18IWCC0730

18IWCC0730

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Filimon Chama
Employee/Petitioner

v.

Elite Staffing - Bolingbrook
Employer/Respondent

Case # **16** WC **19876**

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 **January 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Admissibility of Respondent's Proposed Exhibit 16.

FINDINGS

On the date of accident, June 7, 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 $16,987.36; the average weekly wage was $326.68.

On the date of accident, Petitioner was 47 years of age, *single* with no dependent children.

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

Respondent shall be given a credit of $5,060.00 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $5,060.00. *See* AX1.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's condition of ill-being in the lumbar spine is causally related to his undisputed accident at work as opined by Dr. Salehi.

Temporary Total Disability Benefits & Prospective Medical Treatment

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 67 & 5/7th weeks, commencing September 25, 2016 through January 11, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 7, 2016 through January 1, 2018, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $5,060.00 for TTD benefits that have been paid.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator finds that the recommended prospective medical treatment is necessary and reasonable to alleviate Petitioner of the effects of his injury at work. Thus, the Arbitrator awards the prospective medical care in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid for medical treatment pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment not certified by utilization review 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

February 26, 2018
Date

ICArbDec19(b) p 3

FEB 21 2018

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

Filimon Chama
Employee/Petitioner

v.

Elite Staffing - Bolingbrook
Employer/Respondent

Case # 16 WC 19876

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from September 8, 2016 through January 11, 2018, whether he is entitled to prospective medical care in the form of a two-level lumbar fusion as ordered by Dr. Salehi, and the admissibility of Respondent's Proposed Exhibit 16. Arbitrator's Exhibit[2] ("AX") 1; Tr. at 1-10. The parties have stipulated to all other issues. *Id.*

Background

Filemon Chama (Petitioner) testified that he was employed by Elite Staffing (Respondent) and assigned to a company, Peacock, for approximately one year as a Packer. Tr. at 26. In this position, Petitioner was tasked with bringing down the pallets as well as packing and counting the boxes that went on the pallets. Tr. at 27.

On June 7, 2016, Petitioner testified that he injured his lower back while lowering a pallet. Tr. at 27. He explained that pallets weighed 20-40 pounds. *Id.*, at 28. Petitioner testified that he had not previously had injuries or accidents to his low back or received medical treatment to the low back. *Id.*, at 29. Petitioner reported the accident to his supervisor, but he was not provided with a copy of the report. Tr. at 29.

Medical Treatment

Petitioner presented to Physicians Immediate Care on June 14, 2016 as directed by the company. Tr. at 29. He went for a total of three visits and was placed on restrictions, which were accommodated. Tr. at 29-30. Petitioner testified that he stopped going because they did not take care of him the way they should have. *Id.*, at 30.

The medical records reflect that Petitioner presented at Physicians Immediate Care on June 14, 2016 reporting mid- and lower back pain since June 7, 2016 when he was injured at work "lifting and moving empty pallets then twisted causing him back pain." PX1. He also reported that he "felt like it would go away over times but it has been a week and it is still there. States he has never had back pain in the past." *Id.* Following x-rays and a physical examination, which revealed positive straight leg raise testing on the left and right sides, Petitioner was diagnosed with back pain. *Id.* Stephanie Shirkey, PA-C, a certified physician's assistant, prescribed

[1] Respondent disputes that Petitioner is entitled to temporary total disability benefits after March 1, 2014 when he was released to full duty work by Dr. Moody. AX1.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Ex. _)." Citations to the arbitration hearing transcript will be denominated ("Tr. at page(s)").

medications and instructed Petitioner to apply ice and perform back exercises at least twice a day. *Id.* Additionally, Petitioner was placed on a 25-pound work restriction, which Respondent accommodated. *Id.*; Tr. at 30.

Petitioner followed up with John James, M.D. (Dr. James) at Physicians Immediate Care on June 17, 2016. PX1. He reported continued mid- and lower back pain, made worse by exertion and movement. *Id.* On physical examination, Dr. James noted diffuse tenderness of the thoracic and lumbar muscles as well as continued tenderness over the left lower lumbar sand mid-thoracic spine. *Id.* He instructed Petitioner to continue his medication and start physical therapy, three days a week for four weeks. *Id.* Additionally, Dr. James maintained Petitioner's work restrictions, but increased the lifting restriction to 15 pounds when above shoulder level. *Id.* On June 22, 2016, Petitioner returned to Physicians Immediate Care with unimproved mid and lower back pain. *Id.* Ronald Gregus, M.D. (Dr. Gregus) continued Petitioner on medications, maintained his work restrictions, and recommended that he start physical therapy. *Id.*

On June 29, 2016, Petitioner presented to Rand Medical and came under the care of Ravi Barnabas, M.D. (Dr. Barnabas. Tr. at 30; PX2. Petitioner testified that he heard of Dr. Barnabas through a friend from work. *Id.*, at 30-31. The medical records reflect Petitioner's report that he was injured at work on June 7, 2016 and "he was bringing a pallet down he felt a pain in his lower back." PX2. On physical examination, Dr. Barnabas noted a lot of spasms in the back, positive straight leg raise testing on the right at 40 degrees with decreased sensation at L5-S1, and positive straight leg raise testing on the left at 55 degrees, as well as painful heel-to-toe testing. *Id.* Dr. Barnabas ordered physical therapy and continued Petitioner's work restrictions. *Id.*

On July 5, 2016, Petitioner presented to a chiropractor, Mark Cohen, D.C. (Dr. Cohen), of Chicago Pain Center on referral from Dr. Barnabas. PX3. Following a physical examination and review of Petitioner's symptomology, Dr. Cohen placed him on a conservative treatment course of treatment consisting of electrical stimulation, ultrasound, thermal and hot to cold therapy. *Id.*

On July 14, 2016, Petitioner returned to Dr. Barnabas. PX2. He noted Petitioner's slight improvement with conservative care, then ordered an MRI of the lumbar spine. *Id.* Petitioner underwent the recommended MRI on July 26, 2016. *Id.* The interpreting radiologist noted a broad based right neural foraminal herniation with significant right neural foraminal stenosis and impingement on the exiting nerve root at the L3-4, a 2 mm right paracentral protrusion and a broad-based bulge at L4-5, and lumbar spondylosis. *Id.*

On August 1, 2016, Petitioner returned to Dr. Barnabas at Ortho Spine Surgical. PX4. After reviewing the MRI, Dr. Barnabas diagnosed Petitioner with a disc herniation, disc radiculitis, lumbar disc paracentral protrusion, lumbar spondylosis, severe right canal stenosis, and significant neuroforaminal stenosis. *Id.* He kept Petitioner on work restrictions and referred him for a neurosurgical consultation with Dr. Salehi. *Id.*

On August 5, 2016, Petitioner presented to Suneela Harsoor, M.D. (Dr. Harsoor) on referral from Dr. Barnabas. PX5. Petitioner reported a sharp and stabbing pain radiating to both lower extremities into the feet. *Id.* On physical examination, Dr. Harsoor noted positive straight leg raise testing on the right. *Id.* She noted her review of Petitioner's lumbar MRI showing right-sided disc herniation at L3-L5 with an annular tear at L5-S1 as well as facet arthropathy. *Id.* Dr. Harsoor diagnosed Petitioner with a herniated lumbar disc and chronic lumbar radiculopathy. *Id.* She then recommended an L4-L5 epidural steroid injection and kept Petitioner off work. *Id.*

On August 16, 2016, Petitioner saw Krishna Chunduri, M.D. (Dr. Chunduri) at Advanced Spine and Pain Specialists. PX6. Petitioner testified that he saw Dr. Chunduri for a second opinion regarding Dr. Harsoor's

recommended injection as referred by Dr. Barnabas. Tr. at 32-33. Dr. Chunduri noted Petitioner's report of low back pain radiating into his right lower extremity. PX6. After a physical examination and reviewing Petitioner's lumbar MRI, he also recommended a right L3-L4 epidural steroid injection. *Id.*

On September 7, 2016, Dr. Chunduri administered the recommended right L3-L4 transforaminal epidural steroid injection under fluoroscopic guidance performed at Grand Avenue Surgical Center. PX7. Petitioner testified that the injection helped a little. Tr. at 34.

On September 9, 2016, Petitioner returned to Dr. Harsoor. PX5. He testified that he did not have the transportation means to continue treatment with Dr. Chunduri so he returned to Dr. Harsoor's office as her office provided him with transportation. Tr. at 34. Petitioner explained that he did not have a car. Tr. at 34-35.

During a follow-up on September 12, 2016, Dr. Barnabas noted that Petitioner's pain was severe, and Petitioner was taken off work, and referred to Dr. Harsoor or Dr. Chunduri for a second injection. PX4. Additionally, Dr. Barnabas referred Petitioner for a neurological consultation. *Id.*

On September 27, 2016, Petitioner returned to Dr. Harsoor complaining of worsened symptoms and an inability to sleep because of the pain. PX5. Dr. Harsoor recommended a second injection. *Id.* On October 4, 2016, Petitioner underwent the recommended second right L3 and L4 transforaminal epidural steroid injection under fluoroscopic guidance performed by Dr. Harsoor. *Id.* On October 20, 2016, Petitioner noted temporary relief of his pain. *Id.* Dr. Harsoor discontinued physical therapy, which Petitioner reported worsened his pain, and referred Petitioner for a spine surgery consultation. *Id.*

On November 8, 2016, Petitioner presented to Sean Salehi, M.D. (Dr. Salehi), a neurosurgeon[3], as referred by Dr. Barnabas. PX8; Tr. at 36. Petitioner reported low back pain radiating up into the mid-back and radiating down into the bilateral lower extremities to the feet. *Id.* Following a physical examination, noting Petitioner's prior medical treatment and symptoms, and after a review of Petitioner's MRI, Dr. Salehi diagnosed Petitioner with a herniated lumbar disc at L3-4 as well as annular tears and disc disease at L4-5 and L5-S1 resulting in mechanical back pain and radicular pain. *Id.* Dr. Salehi noted that Petitioner had failed conservative medical treatment and recommended surgery in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion. *Id.* Additionally, Dr. Salehi imposed desk work restrictions including no lifting/pushing/pulling over 10 pounds, no bending/twisting over three times per hour, and alternate sitting and standing every 30-45 minutes as needed. *Id.*

In the interim, Petitioner continued chiropractic care with Dr. Cohen through November 12, 2016, noting only slight improvement. PX3; Tr. at 31.

On November 21, 2016, Petitioner returned to Dr. Barnabas for a follow-up, complaining of an increase in pain and inability to walk due to his right leg giving away. PX2. Dr. Barnabas placed Petitioner off work. *Id.*

First Section 12 Examination & Addendum Report – Dr. Kornblatt

On December 5, 2016, Petitioner presented for a medical evaluation at Respondent's request pursuant to Section 12 of the Act with Michael D. Kornblatt, M.D. (Dr. Kornblatt). RX1. Dr. Kornblatt diagnosed Petitioner with an exacerbation of preexisting multilevel lumbar degenerative disc disease and kinesiophobia. *Id.* He opined

[3] The medical records also reflect that Dr. Harsoor also referred Petitioner for a neurosurgical consultation. PX8.

that the findings on Petitioner's lumbar MRI were preexisting and degenerative. *Id.* In so concluding, he noted that Petitioner "never presented with clinical lumbar radiculopathy consistent with a clinical lumbar disc herniation and nerve root impingement. Mechanism of injury is consistent with that of a myofascial strain with exacerbation of preexisting multilevel lumbar degenerative disc disease." *Id.* Dr. Kornblatt further opined that Petitioner had not reached maximum medical improvement (MMI) and that all of the medical treatment to date had been reasonable and necessary. *Id.* He recommended Petitioner return to light duty work and begin a course of work conditioning therapy, as he was not a candidate for surgery. *Id.*

On December 15, 2016, Dr. Kornblatt authored an addendum report specifying that Petitioner could work four out of the eight hours in a work day, consistent with his light physical demand level. RX2. He also opined that Petitioner could work in a standing position, but he should alternate between standing and walking, and that Petitioner could walk four hours out of an eight hour work day. *Id.*

Continued Medical Treatment

On December 19, 2016, Petitioner presented to Dr. Thomas Dzielawski[4] at Bone & Joint Clinic for a work conditioning evaluation as referred by Dr. Barnabas after Dr. Kornblatt's Section 12 examination. PX9; RX5. Petitioner continued treatment until December 23, 2016, without improvement, and was eventually referred to his doctor for further evaluation. *Id.*

On January 25, 2017, Petitioner presented for a follow-up and Dr. Salehi noted that his pain had increased following work conditioning. PX8. Dr. Salehi suspended work conditioning, reiterated his recommendation for surgery, and kept him off work. *Id.*

Second Section 12 Examination – Dr. Kornblatt

On May 15, 2017, Petitioner presented for a second medical evaluation at Respondent's request pursuant to Section 12 of the Act with Dr. Kornblatt. RX3. Dr. Kornblatt maintained his diagnosis of Petitioner's condition, and opined that Petitioner's complaints of axial low back pain correlated with three-level lumbar degenerative disk disease, which was unrelated to the lumbosacral strain sustained as a result of the accident at work. *Id.* Dr. Kornblatt recommended that Petitioner complete an additional 10 sessions of work conditioning, followed by a functional capacity evaluation. *Id.* He further opined that Petitioner could work within the light physical demand level, which was unrelated to his work injury. *Id.*

Deposition Testimony – Dr. Kornblatt

On August 17, 2017, Respondent called Dr. Kornblatt as a witness and he provided testimony at an evidence deposition. RX4. Dr. Kornblatt testified that he is a board-certified orthopedic surgeon. RX4 at 4-5; RX4 (Dep. Ex. 1). Dr. Kornblatt testified consistent with the information contained in his reports and further explained his opinions regarding Petitioner's condition and its relatedness, if any, to his accident at work. *See generally* RX4.

Dr. Kornblatt testified that kineisiophobia is fear of movement, which highly impacts Petitioner's treatment and recover. RX4 at 9-10. He testified that Petitioner's MRI showed degenerative disc disease, which was

[4] Dr. Dzielawski's credentials as a medical doctor, doctor of osteopathic medicine, doctor of chiropractic medicine, etc. are not apparent from the records of Bone & Joint Clinic. PX9.

degenerative in nature, and that Petitioner's exacerbation was "just an onset of symptomatology attributable to a preexisting condition, whereas an aggravation is a change in the anatomy of the preexisting condition resulting in most commonly significant abnormal objective findings on examination, as well as objective findings noted on workup, such as, an X-ray or an MRI scan." *Id.*, at 11. Dr. Kornblatt opined that conservative medical treatment including "physical therapy, possibly an injection or two might be warranted with patients with Degenerative Disc Disease and exacerbation with a strain. If [Petitioner] was taking narcotics, I don't think narcotics were appropriate." *Id.*, at 11-12. Dr. Kornblatt maintained his opinion that Petitioner could work at the light physical demand level and then full duty after four weeks, including a three-week work conditioning program. *Id.*, at 12.

Dr. Kornblatt maintained the opinions reflected in his addendum report and second Section 12 examination report of May 15, 2017. RX4 at 13-14. Dr. Kornblatt noted no changes, and maintained that Petitioner should not have been taking narcotic pain medication. *Id.*, at 15-16. He also maintained his disagreement with Dr. Salehi's recommendation for surgery. *Id.*, at 17. Specifically, Dr. Kornblatt testified that "...if surgery would be performed, it had nothing to do with a strain that happened at work. But this man doesn't present with surgical indications... clinical lumbar radiculopathy... instability of his lumbar spine. ...." *Id.*, at 17-18.

On cross-examination, Dr. Kornblatt testified that he averages about 500 IME's per year, with about 400 in 2017, with approximately 98-99% of those examinations being performed for the respondent or insurance company. RX4 at 22. He acknowledged that there is no formal test for kinesiophobia, only a general orthopedic examination like the one that he performed, and the diagnosis is made on observation. *Id.*, at 23-24. Dr. Kornblatt testified that he did not see any medical records indicating that Petitioner had radiculopathy at any level. *Id.*, at 25. He did not know whether the records reflected straight leg raise testing, and he stated that "[y]ou'd have to look through the records and see[.] The point is this, you make a diagnosis based upon subjective complaints, objective findings, and workup. And my answer is that there has never been anything in the records that supported a diagnosis of a radiculopathy." *Id.*, at 26. Dr. Kornblatt maintained that "[t]here was nothing in the records that reveal that this patient ever presented with a clinical radiculopathy." *Id.*, at 27. He testified that a positive straight leg raise test, alone, does not mean that Petitioner had radiculopathy. *Id.* Dr. Kornblatt went on to disagree with the radiologist's reading of Petitioner's MRI in the following exchange on cross-examination:

> Q. Well, in conjunction with an MRI that showed significant stenosis at that level or at a different level- -
> A. What do you mean?
> Q. I'm just looking - -
> A. There's no findings of an MRI showing significant spinal stenosis at any level.
> Q. There's an MRI from - -
> A. You're not listening to what you're saying. You said significant stenosis. I'm listening to what you're saying.
> Q. And I'm just reading it off the MRI.
> A. It doesn't say.
> Q. It says significant foraminal stenosis?
> A. Well, mine doesn't, not the way I reviewed it, and mine is important. My review of the MRI scan is very important, much more important than a radiologist's.
> Q. Is it more important than the treating neurosurgeon's?
> A. Probably in this case.

RX4 at 28-29. Dr. Kornblatt maintained his opinions regarding the lack of any causal connection between Petitioner's condition of ill-being and the accident at work beyond a myofascial strain. *Id.*, at 29-32. Dr.

Kornblatt admitted that he had no information regarding Petitioner having any prior injuries or any low back complaints prior to his injury. *Id.*, at 32-33.

Continued Medical Treatment

Petitioner continued to follow-up with Dr. Salehi through September 5, 2017. PX8. Based on Petitioner's continued pain and symptomology, as well as his physical examinations, Dr. Salehi continues to recommend surgery in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion and he kept Petitioner off work. *Id.*

Utilization Review

Respondent submitted utilization reviews from Genex. RX14. The physical therapy provided from July 5, 2016 through September 13, 2016 was not certified. *Id.* The transportation charges for non-emergent transportation were not certified. *Id.* The epidural steroid injections were not certified. *Id.*

Additional Information

Petitioner testified that he wishes to proceed with the surgery recommended by Dr. Salehi because he would like to go back to work, as he is alone and has no family. Tr. at 36-37. Additionally, Petitioner testified that he continues to take pain medications and that he uses a cane and back brace, all the time, due to the pain. Tr. at 39-40.

On cross-examination, Petitioner clarified that he injured his back on line 18, bringing a pallet down from a height of nine feet. Tr. at 41-42. Specifically, Petitioner testified that he was holding the pallet with his hands, to ensure that it did not fall and make a noise, when he injured his back. *Id.* Petitioner also reaffirmed that he did not injure his back in the past or receive any related treatment. Tr. at 43. Petitioner testified that he stopped treating at Physicians Immediate Care because he felt he was not receiving adequate treatment, and that is why he presented to Dr. Barnabas, who then referred him to all subsequent treating physicians. Tr. at 44-46. When asked about a missed appointment with Dr. Salehi in August of 2016, Petitioner admitted that he did not attend the appointment because he did not have transportation. Tr. at 47. When asked whether he has pain in his legs, Petitioner testified that currently he has pain in both, although he previously experienced worse pain on the right side. Tr. at 48.

Petitioner also testified that he could work light duty for a period of time. Tr. at 50-51. Specifically, on November 8, 2016, Petitioner was placed on a 10-pound restriction by Dr. Salehi and testified that he only returned to work for a week, as Respondent wanted him to lift more weight, and Dr. Salehi and Dr. Barnabas placed him off work. *Id.* Petitioner was unable to recall the type of pain medication that he took, but produced hydrocodone-acetaminophen tablets and explained that he takes the pills once a day and uses the patches twice a day to alleviate his pain. Tr. at 51-53. Petitioner testified that he has difficulty walking and getting in and out of cars. Tr. at 57, 62-63. Lastly, Petitioner admitted that he does occasionally help an older woman in his residence sweep the building patio and helps a different woman with her child, and in exchange she provides him with food and helps him with activities he has difficulty performing. Tr. at 58-59, 60-61.

On redirect-examination, Petitioner testified that when he sweeps the patio at his residence it is usually only for about five minutes. Tr. at 63. Petitioner identified the woman who helps him as Secundina, and her daughter as Citlali. Tr. at 63-64. Petitioner testified that Secundina helps him because he is all alone, and in exchange he

helps her with Citlali, by watching her and walking her to school, which is close to their homes. Tr. at 66. Secundina lives on 24th and Pulaski, about a block from Petitioner, and he testified it takes him about 15 minutes to walk there, at his pace and with breaks. Tr. at 66-67. Additionally, Petitioner testified that sometimes Secundina also picks him up with her brother, but that he does not personally drive a vehicle. Tr. at 67. When asked whether his pain varies, Petitioner testified that treatment helps, but increased activities cause his pain to flare up. Tr. at 68. Regarding Dr. Salehi's 10-pound work restriction, Petitioner clarified that he called Dr. Salehi's office on November 16, 2016 to inform him that his pain increased, as a result of the work he was performing. Tr. at 69. At that time, Dr. Salehi recommended that he only perform seated or desk work, which Petitioner testified that Respondent did not accommodate. *Id.* Petitioner reaffirmed that Respondent wanted him to perform work outside of his restrictions, at which time Dr. Salehi placed him off work. Tr. at 70.

Petitioner reaffirmed that he saw Dr. Salehi on November 8, 2016, after he saw Dr. Chunduri and Dr. Harsoor, and underwent two injections. Tr. at 71-72. He also reaffirmed that currently he has pain in both legs, but in the past he has experienced greater pain in his right leg. Tr. at 73. Petitioner further testified that Dr. Barnabas helped him a lot and, as a result, he is pleased with the treatment he received. *Id.* Petitioner was not aware of any criminal background relative to Dr. Barnabas prior to treating with him. Tr. at 77-78.

Surveillance Video

Respondent submitted surveillance video footage taken of Petitioner. RX7-RX10. The parties stipulated that the video surveillance took place over six days, from November 15, 2017 to November 28, 2017, and represents approximately 84 minutes of actual activity, out of 53 hours and 48 minutes of attempted surveillance. Tr. at 81. Petitioner utilized a cane throughout the surveillance, but is observed in limited instances without a cane. *Id.*

Respondent's Exhibit 7 contains surveillance of Petitioner obtained on November 25, 2017, between 12:24 p.m. and 1:40 p.m. Approximately nine minutes of actual activity were obtained showing the following: Petitioner walking with a dog outside of his residence for four minutes; Petitioner entering and exiting a Gold Ford vehicle as a passenger and traveling to pick up a girl from an unknown location and then to Walgreens; and Petitioner arriving in the car back at his residence. RX7.

Respondent's Exhibits 8 and 8a contain surveillance obtained on November 19, 2017, between 6:40 a.m. and 3:00 p.m. Approximately fifteen minutes of actual activity were obtained, showing: Petitioner exiting his residence for three minutes accompanied by three children and a dog; Petitioner exiting his residence accompanied by the children and walking to a Family Dollar and then El Nopal Bakery; Petitioner, accompanied by the children walking to a bus stop then entering the bus and departing; and Petitioner arriving on the bus, exiting it, and entering a private residence. RX8-RX8a.

Respondent's Exhibits 9 and 9a contain surveillance obtained on November 18, 2017 between 6:42 a.m. and 3:00 p.m., and surveillance obtained on November 24, 2017 between 5:56 a.m. and 4:41 p.m. On November 18, 2017, approximately eight minutes of actual activity were obtained showing: a Gold Ford driven by a woman arriving at Petitioner's residence; Petitioner exiting his residence with a dog and conversing with the driver of the Gold Ford; Petitioner entering his resident and later exiting and entering the Gold Ford as a passenger; Petitioner traveling to Taqueria El Milagro in the Gold Ford, entering the restaurant and sitting at a table; Petitioner walking with a woman entering the Gold Ford traveling to a private residence; and Petitioner exiting the private residence accompanied by a woman and entering the Gold Ford and traveling to his residence. RX9-RX9a. On November 24, 2017, approximately thirteen minutes of actual activity were obtained showing:

Petitioner exiting and reentering his residence multiple times; Petitioner bending at the waist to pick up his cane; Petitioner walking to a private residence and entering; and Petitioner exiting private residence and walking to his residence. *Id.*

Respondent's Exhibits 10 and 10a contain surveillance obtained on November 15, 2017, between 6:30 a.m. and 2:45 p.m., and November 26, 2017, between 6:30 a.m. and 2:45 p.m. On November 15, 2017, approximately thirty-one minutes of actual activity were obtained showing: Petitioner exiting his residence and walking to a private residence; Petitioner exiting private residence and walking to his residence; Petitioner entering a Silver Chevrolet, as a passenger, and traveling to a private residence; and Petitioner exiting a residence and raking leaves. On November 26, 2017, approximately eight minutes of actual activity were obtained showing: Petitioner exiting and reentering his residence; Petitioner walking to a private residence, accompanied by a girl; and Petitioner opening the door of his residence to allow individuals to enter. RX10-RX10a.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work as opined by Dr. Salehi. In so concluding, the Arbitrator finds Petitioner's testimony to be credible and further finds the opinions of Dr. Salehi to be persuasive.

There is no dispute that Petitioner was asymptomatic in the low back before his accident at work. He had degenerative disc disease in the lumbar spine noted at Physicians' Immediate Care, the radiologist interpreting Petitioner's lumbar MRI, Petitioner's treating physician, Dr. Salehi, and Respondent's Section 12 examiner, Dr. Kornblatt. Petitioner had continuously worked in his full duty position for Respondent for approximately one year before his injury. Indeed, the medical records reflect that all of the physicians that rendered treatment to Petitioner, as well as Respondent's Section 12 examiner, Dr. Kornblatt, noted that Petitioner only complained of back pain after his accident at work.

"Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994. "Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607 (1st Dist. 2003).

Petitioner's treating orthopedic surgeon, Dr. Salehi, his pain management physicians, Drs. Harsoor and Chunduri, as well as Respondent's Section 12 examiner, Dr. Kornblatt, agree that Petitioner's post-accident radiographic studies show degeneration in the lumbar spine. Dr. Kornblatt conceded that Petitioner had no prior low back symptomatology or medical treatment, but he steadfastly maintained that Petitioner's MRI should be interpreted as he opined, not as interpreted by Dr. Salehi, much less the radiologist, all of whom agreed that Petitioner had significant foraminal stenosis and annular tears. The July 26, 2016 MRI revealed a broad based

right neural foraminal herniation with significant right neural foraminal stenosis and impingement on the exiting nerve root at the L3-4, a 2 mm right paracentral protrusion and a broad-based bulge at L4-5, and lumbar spondylosis. On August 5, 2016, Dr. Harsoor noted her review of Petitioner's lumbar MRI which she also interpreted to show a right-sided disc herniation at L3-L5 with an annular tear at L5 S1 as well as facet arthropathy. On November 8, 2016, Dr. Salehi noted his review of Petitioner's lumbar MRI showing a herniated lumbar disc at L3-4 as well as annular tears and disc disease at L4-5 and L5-S1 resulting in mechanical back pain and radicular pain.

Medical opinions, whether of a treating physician or a physician retained by a Respondent for the purpose of a Section 12 examination, cannot be evaluated in a vacuum. Dr. Kornblatt's confidence in his interpretation of Petitioner's MRI is contradicted by at least three other physicians. His initial, and unchanging, opinion that Petitioner's lumbar condition is related solely to his preexisting degenerative disc disease is contradicted by objective clinical findings at Physicians Immediate Care—Respondent's occupational health facility—that Petitioner had an onset of low back pain and radiating symptoms into the lower extremities within weeks of his accident. Dr. Kornblatt also acknowledged that Petitioner was wholly asymptomatic in the low back and lower extremities before the accident at work. It is also notable that Dr. Kornblatt conducts approximately 500 medical evaluations a year for an admittedly 98-99% of respondents or insurance companies. The overwhelming agreement among the physicians examining Petitioner in this case is that he had degenerative disc disease in the lumbar spine that became symptomatic only after his accident at work. Dr. Salehi opined that Petitioner's lumbar condition was aggravated by the accident at work requiring further medical treatment including surgery, which is supported by objective clinical and diagnostic test findings since shortly after the accident. Thus, the Arbitrator accords no weight to the opinions of Dr. Kornblatt in this case, and finds the opinions of Dr. Salehi to be persuasive given the totality of the evidence in the record.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury 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, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work. The medical bills submitted into evidence related to Petitioner's lumbar spine are for reasonable and necessary medical care to alleviate him of the effects of his injury at work. However, Respondent submitted utilization reviews regarding the reasonableness and necessity of certain medical treatment. The bills that were not certified by utilization review are not reasonable or necessary, and Petitioner's claim for payment of those bills is denied.

Thus, the Arbitrator awards the medical bills incurred by Petitioner for treatment that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment that was not certified by utilization review is denied.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his accident at work as opined by Dr. Salehi. Based on the totality of the record, the Arbitrator finds that the recommended medical treatment is necessary to alleviate Petitioner from the effects of his injury at work and awards the prospective medical care prescribed by Dr. Salehi in the form of a right L3-4 far lateral decompression and L4-S1 transforaminal lumbar interbody fusion.

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

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990. The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003.

Petitioner claims that he is entitled to temporary total disability benefits for a disputed period beginning September 8, 2016 through January 11, 2018. As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work as opined by Dr. Salehi. Petitioner was kept off work or on work restrictions that Respondent did not or could not accommodate beginning on September 25, 2016. Thus, the Arbitrator finds that Petitioner has established his entitlement to temporary total disability benefits as claimed from September 25, 2016 through January 11, 2018.

In support of the Arbitrator's decision relating to Issue (O), admissibility of Respondent's Proposed Exhibit 16, the Arbitrator finds the following:

Respondent offered its Proposed Exhibit 16 reflecting Dr. Barnabas' criminal conviction pursuant to a guilty plea in 2002 to 57 counts of "Participating in a racketeering enterprise" in October of 1998, and asserts that it is relevant to Dr. Barnabas' truthfulness, the reliability of his testimony, and his credibility. Tr. at 17, 19, 23. Petitioner objected on the bases of hearsay, relevance, and foundation. Tr. at 18-19. Noting the age of Dr. Barnabas' conviction, the fact that Dr. Barnabas was only one of Petitioner's many treating physicians, and that Dr. Barnabas was not called as a witness by Petitioner or by Respondent as an adverse witness to testify at the hearing or at an evidence deposition, the Arbitrator overrules Petitioner's foundation objection and sustains Petitioner's relevance and hearsay objections. Respondent's Proposed Exhibit 16 will remain in the record as a rejected exhibit.

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

Willie Young,

Petitioner,

18IWCC0731

vs.

NO: 15 WC 31771

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, medical, notice and being advised of the facts and law, changes 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.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

18IWCC0731

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 2018, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: NOV 30 2018
o10/25/18
DLS/rm
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

18IWCC0731

YOUNG, WILLIE
Employee/Petitioner

Case# **15WC031771**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 4/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.88% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0731

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)

Willie Young,
Employee/Petitioner

v.

Chicago Transit Authority,
Employer/Respondent

Case # **15** WC **31771**

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 M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **January 24, 2018 & February 28, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☒ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **July 10, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$68,220.88**; the average weekly wage was **$1311.94**.

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

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services. Nothing further is owed.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$500.00** for other benefits, for a total credit of **$500.00**.

ORDER

Denial of benefits

Because Petitioner did not provide timely notice of an accident and Petitioner did not prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on July 10, 2015 all claims for benefits/compensation are denied.

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

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

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

Robert M. Harris

Signature of Arbitrator

April 9, 2018
Date

ICArbDec19(b)

Willie Young v. Chicago Transit Authority

15 WC 31771

18IWCC0731

DECISION OF ARBITRATOR

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The following issues were in dispute at trial: 1) Whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on July 10, 2015; 2) Whether Petitioner provided Respondent timely notice of an accident; 3) Whether Petitioner's current condition of ill-being is causally related to the injury; 4) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; 5) Is Petitioner entitled to TTD; and 6) Is Respondent entitled to credit for any payments.

Petitioner, Willie Young, was a 42-year-old married man with one child under the age of 18 and employed by the Chicago Transit Authority on July 10, 2015 (T., p. 8). Petitioner testified he was employed by Respondent as a bus servicer and had been working in that capacity for about 7 years prior to his work-injury but worked for Respondent as a bus operator prior to that (T. pp.15-16). Petitioner has worked for Respondent for a total of about 22 years (T. p 15). Petitioner's job duties included cleaning the interior and exterior of the buses, fueling the buses and checking basic functions of the bus such as fluids, oil and antifreeze (T. p.16).

Petitioner testified that on July 10, 2015 he reported to work at about 8:00 PM (T. p.17). Petitioner went through his normal routine to get ready for work then checked his station and noted that everything was not in place for him to perform his duties (*id.*). Petitioner testified that his station did not have the antifreeze bags ready and he had to go retrieve them (T. pp.17-18). Petitioner noted that while moving a 55-60 gallon antifreeze jug, he felt something pull and get hot in his back (T. p. 18). Petitioner noted pain in the low back above the right buttocks radiating down the right leg and into the right foot (T. p.21). Petitioner testified he was injured between 9:00 and 10:30 that night (T p. 22).

On July 13, 2015 Petitioner presented to Advocate Medical Group. (PX 8). Petitioner followed-up at Advocate Medical Group on July 21, 2015 and underwent an x-ray of the lumbar spine and was advised to remain off work (PX 8). At a follow-up- on July 24, 2015 it was

recommended that Petitioner undergo an MRI of the lumbar spine, attend physical therapy, see an orthopedic surgeon and remain off work (*id.*). An MRI of the lumbar spine was completed on July 30, 2015 and showed degenerative changes most significant at L5-S1 with moderate to severe bilateral neural foraminal narrowing (*id.*).

At a follow-up appointment on July 31, 2015 Petitioner was advised to attend physical therapy and return to work light duty (PX 8). Petitioner testified that he provided the light duty note to Respondent and was advised light duty would not be accommodated (Tr. Pp.31-32). Petitioner presented back to Advocate Medical Group on August 5, 2015 and it was recommended that he remain off work (PX 8). Petitioner also started physical therapy at Physiotherapy Associates on that date (PX 7). Petitioner had a follow-up at Advocate Medical Group on August 26, 2015 and was advised to remain off work and see a pain specialist (PX 8). Petitioner presented to Dr. Ravi Kumar on September 18, 2015 and it was recommended he undergo a lumbar epidural steroid ("ESI") (PX 5). Petitioner proceeded to undergo a lumbar ESI at L5-S1 on September 30, 2015 (*id.*).

Petitioner followed-up with Advocate Medical Group on October 23, 2015 and was advised to remain off work and follow-up- with Dr. Kumar for another injection (PX 8). On November 9, 2015 Petitioner underwent another lumbar ESI at L5-S1 (PX 5). Petitioner presented back to Advocate Medical Group on December 2, 2015 and was advised to see a neurosurgeon (PX 8).

Petitioner presented to Dr. Leslie Schaffer for an examination on December 9, 2015 (PX 2 at 7). He advised Petitioner to remain off work and attend physical therapy (PX 2, p. 9). Dr. Schaffer saw Petitioner again on January 13, 2016 and recommended he remain off work (PX 2 p. 10). He also discussed the possibility of surgery and the possible need for a repeat MRI (*id.*).

Petitioner went to Advocate Medical Group again on January 20, 2016 and was advised to remain off work and continue care with pain management (PX 8). Petitioner followed-up with Dr. Schaffer on February 10, 2016 and he was advised to undergo another ESI (PX 2, p. 11). Petitioner saw Dr. Schaffer again on March 2, 2016 and was advised to attend physical therapy and undergo another ESI. Petitioner underwent a lumbar ESI at L4-5 at Trinity Hospital with Dr. Suneela Harsoor on March 25, 2016 (PX 3).

Petitioner followed-up at Advocate Medical Group on April 6, 2016 and it was recommended that he remain off work and see the neurosurgeon (PX 8). Petitioner saw Dr. Harsoor again on May 2, 2016 and attend physical therapy and remain off work (*id.*). Petitioner went back to Advocate Medical Group on May 6, 2016 and was advised to remain off work and see the neurosurgeon (*id.*).

Dr. Schaffer saw Petitioner again on June 1, 2016 and recommended Petitioner undergo a new MRI of the lumbar spine (PX 6). Petitioner underwent a new MRI of the lumbar spine on June 10, 2016 at Christ Medical Center (Px 5). Dr. Schaffer reviewed the new MRI films and concluded that the findings were consistent with Petitioner's current complaints (PX 2, pp.12-13). On June 22, 2016 Dr. Schaffer recommended Petitioner go back to the pain clinic (PX 6). Petitioner testified that he had follow-up appointments at Advocate Medical Group on June 28, 2016 and August 23, 2016 and was advised to remain off work and attend physical therapy (T. p. 37).

Petitioner presented to Dr. Ryan Trombly for a second opinion on September 6, 2016 (PX 1, p.9). Petitioner presented with back and leg complaints due to pulling a heavy drum of antifreeze (PX 1, pp.10-11). Dr. Trombly diagnosed Petitioner with lumbar radiculopathy from spinal stenosis and lumbar herniated disc (PX 1, p.11). Dr. Trombly recommended surgical decompression surgery (PX 1, pp.11-12).

On November 16, 2016 Petitioner underwent a lumbar 3, 4, 5 and sacral 1 laminectomy, medial facetectomy and foraminotomy under the care of Dr. Trombly (PX 4). Petitioner saw Dr. Trombly following the surgery on December 6, 2016 and was advised to remain off work (PX 1, p.13). At follow-up appointments on January 10, 2017 and February 21, 2017 Dr. Trombly recommended Petitioner attend physical therapy and remain off work (PX 1, pp. 13-14). On March 21, 2017 Dr. Trombly recommended continued physical therapy (PX 1, p.15).

Petitioner saw Dr. Trombly again on April 18, 2017 and he recommended Petitioner undergo a CT of the lumbar spine due to Petitioner's ongoing pain complaints (PX 1, p.16). The same recommendation was made at a follow-up on May 30, 2017 (PX 1, p.17).

On May 30, 2017 Dr. Trombly also dictated a note which he read during his deposition testimony (PX 1, pp.17-20). In the note Dr. Trombly stated Petitioner "was in good health until

an episode at which he dragged a 60-gallon jug of antifreeze for quite a distance, and shortly thereafter, was in severe pain with spasms" (PX 1, p.18). As to causation, Dr. Trombly noted that, "I feel within a reasonable degree of medical certainty that the work-related injury from July 2015 caused the lumbar disc degeneration and incapacitating back pain. Prior to that episode, the claimant had worked for the CTA for many years without chronic back pain, and this further reinforces my opinion" (PX 1, p.19).

Petitioner saw Dr. Trombly again on July 11, 2017 and August 22, 2017 and was advised he could return to work at light duty as of September 1, 2017 (PX 1, pp. 21-23). During the August 22, 2017 visit, the possibility of a fusion surgery was discussed (PX 1, p. 22).

Petitioner testified that he continues to experience muscle tightness and stiffness in his back all the time (T. p 44). He also indicated that sitting for long periods of time and walking long distances aggravates his pain (*id.*). To treat the pain, Petitioner does the stretches and exercises he learned in physical therapy (T. p 45). He is looking to continue medical care with Dr. Trombly to further treat his back pain (T. pp. 45-46).

Regarding the disputed Issue (C) Whether Petitioner suffered accidental injuries that arose out of and in the course of his employment with Respondent on July 10, 2015 and Issue (E) Whether Petitioner gave Respondent timely notice of an accident, the Arbitrator finds and concludes as follows:

It is Petitioner's burden to prove each element of his case by a preponderance of the credible evidence. It is not the burden of Respondent to disprove any issue. Rather, the burden lies with Petitioner, his testimony, character and evidence entered onto the record at the time of trial. *Rambert v. Indus. Comm'n.* 133 Ill App. 3d 895, 87 Ill. Dec. 836, 477 N.E.2d 1364, 1369 (1985).

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). "[C]laimant has the

burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

On the Request for Hearing form/stipulation sheet admitted at trial, Petitioner alleges he gave timely notice at the time of the accident to a "Mr. Mendenhal", his manager. (Arb. Ex. 1). At trial, Petitioner testified he spoke to his manager, Mr. Kendall Mendenhall, on July 10, 2015. (T p. 18.) Petitioner specifically testified he reported his injury to Mr. Mendenhal. (T p. 22). However, Petitioner then went on to testify he asked Mr. Mendenhal for "help" moving the anti-freeze barrels around 9:00 or 9:15. (T p. 22-23). Petitioner further testified, in direct contradiction to this immediate prior testimony that he reported his injury to Mr. Mendenhal, that he specifically **did not** tell Mr. Mendenhal he injured his back during his shift. (T p. 23). Petitioner testified, "the antifreeze was too heavy for me to push by myself," so he asked Mr. Mendenhal for help, not that he injured his back. In fact, Petitioner testified specifically that he did not report that he injured his back. (T p. 23). Petitioner testified that he finished his shift that evening. (T p. 24). (However, it should be noted that Petitioner's treating physician Dr. Trombly testified that Petitioner told him he could not continue working that day after the accident due to severe back pain with spasms, PX 1, p. 18). Petitioner testified he did not report to work that evening (the next calendar day) because his back was still hurting. (T p. 26).

The Arbitrator notes that neither party called "Mr. Mendenhal" as a witness to offer testimony at trial. However, the Arbitrator takes as significant Petitioner's testimony that he admitted he did not tell Mendenhal that he injured his back during his shift.

The Arbitrator further notes that Petitioner called no witness to offer any testimony on his behalf.

Petitioner then testified he notified Respondent of this injury. (T p. 26). Petitioner testified he called his manager on duty, the next day, July 11, 2015, to "let him know that I wouldn't be able to come in." (T p. 26). However, Petitioner further specifically testified that he told his manager he couldn't come in because he **"was sick."** (T p. 26). Petitioner testified he was sick and **not** that he was having problems with his back or suffered a work injury (T p. 26). When asked why he said this, Petitioner testified, "I just said I was sick because we can't take days off, so the second or the third day we're off work we have to be under doctor's care." (T.p.26.) The Arbitrator emphasizes and takes specific note of the compelling fact that Petitioner explicitly testified more than once that he did **not** notify his managers of any injury to his back on July 10, 11, or 12 when he had apparently had every opportunity (and incentive) to do so The Arbitrator further notes that it is inexplicable that Petitioner failed to report his injury, especially so even when his manager was physically right next to him when Petitioner asserted he asked his manager for help at the time of the alleged injury to move the anti-freeze. Petitioner did not offer testimony that he told his manager **why** he needed help. Petitioner never offered any explanation as to why he failed to report this injury. This scenario casts serious doubts on Petitioner's credibility.

Based on the above, the Arbitrator finds and concludes Petitioner failed to prove timely notice under the Act pursuant to Section 6(C).

The Arbitrator has carefully reviewed the records admitted into evidence, including the medical records. **The Arbitrator finds and concludes these records are filled with glaring internal contradictions and inconsistencies regarding accident history, mechanism of injury** and dates on which the symptoms started or occurred. These records are therefore of very narrow and limited use and value, if any at all, in determining and resolving the disputed accident issue. Many medical notes contain entries on the very same page for the same date of service that contradict each other. Some medical notes clearly do not relate to a work accident, while others clearly do. It is also clear that these records were not proof-read. **Therefore, these records are obviously and inherently unreliable and untrustworthy. As such, they cannot and do not prove Petitioner's claims.**

This is all revealed as follows:

May 2, 2016, Dr. Harsoor: History of Present Illness: "He has been symptomatic of the last 8 months. **He reports onset of pain gradually over time.**" Employment: "The last day he worked was 07-10-15. He denies being on disability. The patient denies being on workers compensation." Plan: "5) **He is off work from 2015 July after being injured at work" (PX 8)**

November 30, 2015, Dr. Ghannam: "...herniated lumbar discs due to **repetitive injury** at the patient's place of employment." The Arbitrator notes that this is **not** a repetitive trauma claim. (PX 8)

August 17, 2015, Physiotherapy Associates, Progress Note: "Pt presents to physical therapy with c/o R-sided **LBP which has been present over the past approx. 5 weeks and was insidious in onset." (See also PX 6, identical entry in "Initial Evaluation" records dated August 5, 2015). The Arbitrator notes that "approx.. 5 weeks" past is well before July 10 and "insidious in onset" (gradual) would disqualify any claim to a specific acute trauma.**

July 31, 2015, PCP Primary Care Note: "The patient has been treated in the clinic a couple of times due to severe back pain started this month. He needs some forms to be filled for his disability and also for his job" (PX 8)

July 24, 215, PCP Primary Care Note: History of Present Illness: "Patient presents with chief complaint of Low Back Pain that has been present since July 12, 2015. **Not a job related injury.**" (PX 8)

July 14, 2015, PCP Primary Care Note: History of Present Illness: "Patient presents with chief complaint of mid back pain. **He has had pain for two weeks. Not a job related injury."** Review of Systems: "The symptoms resulted from a lifting motion, bending over motion and twisting. **The injury occurred at work. Episodes started about 4 weeks ago.**" (PX 8) These two entries obviously cancel out each other.

July 13, 2015, PCP Primary Care Note: Reason for Visit: "...patient here today for a chief complaint of Back pain X 2 days, pt request RTW." History of Present Illness: "...presenting with back pain and stiffness for two days. **Denies trauma.**" Review of Systems: The patient presents with complaints of **gradual onset of right mid back pain**..." (PX 8)

Petitioner went for treatment at Advocate Medical Group (T pp. 26-27; PX 5). The formal, typed "Report" dated September 18, 2015 written by consultant Dr. Ravi Kumar indicates, "...a chief complaint of low back pain, radiating down his right lower extremity since March 2015. The patient denies any history of trauma and his pain started gradually." (PX 5). The Arbitrator interprets this to mean Petitioner has had low back pain with right lower extremity pain that developed gradually since March 2015. Further, the doctor's hand-written notes also found in this exhibit are the basis for the formal, typed "Report", and both are consistent with each other. **The Arbitrator finds this detailed typed report very significant and assigns greatest weight and credibility to its factual reporting, which serves to severely discredit Petitioner's claims of an accidental injury. Further, as opposed to the many other medical records, there are no internal contradictions or inconsistencies in this report, which therefore greatly bolsters its credibility.**

Further, the "Pain Management Center Patient History Admission Record is a a form filled out, or at least signed by, Petitioner on September 19, 2015 (and a nurse). The form has a line labeled "Workers Compensation" – the box marked **"No"** immediately following is checked. This is nearly two months after the claimed incident. (PX 5). This indicates that Petitioner, the nurse, or both, agreed this admission was not considered a workers compensation matter more than two months after the alleged date of injury.

Respondent submitted five exhibits. Three of these were faxes of forms and medical records submitted to Sedgwick. The others are forms filled out by various treating doctors. None of these forms make mention of any work accident. In fact, Petitioner testified he did submit paper work to Sedgwick and did receive some benefits under a short term disability claim. (T. p30). Petitioner did not testify that he ever reported a work accident or a workers' compensation claim to anyone at Sedgwick or his employer.

Petitioner treated with Dr. Leslie Schaffer at Neurosurgical Professionals, Ltd. (PX 6). Dr. Shaffer first saw Petitioner on December 9, 2015 but hos hand-written notes (which are very difficult to read) make no mention of a work accident (on any date; PX 6). In fact, it is not until March 2, in a handwritten note from Dr. Schaffer, that there is any specific mention of moving ("pulling") 55 gallon drums 2 blocks and then felt pain. At the request of Petitioner's attorney, Dr. Schaffer wrote a narrative report dated April 19, 2016 (PX 6). After outlining treatment, there

is a very short discussion of causation, where Dr. Shaffer noted Petitioner's pre-existing lumbar spine condition and opined causation based on a theory of an aggravation. There is no discussion of a mechanism of injury or any injury.

In his deposition testimony, Dr. Schaffer admitted he didn't know what Petitioner's actual job title was, what his work activities were, what his job description was, and his notes had no mention of any specific injury or complaints while Petitioner was working until he was asked to prepare a causal connection letter. (PX 2, pp. 16-19). Dr. Shaffer agreed that in his treating records from December 9, 2015, January 13, 2016, and February 10, 2016 **there are no notes at all regarding any specific injury or any specific complaints about work from Petitioner** (PX 2, p. 17). Dr. Schaffer did testify, however, and somewhat disingenuously, that he and Petitioner died discuss the type of work Petitioner did and the kind of injury he had and his symptoms when they first met (PX 2, pp. 17-18). Dr. Schaffer opined causation based on a theory of aggravation of a pre-existing lumbar spine condition (PX 2, p. 14-15). The Arbitrator is not persuaded by Dr. Schaffer's testimony or opinion regarding accident or causation.

PX 4 are the records from Advocate Medical Group and Dr. Ryan Trombly, a neurosurgeon. On September 6, 2016, Petitioner saw Dr. Trombly for a neurological consultation. Dr. Trombly's notes reference this history: "Patient reports that pain started July 2015 after he pulled a 55 gallon drum of antifreeze at his place of employment. Patient felt pain immediately but did not seek medical treatment until a month later because he was unable to get out of bed due to the pain." The Arbitrator notes that this history is clearly inconsistent with Petitioner's testimony and with the treatment records entered into evidence at trial, again further supporting the finding that Petitioner is not credible. Dr. Trombly wrote a letter on the same date opining causation based on a theory of aggravation of a pre-existing condition.

At his deposition (PX 1) Dr. Trombly testified he relies on what the patient tells him and that he considers his patients to be truthful but did not make any effort to verify the truthfulness of Petitioner's claims; he "never spend time in a forensic manner going back to the incident, **especially when it is almost two years prior**." (PX 1, p. 20-21.)

Further, and very significant, in his deposition testimony, Dr. Trombly admitted that he didn't "recall" whether he had the opportunity to review any records from Dr. Schaffer or the

records from any other doctor (PX 1, p. 29). In light of a lack of history in other medical records and the fact that this alleged history was given over two years after the alleged accident when litigation was ongoing in this case, the Arbitrator is also not persuaded by Dr. Trombly's testimony or opinion regarding causation or accident. Further, since Dr. Trombly apparently did not review medical records from any other physicians, he was unbale to consider and assess all of the relevant evidence relating to the accident, mechanism of injury and reported symptoms; nor was he able to fully and properly assess Petitioner's credibility, which renders his opinion that he considers his patients to be truthful meaningless.

In summary, Petitioner's own testimony at trial was that he did not give notice to his manager of any work injury (to his back or otherwise). Petitioner offered no testimony that he gave timely notice to anyone representing Respondent. Petitioner had ample opportunity to report a work accident yet did not do so. While he did call out sick, he specifically admitted he did not tell the manager of an injury to his back either that day or the next two days he called in sick. There is no history of any work accident in the medical records immediately following the accident. While the requirements of notice under Section 6 (C) are not strictly enforced, in this case, Petitioner admitted he did not give timely notice (which also impacts on the issue of accident).

Petitioner's own testimony, combined with the lack of early history in the medical records and the numerous and significant inconsistencies and contradictions contained therein, directly leads the Arbitrator to find and conclude that notice was not prove and that Petitioner failed to prove his claim of accident, particularly in light of treating medical notes which indicate "no trauma" and/or a gradual onset of low back pain beginning in March 2015.

Therefore, the Arbitrator finds Petitioner failed to prove timely notice was provides to Respondent and failed to prove accident.

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

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of causal connection is moot.

J. & K. Are the medical bills outstanding owed by Respondent? Is Petitioner entitled to prospective medical care?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of medical is moot.

L. What TTD benefits are owed to Petitioner?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of TTD is moot.

N. Is Respondent entitled to any credit for payment?

Because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, the issue of credit is moot.

Based on the above, because the Arbitrator finds and concludes Petitioner failed to prove accident and notice, Petitioner's claim for compensation is therefore denied.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: April 9, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLY COULEAS,

Petitioner,

18IWCC0732

vs. NO: 17 WC 15176

STATE OF ILLINOIS – PINCKNEYVILLE CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's 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.

It was stipulated that Petitioner sustained repetitive trauma injuries to both upper extremities engaging in her normal office activities. Petitioner had an EMG/NCV on June 27, 2007 which showed moderate sensory motor median neuropathy across the left carpal tunnel. Petitioner did not receive medical treatment at that time. Petitioner testified her symptoms worsened and an EMG/NCV taken on April 14, 2017 showed rather severe chronic bilateral sensory motor neuropathies and it was noted that the left-sided neuropathy deteriorated since 2007. There was also moderate demyelinative ulnar neuropathy across the left elbow with partial sensory axonal involvement. There was no evidence of right-sided cubital tunnel syndrome.

On August 21, 2017, Dr. Mall performed left cubital tunnel decompression/ulnar nerve transposition and left carpal tunnel release for left carpal tunnel syndrome and cubital tunnel syndrome. On February 2, 2018, Dr. Mall performed right cubital tunnel decompression and right tunnel release for right carpal tunnel syndrome and cubital tunnel syndrome.

Petitioner testified that immediately after the surgeries, her numbness resolved and she "had very little pain in" her forearm. The only issues she had currently were grip and strength. Her right palm was still tender and sore. She noticed symptoms while using a big stapler on "big wads of paper." She also noticed symptoms carrying big boxes. She used an arm brace when she had pain and a gel pad all the time at work and while driving. She took Tramadol at the end of the day because her hands were tired. Last fall she was not able to garden and picking up her grandchildren was an issue. She also noticed that when she took minutes at meetings, by the end of the day she could not grip with her right hand.

On cross examination, Petitioner testified that at the hearing she did not have any problems, but she had not done "any writing or anything like that." She did not do "too much" for her left side. She would use a brace on the left in the anticipation of using it more, such as when she saw her grandchildren. Her surgeries were in in the fall in 2017 and then in February. Her recovery had gone "pretty well." She had no numbness or tingling, but she had tenderness at the incision on the right. She had that symptom on the left as well, but it improved. Dr. Mall expected the right side to improve also, in time. She hoped to garden as the season progresses. She was not able to hunt at all the current year, but she had applied for a deer-hunting license and hoped to hunt with a shotgun that fall. She planned no additional appointments with Dr. Mall and did the exercises he taught her. She had formal physical therapy for her left side, but not the right side. Petitioner was working without restrictions and she had no reason to believe there was any issue with her job performance.

The Arbitrator awarded Petitioner 112.325 weeks of permanent partial disability benefits representing loss of the use of 15% of the right arm, 12.5% of the right hand, 12.5% of the left arm, and 10% of the left hand. In arriving at his permanent partial disability award, the Arbitrator gave no weight to the factor of diminishment of earning potential, gave moderate weight to Petitioner's testimony about continuing difficulty performing her work, and significant weight to Petitioner's ongoing complaints, right more than left. Respondent argues the award was excessive. It stresses that the Arbitrator should have given weight to the fact that Petitioner had no loss of earning potential. In addition, it notes Petitioner's speedy and successful recovery. It recommends an award of 45.80 weeks of permanent partial disability benefits representing 5% loss of the use of each hand and 5% loss of each arm. Petitioner asks for an award of 129.15 weeks of permanent partial disability benefits representing loss of 12.5% of each hand and 15% of each arm.

In awarding Petitioner greater benefits for the right-sided neuropathies than the left, the Arbitrator noted that Petitioner's complaints about her right side were greater than the left. However, the medical records are clear that the left side pathology was more severe than the right. In fact, there did not appear be any electrodiagnostic evidence of right cubital tunnel syndrome and there did not appear to be any actual diagnosis of right cubital tunnel syndrome. It should also be noted that Dr. Mall's operative reports indicate that he did not perform ulnar transposition on the right, while he did on the left. Finally, while Petitioner testified that currently she experienced greater impairment on the right side, that was the side of the more recent surgery and she agreed that Dr. Mall informed her that her right-sided symptoms should improve with time, as did the left.

18IWCC0732

In addition, Petitioner's testimony about ongoing problems does not show extreme ongoing impairment. In fact, she testified that she hoped to resume gardening and hunting with a shotgun later in the year of the hearing. In looking at the entire record before us, based on the lack of any reduction in earning potential, the greater objective evidence of pathology on the left side than the right side, the fact that the more recent surgery was on the right side, and the limited evidence of significant ongoing impairment, the Commission concludes that the award for the conditions of ill-being on Petitioner's right-side should be reduced. Accordingly, the Commission reduces the right hand award to loss of the use of 10% of the right hand, to correspond to the award for the for the left hand, and the award for the right arm is reduced to the loss of the use 10% of that arm, based on the lack of objective evidence of cubital tunnel syndrome pathology on the right side and the fact that the surgery performed on the right arm was less extensive than the surgery performed on the left arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $718.59 per week for a period of 2&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 $646.73 per week for a period of 97.925 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 10% of each hand, loss of the use of 10% of the right arm, and loss of the use of 12.5% of the left arm.

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: NOV 30 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-11/15/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0732

COULEAS, KELLY
Employee/Petitioner

Case# **17WC015176**

STATE OF IL/PINCKNEYVILLE C C
Employer/Respondent

On 5/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.00% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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
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SPRINGFIELD, IL 62794-9255

0558 ILLINOIS ATTORNEY GENERAL
SHANNON D RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 14 2018

18IWCC0732

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Kelly Couleas
Employee/Petitioner

v.

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

Case # 17 WC 15176

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 10, 2018. By stipulation, the parties agree:

On the date of accident, February 20, 2017, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $56,050.00; the average weekly wage was $1,077.88.

At the time of injury, Petitioner was 55 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,515.39 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,515.39. Respondent stipulated Petitioner was entitled to further TTD benefits of two and four-sevenths (2 4/7) weeks commencing August 23, 2017, through September 9, 2017.

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 TTD benefits of $718.59 per week for two and four-sevenths (2 4/7) weeks commencing August 23, 2017, through September 9, 2017.

Respondent shall pay Petitioner permanent partial disability benefits of $646.73 per week for 112.325 weeks because the injuries sustained caused the 12 1/2% loss of use of the right hand, 15% loss of use of the right arm, 10% loss of use of the left hand and 12 1/2% loss of use of the left arm, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher

May 9, 2018

William R. Gallagher, Arbitrator

Date

ICArbDecN&E p. 2

MAY 14 2018

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 20, 2017, and that Petitioner sustained an injury to bilateral hands, wrists, elbows and arms as a result of repetitive duties (Arbitrator's Exhibit 2). At trial, the only disputed issue was the nature and extent of permanent partial disability. Petitioner claimed she was entitled to temporary total disability benefits of four and five-sevenths (4 5/7) weeks, commencing August 23, 2017, to September 10, 2017 (through September 9, 2017) and March 1, 2018, to March 15, 2018 (through March 14, 2018). Respondent stipulated it owed temporary total disability benefits for the aforestated periods of time; however, it was determined that Respondent had not paid Petitioner temporary total disability benefits for the initial period of lost time of two and four-sevenths (2 4/7) weeks, August 23, 2017, through September 9, 2017.

Petitioner was employed by Respondent as an Executive Secretary and worked for two Assistant Wardens and one Administrative Major. Petitioner's job duties required a significant amount of repetitive use of both upper extremities. Petitioner's counsel tendered into evidence her job description and Petitioner testified that the information contained therein was accurate (Petitioner's Exhibit 9).

Petitioner was initially seen by Dr. Stevens, her family physician (his/her records were not tendered into evidence at trial). Dr. Stevens referred Petitioner to Dr. Daniel Phillips, a neurologist.

Dr. Phillips saw Petitioner on April 14, 2017, and performed EMG/nerve conduction studies on both upper extremities. The diagnostic tests were positive for severe bilateral sensory motor neuropathies across the carpal tunnels and moderate ulnar neuropathy across the left elbow. Dr. Phillips recommended Petitioner be seen by a surgeon (Petitioner's Exhibit 3).

Petitioner was subsequently evaluated by Dr. Nathan Mall, an orthopedic surgeon, on May 3, 2017. Dr. Mall reviewed the EMG/nerve conduction studies and examined Petitioner. He opined Petitioner had bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. While Dr. Mall noted Petitioner had non-work risk factors, namely, obesity and a thyroid condition, he specifically referenced Petitioner's work duties and opined that they were a factor in the development of both bilateral carpal tunnel and cubital tunnel syndromes (Petitioner's Exhibit 4).

Dr. Mall performed surgery on August 21, 2017, and the procedure consisted of a left cubital tunnel decompression and ulnar nerve transposition and a left carpal tunnel release. Following surgery, Dr. Mall ordered physical therapy and directed Petitioner to do home exercises (Petitioner's Exhibit 6).

Dr. Mall performed surgery on February 22, 2018, and the procedure consisted of a right cubital tunnel decompression and ulnar nerve decompression/transposition and a right carpal tunnel release. Following surgery, Dr. Mall again ordered physical therapy (which Petitioner did not obtain) and directed Petitioner to do home exercises (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on September 28, 2017. Dr. Williams reviewed medical records and information regarding Petitioner's job duties provided to him by Respondent. Dr. Williams agreed Petitioner had left cubital tunnel and carpal tunnel syndrome as well as right carpal tunnel syndrome. In regard to causality, Dr. Williams opined these conditions were aggravated by Petitioner's job duties (Respondent's Exhibit 4).

At trial, Petitioner testified that following the surgeries the numbness in both of her hands resolved. However, Petitioner stated she still has diminished grip strength in both of her hands. Petitioner also said she continues to have an area of tenderness in the palm of her right hand and notices it especially when she has to pick up large boxes and when she uses a big stapler in her office. Petitioner also wears a gel pad on her right elbow while at work and when driving. Petitioner is right hand dominant and does have to take minutes at various meetings at work by hand.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 12 1/2% loss of use of the right hand, 15% loss of use of the right arm, 10% loss of use of the left hand and 12 1/2% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner's job required the active and repetitive use of both upper extremities. Petitioner was able to return to work to that job; however, Petitioner has difficulties performing some of her job duties because of her conditions, especially in regard to her use of her right upper extremity. The Arbitrator gives this factor moderate weight.

Petitioner was 55 years old at the time of the accident. There was no evidence that Petitioner's age had any effect on her condition. The Arbitrator gives this factor no weight.

There was no evidence that Petitioner's injury had any effect on her future earning capacity. The Arbitrator gives this factor no weight.

Petitioner was diagnosed with bilateral cubital tunnel and carpal tunnel syndromes and surgery was required. Petitioner continues to have complaints consistent with the injuries she sustained, more so on the right than left. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Brent Ellis,
Petitioner,

18IWCC0733

vs.

NO: 13 WC 6834

Fayette County,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 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: NOV 30 2018
o11/1/18
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the majority's award of 22.5% MAW. I would have instead found Petitioner suffered a 15% MAW disability based on the §8.1(b) statutory factors.

Petitioner returned to full duty work on May 21, 2012 and worked in his regular position for a year and a half before the position was eliminated from Respondent's budget. Petitioner left Respondent's employment in November or December 2013 and was subsequently hired by the St. Louis Highway Department in August 2015. He still worked for the St. Louis Highway Department at the time of hearing with job duties that include repairing highways, fixing potholes and trimming trees. Petitioner testified this position involves "extreme physical labor." (Transcript at 36). Nevertheless, Petitioner is able to complete the physical aspects of his job with the aid of only over-the-counter medication.

In consideration of criterion (ii) of §8.1(b), the occupation of the employee, the Arbitrator found the tremendously physical aspect of Petitioner's new job established a greater degree of permanency. However, I would have found Petitioner's ability to return to his regular position for a substantial period of time and then transition to a more physically demanding job shows a lesser degree of permanency. Thus, in analyzing the §8.1(b) factors, as well as the record in its entirety, I would have found Petitioner established permanent partial disability of 15% MAW and modified the award accordingly. For the reasons stated above, I respectfully dissent from the Decision of the majority.

DLS/met
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Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0733

ELLIS, KELLY BRENT
Employee/Petitioner

Case# **13WC006834**

FAYETTE COUNTY
Employer/Respondent

On 11/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% 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:

0390 McGLYNN & McGLYNN
MICHAEL McGLYNN
116 S CHARLES ST
BELLEVILLE, IL 62220

0000 INMAN & FITZGIBBINS LTD
MICHAEL BANTZ
301 N NEIL ST SUITE 350
CHAMPAIGN, IL 61820

18IWCC0733

18IWCC0733

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

KELLY BRENT ELLIS
Employee/Petitioner

v.

FAYETTE COUNTY
Employer/Respondent

Case # 13 WC 06834

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 19, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,501.52**; the average weekly wage was **$913.49**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of an in the course of his employment on September 29, 2011. The Arbitrator further finds that the Petitioner's cervical condition of ill-being at C5/6 is causally related to the September 29, 2011 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$608.99 per week** for **32-6/7 weeks**, commencing **October 4, 2011 through May 20, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibits 9 and 10, as provided in Sections 8(a) and 8.2 of the Act, with the exception that the Petitioner is not entitled to the expenses claimed by Phoenix Physical Therapy, as this appears to be an independent evaluation requested by the Petitioner's attorney, and does not constitute reasonable and necessary treatment under Section 8(a).

Respondent shall pay Petitioner permanent partial disability benefits of **$548.09 per week** for **112.5 weeks**, because the injuries sustained caused the **22.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **October 16, 2012** through **November 3, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

18IWCC0733

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 15, 2017
Date

NOV 29 2017

STATEMENT OF FACTS

Petitioner testified he worked as the Chief Deputy for Respondent's Sherriff's Department since 2006. On 9/19/11 at the end of the day, he was preparing to go on vacation and trying to tie everything up before he left. He testified that he went to get ticket books, which were in a box in his "cluttered little office," to put out for the officers to use. As he was doing so, he was moving boxes around, had the ticket box in hand, turned to go to the door and tripped over a broken drawer that was underneath his desk. His head "speared" the wall. Petitioner testified he "saw stars", it felt like electricity throughout his body, and he noticed numbness and tingling in his neck. He also noticed his head was bleeding.

Petitioner testified that the photos submitted as Px11, taken by Petitioner's wife a few weeks after the accident, fairly depict his office at the time of his injury. Petitioner indicated that photo "A" shows the drawer sticking out from the front of his desk. He testified that the drawer was about 3' to 4' wide on a 6' desk, and because it had been broken for several months to a year and would fall and drop all of his belongings out, he kept it on the floor. Photos "B" and "C" show the office door. The Petitioner testified this is the area where he fell and struck his head, but he couldn't say exactly where he hit. Photo "D" depicts how "messy and cluttered" his office was. He testified he didn't do a good job of removing clutter, but that his office was also a "catch all" room for deputies for things like evidence, radios, etc. (Px11).

No one else was in the office when the incident occurred. After he gathered himself, he put out the ticket books and went home. He had already let his wife know he had tripped and fell, and when he got home he laid down. His wife questioned him lying down with a head injury when she got home, but Petitioner wanted to see how he was after some rest. He still had neck pain the next day, but he had already paid for a vacation cruise, so he wanted to tough it out and go on the trip. His wife suggested that he report the injury to Respondent, and within a day or two, he and his wife went to see Sherriff Aaron Lay, reported the incident and completed an accident report.

Petitioner went on vacation, testifying he suffered in pain throughout the trip, but tried to have a good time. He took a lot of ibuprofen and drank liquor, and took naps when it got really bad, but testified he wasn't able to do things he normally did on cruises in the past, such as using pool slides and seeing shows. In addition to the tingling and neck pain, when he turned his head it felt like a "bone on bone catch", and he would get a stabbing pain that radiated throughout his upper body, mainly in his right arm, so he tried to avoid turning his head.

Since the fall, Petitioner testified he's had pain radiating down the right arm, as well as numbness into the right thumb, index and middle fingers. When he returned from the trip, he sought treatment with his primary

provider, Dr. Dossett, on 10/4/11. Following an MRI, the results of which sounded "a little worse than I was hoping", Dr. Dossett prescribed physical therapy, medications and ultimately referred Petitioner to a surgeon. He also had injections. None of this helped, and he in fact felt he got worse during therapy. Petitioner testified he was held off work from the Dossett visit through his surgery.

After surgery, Petitioner testified his symptoms were greatly improved, but he still had headaches and numbness and tingling in the back, shoulders and arms. He was able to return to work full duty on 5/21/12. He continued to work for Respondent for another year and a half until 12/1/13. He has been working for the St. Louis County Highway Department since August 2015, performing highway repair, potholes, tree trimming, etc. He testified it involves pretty heavy physical labor, and he is able to do it, but he takes his fair share of over-the-counter medications.

Petitioner has pain and numbness in the right arm and hand daily. In the mornings, he has considerable ache in the right shoulder and arm, and he will take an Aleve before and after work. He testified to various work duties that will trigger pain and/or headaches. He also "tightens up" with the physical labor – on good days, it is only the right side, and on other days the pain goes into the left shoulder and he sometimes gets tingling and shooting pain in the left arm as well. He testified to difficulties with handwriting, recreational activities and exercise.

Petitioner testified he didn't have any of these symptoms prior to the 9/19/11 incident at work. As to an ER visit of 7/19/11, two months before the work injury, Petitioner testified he was driving around while on duty when he started to have slight chest pains that got worse until it radiated into his neck, face and arm with vision problems, and he thought he was having a heart attack. He testified that "everything ached" - his head, neck, chest and arm - but the hospital believed it was anxiety or a migraine. He has not had a similar situation since, and he testified the symptoms were not like anything he has had with the work incident.

On cross exam, Petitioner again testified his desk drawer had been broken for months, and that both he and the maintenance man unsuccessfully tried to repair it. He decided to put the drawer under his desk because it had fallen multiple times and scattered his belongings. In order to comfortably sit at his desk, he had to position the drawer to where it would stick out from two sides of the desk. He agreed he was used to it being there and having to walk around it. He testified the Sheriff was aware of the drawer problem, and agreed that other people would access his office and put items in it.

From his testimony on cross, Petitioner went to his office around 4 or 4:30 on 9/19/11 to basically finish up things before leaving for a two week vacation, and in particular to put out the ticket books, which were generally locked up. He did testify that the Sherriff and the secretary also had keys. Again, the deputies needed the books to write tickets, and he had to mete them out or the deputies would take them all. When he fell, to the best of Petitioner's recall, he was carrying a box of ticket books.

Petitioner testified that he left town on 9/23/11, which he believed was a Friday, driving to Terre Haute, IN to catch a flight to Florida. He agreed he did go swimming and did see some late night shows, but again testified he didn't do everything he normally would have done on the cruise, and when he did he would take ibuprofen, have some drinks and go to bed.

The Arbitrator's review of the photographs of Petitioner's office (Px11) indicates a cluttered desk with paperwork, boxes stacked up on a chair and the floor in one area where the Petitioner would look if seated at the desk, and the desk drawer is depicted under the desk, sticking out several inches. The room is carpeted, and the area where the desk drawer sticks out is between the desk and two guest chairs, and is in line with the office door if one were walking parallel to the desk.

Petitioner's wife, Theresa Ellis, testified that when she came home on 9/19/11, the Petitioner was in bed and said he had a headache. He said he was getting some ticket books, tripped and fell and speared his head against a wall at work. He had a bump on his head, but he said he wanted to see how he felt before seeing a doctor. She tried to get him to avoid sleeping due to the head trauma. She testified the Petitioner also had a small area of significant bruising near the right hip, where it was dark purple. She indicated that if he was not going to see the doctor that he at least needed to report the injury, and they went in and spoke to Sherriff Lay.

They left for a prepaid, 7 day cruise with two other couples on 9/23/11, which cost about $2,000 per couple. Mrs. Ellis testified that Petitioner's injury did slow them down, and the fact he didn't feel well prevented them from doing all the activities they planned, including slides, zip lining, jet skis and excursions. She said the Petitioner pushed forward despite the pain, doing what he could and took ibuprofen, as he didn't want the other people on the trip to have a bad time because of him. When they returned to town, she accompanied Petitioner to see Dr. Dossett. Between that day and the day he had surgery, Mrs. Ellis testified the Petitioner had: "A lot of numbness, a lot of headaches. His shoulders would hurt, his neck would hurt when he would turn, things like that, and he tried therapy. It didn't work very well. He was really sore after that the next day." She had no knowledge of Petitioner ever having any similar prior problems before the incident at work.

Mrs. Ellis testified that neck surgery did help Petitioner: "He didn't have as much pain. He still had -- he still has headaches. He still has cold -- problems when it's cold outside. He has a lot of stiffness in his neck. He's got numbness in his fingers. But the pain, I think the shooting pains and everything are gone." With his current job, Mrs. Ellis testified the Petitioner is tired when he gets home from work, takes ibuprofen and sits in a chair until bedtime. They no longer do any boating or water sports. Someone else mows their lawn because it hurts his hands and neck. Handwriting causes numbness if he does it for too long. He also has problems with headaches and his neck with cold weather.

Both the Petitioner and his wife were asked about an alleged fall from a trailer at their property on Vandalia Lake, and both testified there was no such fall.

Teresa Durbin, Respondent's administrative secretary for the last 36 years, was called by the Respondent as a witness. She testified that her job includes workers' compensation claims and submitting claims to the board. She has known Petitioner for about 10 years. Ms. Durbin testified that Petitioner reported the alleged accident on 9/21/11 (Wednesday): "He said he was moving things in his office. He fell into the door with his head, and the chair arm with his side" on 9/19/11. She testified that Petitioner didn't say anything about tripping over a drawer, and that she was not aware of there being a broken drawer. When he reported the accident, Ms. Durbin testified she went and looked in his office, and she did not recall seeing any boxes.

Ms. Durbin testified that she had been in Petitioner's office during September 2011. She agreed she leaves work at 4 p.m., and no one else would have been in the office at the time of the alleged incident, around 4:30 p.m. She agreed it would be unusual for Petitioner to be at the office that late, but she had not reviewed any of Petitioner's log in/log out information.

Ms. Durbin was shown the photographs of Petitioner's office (Px11), and testified that she did not believe they were accurate as to what she saw she looked in Petitioner's office, and that there was no drawer on the floor where one is depicted in picture "A". She testified: "I actually went in and tried to determine how it could have happened, that his bruise -- that this could have happened the way he told me, so I checked everything. There was not boxes like in those pictures. I did not see anything like that. There was two chairs along the west wall that are just north of the file cabinet. The file cabinet was behind the door if you would open the door up. There

was no -- no drawer on the floor because I laid on the floor to try to determine where you would hit if you were to hit the chairs. And I know he's taller than me, I know he's bigger than me, but it just was -- I mean, I'm not an expert of any kind, but it just was not feasible the way that it supposedly happened." On redirect examination, Ms. Durbin agreed that Petitioner reported moving boxes when he was injured, and she indicated this on the Form 45, as well as that ticket books were kept in boxes.

Ms. Durbin testified that the documents contained in Rx3 are Petitioner's work records, and include documentation of all vacation, personal and sick time that was accrued and used by him in 2011 and 2012. They indicate the Petitioner was off work from 10/4/11 through 5/21/12, and he was initially paid salary until 3/1/12, when he went on FMLA. It appears that at least a portion of the time he was paid salary involved sick time, but it is unclear to the Arbitrator how much. His position was eliminated on 11/30/13 due to budget constraints. Ms. Durbin testified that she has handled probably 6 workers' compensation cases during her tenure, and she is suspicious and doesn't believe he had the accident he claims.

On cross exam, Ms. Durbin reiterated it was not routine for Petitioner to be working night hours, but it's possible he was on 9/19/11. She had no knowledge of Petitioner having a broken desk drawer, had never seen the drawer on the floor, and had never seen the drawer missing from his desk. Petitioner, the Sherriff and Ms. Durbin had keys to Petitioner's office. In this regard, she testified that it was not a problem to go into Petitioner's office at any time to get a ticket book for an officer when needed. Ms. Durbin agreed Petitioner and his wife came to the office to report his alleged injury, and she herself saw the scrape on his head and the bruise on his right side, though she believed the yellow/green color of the bruise did not appear to have occurred only two days prior. She did not recall the Petitioner going into an office to discuss the incident with the Sherriff while she spoke to Petitioner's wife. She testified that Petitioner and his wife stood at her desk while she typed the information into a Form 45.

The Form 45 states: "Tripped and fell head first into office door striking head and falling into chair hitting right side." It is undated. (Px12).

Mrs. Gay Claycomb, a dispatcher for the Respondent, testified that she went on the September 2011 cruise with Petitioner and his wife, from 9/25 (Sun.) to 10/2/11. She has known the Petitioner for 10 or more years. She testified they drove to Indianapolis and took a two hour flight from there to Florida. While on the cruise, they did socialize. They visited three islands, and their activities included going to dinner, a piano bar and drank alcohol. He didn't seem to have any difficulties swimming, driving or partying. She identified the Petitioner in the vacation photos contained in Rx2. In one, she noted he was getting dunked in the water. Ms. Claycomb did not recall Petitioner ever saying he was in pain during the trip. On the way home, he said he didn't feel good, and she admitted she didn't ask what this meant exactly. She did not recall Petitioner mentioning a work accident. The Petitioner drove back from Indiana after they flew home, and didn't ask anyone else to drive.

Respondent also called their Deputy Sherriff, Ed Durbin, to testify. He has known the Petitioner for at least 12 years, and he also went on the September 2011 Caribbean cruise with Petitioner. He testified that the Petitioner never mentioned or alluded to an accident at work. He didn't complain of any pain to his neck or arms, and he didn't appear to be in pain. They would sometimes dine together, they went drinking together at the piano bar, and swam together as well. He also identified the Petitioner in the photographs in Rx2. The Petitioner didn't have any difficulty driving that he was able to tell.

The Arbitrator's review of these pictures does not indicate anything more significant that the Petitioner standing in the ocean. In one photo the water is at about shoulder level, and in another it is around the abdomen, and a

woman appears to be attempting to dunk him into the water. He is also depicted holding a beer in one photo. (Rx2).

MEDICAL EVIDENCE

On 7/19/11, Petitioner presented to Fayette County Hospital's emergency room (ER), complaining of the spontaneous onset of nausea, headache, blurred vision, jaw pain, double vision, and right arm tingling. He also noted a "weird feeling" in his jaw and neck. A CT scan of his head was read as normal. He was diagnosed with an ocular injury, prescribed Tramadol, and he was to follow up with his primary provider if symptoms persisted. (Rx4). As to the 7/19/11 ER visit, Petitioner agreed he "probably" reported neck pain with tingling into the right arm. Mrs. Ellis recalled he called her from the hospital indicating he thought he was having a heart attack. She testified his symptoms at that time were not like his symptoms after the 9/19/11 incident.

Following the alleged accident date of 9/19/11, Petitioner initially presented to his primary provider Dr. Dossett on 10/4/11, stating that he fell at work on 9/19/11: "He was in a close room and given some chairs when he tripped and build up some momentum and fell head first into a closed a door [sic]. He felt a sudden severe electrical sensation down to his toes can be from his head." Petitioner stated that he went on a cruise with 6 people because he had already paid for it. He had a sharp pressure sensation in both sides of his neck – the left 80% of the time and the right 20% of the time. Dr. Dossett also noted he struck a chair and had a bruise above his right hip. Petitioner stated that he slept for 15 hours the day after the accident and hurt all over. He had good range of motion (ROM) in his neck but was tender between his shoulder blades with palpation at T1/2. His cervical spine was non-tender in the midline but was tender bilaterally with tense muscles. Thoracic x-rays showed age indeterminate, subtle, multilevel veterbral height loss and degenerative changes. Cervical x-rays revealed no evidence of acute fracture or subluxation, but did reveal osteopenia and multilevel degenerative change, osteophyte formation, and straightening or lordosis due to positioning or muscle strain. Dr. Dossett diagnosed a head injury with subsequent cervical and thoracic spine pain, with a possible spinal cord contusion. Petitioner was restricted from working for a week and it was noted that he would need an MRI of the cervical and thoracic areas if his symptoms persisted. (Px3, Px5).

Petitioner returned to Dr. Dossett on 10/11/11 with the same symptoms, with intermittent sharp pains radiating down the right shoulder to the elbow, as well as a continued occasional catch in his neck with very sharp pain in the center of his spine, and a constant dull ache in his thoracic spine. He was diagnosed with cervical pain with right radiculopathy, multilevel loss of vertebral heights in the thoracic spine, and a questionable compression fracture. He was restricted from work for a week and was prescribed cervical and thoracic MRIs. (Px3).

The 10/12/11 cervical MRI was read by the radiologist as showing no evidence of cervical disc herniation, but multilevel cervical spondylitic changes, most pronounced right paracentrally to laterally at C5/6. It was also noted that there was a broad based posterior osteophyte in close proximity to the right-side nerve root at C5/6, and an adjacent bulging disc, but no central canal stenosis. No neuroforaminal narrowing was noted at any other level, but there was bilateral facet hypertrophy at C4/5 and a mild disc bulge at C6/7. Thoracic MRI from the same date noted no herniation, neuroforaminal or canal stenosis, but mild multilevel disc desiccation. (Px3, Px5, Rx5).

Petitioner followed up with Dr. Dossett on 10/18/11, and he noted the thoracic MRI was completely normal, while the cervical MRI showed a bone spur and some adjacent disc narrowing, as well as borderline right sided neuroforaminal narrowing, but no disc herniations. Petitioner was referred to neurosurgeon Dr. Russell for consultation, and was held off work pending same. (Px3).

On 11/11/11, Petitioner presented to Dr. Russell at Springfield Clinic. He reported a 9/19/11 fall: "Apparently he tripped and fell back in September while at work. He had previously been scheduled for a vacation and went ahead and took his vacation and he was off work for a couple of weeks. The pain never really resolved." An intake form Petitioner completed indicated he tripped and fell head first into a door/wall. He complained of pain between his shoulder blades and down his right arm with numbness and tingling at times, and no left arm symptoms. Neurologic examination was essentially normal except for a possible area of hypesthesia over the lateral forearm. Dr. Russell opined that, clinically, he had C6 nerve root symptoms that corresponded with a sizable disc herniation at C5-6 on the right. Dr. Dossett recommended physical therapy and epidural injections, and if that failed a possible C5/6 discectomy. (Px4).

On 11/16/11, Petitioner began physical therapy at Fayette County Hospital. He reported aching pain in his neck and between the shoulder blades, as well as throbbing/aching pain and tingling in the right arm into the fingers with some numbness. It was recommended that he undergo physical therapy two to three times a week for three to four weeks. (Px5).

On 11/17/11, Petitioner requested an off-work note and a muscle relaxer from Dr. Dossett. He said that the physical therapist sent him home today because his muscles were so tight. The diagnosis was continued neck pain with radiculopathy and muscle spasms. Petitioner was prescribed ongoing therapy, Vicodin and Flexeril, and was restricted from working for two to three weeks until he followed up with Dossett or Russell. At 12/7/11 follow up, Petitioner notes excellent range of motion improvement with therapy, but no pain reduction, and his right grip was weaker than the left. Petitioner notes Dr. Russell wanted to try epidurals, and if that failed surgery would be the last resort. Dr. Dossett now diagnosed Petitioner with a herniated cervical disc. He refilled Petitioner's Vicodin and flexeril and restricted him from working for one month, or if he had marked improvement with epidural. (Px3).

Petitioner had an initial 11/16/11 therapy evaluation, noting complaints of cervical pain radiating into the right arm, stabbing cervical pain with movement, and throbbing radicular pain in the right biceps, forearm and thumb. There was significant cervical guarding, with the therapist noting he tended to rotate his whole body than just his neck. On 12/14/11 Petitioner's physical therapist noted the Petitioner had not progressed, had significantly reduced right grip strength versus the left, and had pain with daily activities. She recommended putting therapy on hold, and he was discharged shortly thereafter. (Px4).

Petitioner underwent epidural injections at C5/6 with Dr. Narla on 12/15/11 and 1/5/12. The diagnosis indicated was C5/6 broad-based osteophyte disk complex and associated right C6 radiculopathy. The 1/5/12 report diagnosis indicated "helped by previous injection to some extent." (Px3, Px6).

On 1/6/12, Petitioner went to the Fayette County ER with complaints of chest pain. He reported that he had received an injection for a pinched nerve and developed swelling on both sides of his neck, right greater than left. A chest CT scan was performed based on fullness in the supraclavicular regions, and the findings included mild axillary lymphadenopathy. He was discharged with a non-specific diagnosis, advised to continue his medications and was advised to follow up with his primary care provider. (Px5).

On 1/9/12, Dr. Dossett issued an off work note from 1/3/12 through 1/19/12, though it appears there is no progress note for either 1/3 or 1/9/12. On 1/19/12, Dr. Dossett reported that Petitioner was there mainly to review records, and noted that he had a 1/19/12 work related injury. He had undergone therapy and injections but continued to note right arm pain with numbness in the 2nd and 3rd fingers and decreased right grip. He now was complaining of similar symptoms on the left side. Dr. Dossett diagnosed chronic right upper extremity pain secondary to herniated disc. He was scheduled for a third epidural, and Petitioner noted he wanted to delay

surgery if possible. Vicodin and flexeril were prescribed, and Petitioner was restricted from working for six weeks. (Px3).

On 1/24/12, Petitioner returned to Dr. Russell. His complaints remained the same following therapy, though he felt physical therapy helped with his cervical ROM, and the injections reduced the intensity of the pain. Dr. Russell noted the right arm symptoms seemingly fit into a C6 distribution, and he had degenerative changes and osteophytes at the C5/6 level. Petitioner wished to pursue surgery, as he didn't otherwise think he would be able to return to work. (Px4).

On 2/1/12, Petitioner was cleared for cervical surgery by Dr. Dossett. (Px3).

On 2/13/12, Petitioner underwent surgery with Dr. Russell. The preoperative and postoperative diagnoses were cervical disc disease. The report noted: "The disk itself was very well collapsed with rather significant degenerative disk disease." Dr. Russell performed an anterior discectomy and interbody fusion at C5/6. (Px7).

On 2/28/12, Petitioner reported to Dr. Russell that his proximal arm pain had resolved but he still had numbness and tingling in his fingers. He was instructed to begin home exercises and to follow up in three to four weeks for X-rays. (Px4). On 3/2/12, Petitioner returned to Dr. Dossett. He indicated he no longer had severe pain in his right neck and thoracic area or stabbing pain in his right arm. He did note residual numbness in his right thumb, index, and third fingers. Dr. Dossett restricted Petitioner from working until follow up with Dr. Russell. (Px3). On 3/28/12, Dr. Russell noted Petitioner doing "tons better." X-rays showed excellent positioning of the grafts and plate and Petitioner was instructed to return in six to eight weeks. (Px4). An unsigned health status form was completed that same day, 3/28/12, in which it was indicated that Petitioner was restricted from working until April 24, 2012. (Px3).

Petitioner underwent physical therapy at Springfield Clinic on April 10, 2012 and continued through May 30, 2012. He was discharged from therapy on 5/31/12. The discharge note indicated good improvement in ROM, strength and activity tolerance, and that Petitioner had returned to work without difficulty or increased pain. He did have ongoing right wrist pain that the therapist felt needed further assessment. (Px3).

On 4/24/12, Petitioner returned to Dr. Russell, and he was doing very well. He had started therapy x-rays showed good healing with no abnormal motion. X-rays showed the hardware from the fusion and other degenerative cervical changes, including spurring at C3/4, C5/6 and C6/7. Dr. Russell noted that he planned to return the Petitioner to unrestricted work following an additional 2 to 3 weeks of therapy. He was to follow up in three months. Another unsigned health status form was completed on 4/24/12, indicating that Petitioner could return to work without restrictions on 5/21/12. (Px3, Px4).

On 6/1/12, Petitioner reported to Dr. Dossett that he was doing well with no pain and only minor numbness in the thumb and fingers. He was doing well after having returned to work for two weeks, and was very happy with the surgical results. He was otherwise to follow up with Dr. Russell. (Px3).

On June 12, 2012, Petitioner reported he was doing well and had been able to get back to work. He still had some numbness in his fingers but no longer had significant radiating arm pain. Dr. Russell indicated he could continue "bumping up" his activities, and should follow up in the fall. (Px3).

On 9/5/12, Dr. Dossett indicated Petitioner reported reduced energy and libido. His cervical disc disease was stable with the exception of residual numbness in his fingertips. (Rx3).

On 10/16/12, Petitioner told Dr. Russell that he was doing very good and that his neck felt "great." Petitioner's only complaint was numbness in his right fingers. X-rays showed grade 1 retrolisthesis of C6 over C7, similar to prior films, stable C3/4 and C6/7 disc height narrowing with posterior endplate osteophytes, and stable fusion with interval bone bridging versus 4/24/12 films. Petitioner was not given any restrictions and was discharged from care to return as needed. (Px3, Px4).

On 11/8/12, Petitioner presented to the ER at Fayette County Hospital with complaints of substernal chest pain and tingling from the left bicep to finger, an achy feeling, and he was flushed. He reported being at work when the symptoms began, and that he had similar pain one year prior. He was admitted, and then a note of Dr. Dossett from the hospital notes chest pain that had started the night before and radiated down his left arm with associated tingling. It also noted that Petitioner had neck surgery in February and had no neck pain at this time, but prior to surgery "had tingling down his right and left arms at different times." Petitioner reported being under a lot of stress at work and that he nearly lost his job a few weeks prior. Petitioner complained of chest pain going down his left arm and that he had been gassy for the past few weeks, despite being on Prontonix. He was given nitro, which resolved the arm tingling but caused a headache, medications for his depression and peptic ulcer, and it was noted that he might require a nitro pill. (Px3).

On 11/13/12, Dr. Dossett noted the ER visit and that Petitioner was there for elevated blood pressure, headaches, and chest pain. He noted the chest pain and arm numbness had resolved, but that Petitioner would be undergoing a stress test. On 12/4/12, Petitioner was to get his stress test done, and that this should rule heart problems in or out. Dr. Dossett noted complaints of persistent numbness in the same three right fingers. Dr. Dossett also noted midthoracic pain, that x-rays from the year before showed bone spurs but his MRI was negative, that the chest pain could potentially from his cervical spine disease or from heartburn, and that the thoracic pain was from arthritis or from silent reflux. The stress test appeared to indicate no abnormalities.

On 2/12/13, Petitioner met with Brian Buescher, PT, at Phoenix Physical Therapy, for a physical therapy evaluation. It is unclear how the Petitioner made his way for this evaluation, but the report is addressed to his attorney. Petitioner reported that he continued to have cervical pain, daily headaches, and numbness in his thumb, index, and long fingers. He also reported mild limitation in grip strength and fine motor skills like handwriting. Despite regular use of over-the-counter medication, he has been unable to alleviate his conditions. Mr. Beuscher opined that if Petitioner were to improve his rotator cuff strength and scapular stabilizers, this would improve his neural plasticity and his overall pain and symptoms. (Px8).

On 10/15/14, Petitioner was examined by Dr. James Stiehl at the request of the Respondent. Petitioner reported he was doing paperwork in his office on 9/19/11 when he tripped and fell to the floor, landing on his face, developing pain and stabbing in his neck and tingling in a C6 distribution. Petitioner complained of ongoing chronic neck pain, pain with weather changes, occasional migraines and daily headaches. Petitioner's further history of the accident was that he was arranging paperwork in his office, and that he also had a contusion and was bleeding from the head. He reported surgery helped with the pain, but not with the tingling and numbness. Dr. Stiehl reviewed and summarized Petitioner's medical records and performed a physical examination. (Rx1)

The exam showed unrestricted range of motion, negative Spurlings testing and intact strength, reflexes and sensation. Dr. Stiehl opined that Petitioner had chronic cervical neck pain with age related MRI findings, and that he did not believe there were verifiable neurological complaints seen in the Petitioner, and that surgery was performed for chronic cervical arthrosis. Dr. Stiehl opined that if Petitioner did in fact fall as he alleged, then he would have aggravated his degenerative condition, and that it "could have" been a temporary aggravation given no acute findings on MRI. He stated: "He did not offer evidence of radiculopathy on those early findings, and therefore that could not be attributed to the injury state. Typically, one would expect this patient to return to

normal within 3 to 4 months following such an injury. On the other hand if he had preexisting arthrosis of his cervical spine, that condition could have progressed after the above noted injury." Dr. Stiehl indicated it did not appear that Petitioner needed work restrictions other than post-surgery, and had been released to full duty as of 10/16/12. Regarding the surgery itself, Dr. Stiehl opined that the fusion surgery was "probably not" due to Petitioner's alleged fall: "He may have progressed into having numbness and tingling at some later point, but we can see for at least a period of six weeks, there were no complaints of significant radiculopathy of the upper extremities." Dr. Stiehl specifically notes that while the Petitioner told him he had numbness and tingling from the outset of his injury, this is not documented in the medical records, and this was "a substantial issue for causation in this case." He agreed that the treatment Petitioner received, including surgery, was reasonable based on Petitioner's chronic cervical condition. (Rx1).

Dr. Stiehl issued an 11/30/15 addendum report following his review of the 7/19/11 ER records from Fayette County, prior to the alleged accident. Dr. Stiehl noted Petitioner complained significant headaches and blurred vision for an ocular injury, with a normal head CT scan. He noted Petitioner also complained of moderately severe symptoms in his jaw and neck as well as right arm numbness and tingling. He also stated that Petitioner did not report any history of prior headaches. Dr. Stiehl opined that these complaints were evidence that Petitioner had a "significant" active cervical spondylosis condition prior to the accident, which was not aggravated by the accident. He also referenced the fact that Petitioner did not seek any post-accident treatment until 10/4/11. (Rx1).

Dr. Russell was deposed by the parties on 10/17/16. Dr. Russell testified that Petitioner's reported numbness and tingling symptoms appeared to be in a C6 distribution, which would correlate to a C5/6 disc herniation, and that he observed a sizable disc herniation at that level. He also was noted to have degenerative changes and osteophytes at C5/6 as well. (Px1).

On 2/13/12, Dr. Russell performed a C5/6 anterior fusion. He noted the disc was "well collapsed" with "rather significant" degenerative changes. Following surgery, Petitioner reported his arm pain was gone, but he had some ongoing numbness in the fingers. Petitioner's symptomatic relief supports that the symptoms are related to C5/6. Post-surgical x-rays showed healing and good graft positioning, and at the last visit in October 2012, Petitioner was doing well and had returned to work with no significant arm pain or unusual difficulties, with some ongoing tingling. He was to have returned to work following his discharge from therapy, likely in May 2012. Dr. Russell opined the mechanism of the alleged work injury could have caused the disc or aggravated the preexisting condition at C5/6, causing arm pain and C6 radiculopathy. He further testified that his treatment, including surgery, was necessary as a result of Petitioner's alleged work accident. (Px1).

With regard to the 7/19/11 ER records, Dr. Russell noted the diagnosis was an ocular migraine, involving a headache with vision problems, though Dr. Russell acknowledged there were complaints of tingling in his right arm at that time. He opined these symptoms were not describing a C5/6 problem, and there was no diagnosis of radiculopathy. Dr. Russell testified that Petitioner's stated history was that he had no prior cervical pain or disability. (Px1).

On cross examination, Dr. Russell couldn't determine a specific date when Petitioner returned to work, but that he had released him to full duty by 5/31/12. He agreed that in workers compensation claims it can be helpful to review all of the relevant records in determining causation. He agreed he didn't review any of Petitioner's medical records predating 9/19/11, or possibly from prior to his 11/11 initial visit. Petitioner told him that, during his two week vacation following 9/19/11, he was resting and taking pain medication. Petitioner didn't report what caused him to fall, just that he fell head first at his office, and it involved a door/wall. (Px1).

Respondent's counsel noted that a herniated disc was not specifically noted in either the cervical MRI report or the surgical report. Dr. Russell explained that a collapsed disc can have a component of disc herniation as well, and that a herniation was seen during surgery: "There's usually a combination of disc material as well as the osteophytes or the spurs, and that corresponds with the degenerative disc disease", and "This was not just a disc herniation, this was more degenerative disc disease." He agreed that such degeneration worsens over time. In response to the question, "Okay. It was degenerative disc disease rather than a disc herniation?", Dr. Russell replied, "Right." Dr. Russell also conceded that, regarding his opinions on causal connection, he relied upon what the Petitioner told him, and that he indicated that the symptoms that were consistent with C6 that he did not have prior to the fall at work. (Px1).

On re-direct, Dr. Russell opined that the disc herniation, osteophytes, and degenerative changes at C5/6 were all objective findings during surgery that corresponded to Petitioner's symptoms. The Petitioner's loss of cervical lordosis was a nonspecific finding. Dr. Russell agreed that Petitioner's degenerative C5/6 changes were preexisting, but that he performed surgery due to unrelenting arm symptoms that persisted despite conservative treatment, the worst of which were relieved by the surgery, not the degenerative condition itself: "I'm not operating to make his X-rays look better, we're trying to relieve the nerve pain." On re-cross, Dr. Russell agreed his surgical report doesn't specifically note he found a herniated disc, but that there are always disc fragments with a collapsed disc. He testified the indication that he drilled through the disc space "includes herniated fragments, that includes degenerated fragments, that includes maybe some normal disc as we clean that out." Surgery also addressed degenerative findings like osteophytes (Px1).

Primary care provider Dr. Dossett testified on 6/24/16. Dr. Dossett testified that he had been treating Petitioner since 2005. On 10/4/11, Petitioner reported a 9/19/11 injury where he was in a closed room lifting some chairs and tripped, causing him to build up some momentum as he fell forward and his head hit into a closed door. Petitioner said he felt a sudden severe electrical sensation from his head to his toes, which could be due to a pinched nerve, and a sharp pressure sensation in the bilateral neck, left greater than right, which could have been due to muscles or nerves. He diagnosed injury to the head, cervical and thoracic spines. He testified that pinching of a nerve could cause bruising and/or swelling of the nerve, or something more permanent. Cervical X-rays showed multilevel arthritis, and tight muscles / loss of lordosis that could be due to the 9/19/11 incident. Petitioner next complained of right shoulder pain into the arm, which could be radicular. Dr. Dossett opined that the arthritis was preexisting, with stenosis of the foramina, but that injury to the nerve could have caused swelling, resulting in greater squeezing of the nerves and radicular symptoms. This determination was supported, in his opinion, by the initial electrical sensation and the subsequent neck tightness and pressure sensation. Dr. Dossett testified that, per the MRI report, "the good news was there was no herniated disk, but there was a lot of arthritis, particularly at C5-6. They described a broad based posterior osteophyte, which is a big bone spur, and was resulting in some narrowing of the disk, and this bone spur was very close to where the right nerve root would exit at one of the images, producing some narrowing at the C5-6 disc area." Dr. Dossett continued Petitioner off work through the surgery, and continued to prescribe medications for him after surgery. Dr. Dossett noted he had diagnosed a herniated disc on 12/7/11, and that he was "not sure if that is technically correct." On 12/7/11, Petitioner reported weakened right grip. On 1/19/12, he reported a new complaint of similar left arm symptoms. To his knowledge, Petitioner did not have cervical complaints prior to the 9/19/11 fall, going back to when he initiated treatment in 2005. Dr. Dossett agreed that Petitioner's 2/13/12 surgery was an appropriate intervention, given Petitioner's symptoms, and that it was related to the 9/19/11 fall, but agreed he believed there was a fusion but hadn't reviewed the operative report. (Px2)

On 3/2/12, Petitioner returned to Dr. Dossett and had improved with surgery, with normal findings other than reduced sensation of his right thumb and index finger and complaints of some continued right finger numbness. By 6/1/12, Petitioner had no pain in his neck or arm and normal right grip, and he was doing well after two

weeks of regular work. Petitioner was happy with the results. On 9/5/12, Dr. Dossett noted persistent numbness in his fingertips was related to the alleged work accident, testifying that, "I would say the only complaint related to the original injury was the persistent numbness in his fingertips." Petitioner reported that Dr. Russell said the numbness should continue to improve over time. As to complaints of chest pain on 11/13/12, Dr. Dossett agreed it could be residual neck discomfort, but could be unrelated. Dr. Dossett did not review any physical therapy records. (Px2).

On cross-examination, Dr. Dossett did not believe he reviewed the 7/19/11 Fayette County ER records. He agreed that posterior headache complaints like those Petitioner made on 8/16/11 could be cervical related, but that he had a migraine on that date that was unrelated to the neck. Dr. Dossett conceded that Petitioner's cervical arthritis was degenerative and could worsen with activities of daily living. Dr. Dossett also conceded that that his only information regarding Petitioner's alleged accident were from what Petitioner had told him, and that if the facts of the alleged accident were different, it could affect his causation opinion. (Px2).

The evidence deposition of Respondent's Section 12 examining orthopedic surgeon Dr. Stiehl was taken on 3/3/16. Dr. Stiehl testified he is board certified, and for the past 7 years has a general orthopedic practice. While he has experience with a significant number of spine cases in his career, his spinal practice is a small percentage of his patients. Petitioner provided a history of doing paperwork on 9/19/11 when he tripped and fell to floor, after which he went on vacation and did not seek treatment until 10/4/11. He noted his 10/15/14 examination of Petitioner was normal, and MRI showed degenerative arthritis, most pronounced at C5-6, but no disc herniation or significant canal or foraminal stenosis: ". . . I could not prove that he had radiculopathy from my point of view." He believed Petitioner had cervical arthritis and "at some point" developed radiculopathy that led to the need for surgery. He opined that the 9/19/11 fall did not cause the condition, but that Petitioner suffered a temporary aggravation of his pre-existing degenerative arthritis on 9/19/11, and that his need for cervical surgery was not due to this incident. This was based on Petitioner not seeking immediate treatment and "there was no way of verifying his claim." (Rx1).

Following his review of Petitioner's 7/19/11 records from the Fayette County Hospital ER, which showed complaints of headaches, blurred vision, severe symptoms in his jaw and in his neck, and also right arm numbness and tingling, Dr. Stiehl revised his opinions. He testified that these records indicated a chronic right radiculopathy given the report of numbness and tingling in his right hand. The chronic arthritis was clearly preexisting, and severe enough on 7/19/11 for him to go to the ER. After the alleged injury, however, he didn't seek treatment until 10/4/11, after going on a cruise and being off work for two weeks. He didn't believe there was a significant injury on 9/19/11. He testified: "I have no evidence in the record or actually by his own admission that there had been an injury that caused a neck condition . . . Or aggravated it." Dr. Stiehl noted that Petitioner's symptoms were severe enough on 7/19/11 that he went to the emergency room, where he noted right arm numbness and tingling and had pain enough to undergo a head CT, but after the 9/19/11 incident he did not, and instead went on a cruise. Dr. Stiehl testified that cervical arthritis is a degenerative condition that worsens over time, but: "There can be conditions where we know that the cause was significantly aggravated by a neck condition, like if you're in a car wreck its extremely common to have whiplash and that can be an aggravation that can actually aggravate patients wo have arthritis." Dr. Stiehl also opined that Petitioner may have had to have the surgery that he underwent even if he did not suffer the alleged work accident. (Rx1).

On cross-examination, Dr. Stiehl agreed that he has never performed cervical surgery himself, and that he operates on knees and shoulders. He agreed that Dr. Russell would be more knowledgeable about surgical treatment, but that he is highly qualified to evaluate cervical conditions and would be equally qualified to make determinations regarding causation of cervical spine conditions. Dr. Stiehl agreed that Petitioner's cervical treatment was reasonable and necessary, including surgery, and that he did not question the Petitioner's veracity

or desire to recover. He agreed the Petitioner reported having numbness and tingling since the injury, which is significant to him, and that while he Petitioner reported an immediate electrical sensation, "I don't know what led to that." (Rx1).

Dr. Stiehl testified that he did not think that Petitioner's arthrosis was caused by the September 19, 2011 injury, but stated the he had written in his first IME report that if Petitioner had pre-existing arthrosis of his cervical spine, that condition could have progressed after the above-noted injury. His review of the MRI films showed osteophytes, but no evidence of a disc herniation. He opined that 10/5/11 cervical x-rays showed no significant changes beyond degenerative arthritis and a C5/6 osteophyte, and that the degeneration he saw was normal for Petitioner's age group. He initially testified that he did not see a loss of lordosis in cervical films, and then indicated he did not know if he did or not. He agreed the Petitioner's stated mechanism of injury could have resulted in an acute disc herniation. Dr. Stiehl conceded that Petitioner was not diagnosed with C6 root symptoms during his pre-incident 7/19/11 ER visit, but noted Petitioner had complaints of the occipital area of the head, i.e. base of skull which he would consider the neck, as well as numbness and tingling in the right upper extremity. As such, he believed this was evidence of a preexisting cervical condition, and he testified that he disagreed with the ocular diagnosis at Fayette County. Dr. Stiehl testified that he did not see any finding of a disc herniation noted in Dr. Russell's operative report. (Rx1).

On re-direct, Dr. Stiehl agreed that he changed his opinion regarding the 9/19/11 incident and progression of the preexisting condition after he reviewed the 7/19/11 ER report. His review of the MRI agreed with the radiologist's report regarding no evidence of cervical body compression forming or cervical disc herniation. Dr. Stiehl agreed that had Dr. Russell documented a herniated disc in the operative report, he would not be able to dispute it since he was not present during surgery. Had he found one during surgery, he would have reported it. (Rx1).

Petitioner presented his medical expenses as Px9 and 10. According to Arbx1, the exhibits contain a subrogation claim from the Petitioner's wife's health insurance plan totaling $60,955.85, as well as an outstanding bill from Phoenix PT totaling $194.00.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained his burden of proof that he sustained accidental injuries arising out of and in the course of his employment on 9/19/11.

The Petitioner testified that he was at his office on the late afternoon of 9/19/11 to tie up some loose ends before starting his vacation. He testified that he was moving a box of ticket books when he tripped over a desk drawer he had on the floor of his office, causing him to fall headfirst into the office door.

With regard to the "in the course of" element to accident, the Petitioner testified that he was present at the Respondent's business office, and in his own office, for work activities. The activities described by Petitioner would clearly be within the course of his work duties. No evidence was presented in rebuttal, other than that regarding credibility as noted below. The Arbitrator finds the Petitioner's testimony to be credible regarding his

presence and work activities on 9/19/11, and this he has proven by the preponderance of the evidence the "in the course of" element of his accident claim.

The main thrust of Respondent's dispute is with regard to the "arising out of" element of the accident claim. As the Petitioner was the only party present, per the evidence presented, when the alleged incident occurred on 9/19/11, the only real defense the Respondent has to this claim is the argument that the Petitioner's story is not credible, and that the accident did not happen the way he said it did.

Taking Petitioner's testimony alone, he was walking in his small office, carrying a box, and tripped over a drawer that was lying on the floor because it was broken. The Arbitrator notes that while the act of walking, in and of itself, would be a neutral risk that would not be increased over and above the employment, the noted facts indicate that the employment increased the risk of injury. The photographs of the Petitioner's office support that the office was small in terms of area to walk. The Petitioners wife took the photos several weeks after the accident, apparently when they had returned from their cruise, however the Petitioner testified the photos accurately depicted what the office looked like on the accident date. The photos also support the Petitioner's testimony that the office had piles of paperwork and boxes in it. The Arbitrator believes that these factors, along with the Petitioner's testimony that he was carrying a box in that office, supports that there was an increased risk of injury which arose out of the employment.

There are three things which the Arbitrator agrees leads to questions in this case. First, Petitioner did not report the injury until 9/21/11. Secondly, Ms. Durbin's testimony is noted. She testified that when the Petitioner reported the accident, he did not indicate that he tripped over the drawer, and when she went into the office to look at how he could have tripped following his reporting, she did not see a drawer on the floor or boxes in the office. She further testified that she had no knowledge that the Petitioner's desk drawer was even broken. Third, he did not seek any medical treatment prior to or during his vacation, and thus waited over two weeks for an initial examination.

With regard to the initial question, while the Arbitrator notes this was two days after the alleged incident, it only skipped a single "work day", as the accident occurred in the late afternoon/evening of 9/19/11. This delay in reporting does not appear to be unreasonable given the Petitioner's testimony that he wanted to see if he would improve, and that he was trying to get ready for a pre-planned vacation.

While Ms. Durbin testified that Petitioner didn't say anything about tripping over a drawer, he did indicate he was moving things in the office when he fell. Her testimony that she went and looked in his office and did not recall seeing any boxes would mean that the Petitioner essentially staged the photographs of his office that were taken by his wife. The photos just do not appear to the Arbitrator to have been staged, and they depict a significantly messy and small office space. Ultimately, the Arbitrator finds the Petitioner's testimony regarding the office status to be credible. There is some question as to whether the drawer was on the floor, as Ms. Durbin testified that she laid down on the floor to look and see what the Petitioner could have tripped on. However, again, the issue with the drawer would appear to the Arbitrator to be a strange story for the Petitioner to have made up. Additionally, the Arbitrator believes that the cramped office and carrying the box when he fell would in itself be sufficient evidence that a compensable accident occurred regardless of the drawer. Tripping over the drawer would just make it even more clearly a compensable accident.

As to the treatment, it does appear that, based on the witness testimony, the Petitioner went on his vacation and enjoyed himself while engaging in a number of activities. However, at the same time, the fact that he wasn't totally disabled does not prove that he was not in pain, and it does seem reasonable to the Arbitrator that the Petitioner would have tried to enjoy a preplanned and paid for vacation with other people. The witnesses who

testified appeared credible in terms of the Petitioner not mentioning pain or that an incident occurred at work. However, the Petitioner had already reported the accident at that point, so it certainly doesn't seem that he made it up. This adds credibility to his wife's testimony that he did not want to cause the other people they were on vacation with to have a bad time because of him.

Overall, while the Respondent's dispute in this case is reasonable, the Arbitrator believes that the greater weight of the credible evidence in this case supports that the Petitioner sustained a compensable accidental injury on 9/19/11.

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 sustained his burden of proving that his cervical condition of ill-being is related to the 9/19/11 accident.

First, the Arbitrator's review of the 7/19/11 ER report reflects a completely different situation than the one Petitioner had following the 9/19/11 accident. On 7/19/11, at the ER, the Petitioner's complaints included nausea, headache, blurred vision, jaw pain, double vision, and right arm tingling. It was also noted that he had a "weird feeling in jaw and neck." He testified that this came on spontaneously while he was driving during work. The diagnosis was an ocular problem. The only films that were obtained were of the Petitioner's head. While Dr. Stichl opined that this may have been an incorrect diagnosis and that the complaints related to the cervical spine, the greater weight of the evidence does not support this speculative opinion. The complaints, while they did include the neck to some degree and the right arm, involved other complaints that clearly predominated based on the evidence in the ER records. The cervical complaints after the accident are more significant, and the accident itself involved a trauma where the Petitioner went headfirst into a door or wall, which would constitute, in the Arbitrator's view, a fairly significant trauma to the head and likely the spine. There was no trauma indicated on 7/19/11, but rather a spontaneous onset of symptoms, the greater degree of which does not appear to involve the cervical spine in any way. Dr. Russell's opinion in this regard is more persuasive to the Arbitrator, as Dr. Stiehl's opinion is more reliant on speculation.

Otherwise, there is no evidence that the Petitioner had preexisting symptoms similar to that which he had after the accident. The accident itself, as described by Petitioner, as noted, appears to be a significant trauma in that he tripped headfirst into a solid object. He tripped with enough force to cause his head to bleed, and to strike a chair resulting in a significant bruise. The mechanism of injury therefore, just by common sense, could have injured the cervical spine.

Dr. Stiehl's testimony regarding a denial of a causal relationship in this case is not persuasive to the Arbitrator. At one point, he testified: "I have no evidence in the record or actually by his own admission that there had been an injury that caused a neck condition . . . Or aggravated it." This is simply false. The Petitioner specifically reported an injury that he indicated caused his symptoms. To say there is "no evidence in the record" seems to the Arbitrator to show a level of bias on the part of Dr. Stichl in this case. Dr. Russell opined the mechanism of the injury could have caused the C5/6 disc or aggravated a preexisting condition at that level, resulting in symptoms, and that the symptoms resulted in the need for surgery. Ultimately, the Arbitrator finds the testimony of Dr. Russell supporting a causal relationship to be more persuasive than that of Dr. Stiehl.

The Arbitrator's review of the evidence indicates the Petitioner had fairly significant preexisting cervical degeneration. While Respondent argues, in part, that any cervical condition the Petitioner had was due to a preexisting condition, the case at bar calls to mind the case of *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 797

N.E.2d 665, 278 Ill.Dec. 70 (2003). In that case, the Supreme Court reiterated the axiom: "It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." The key question is whether the work incident is a causative factor in the claimant's condition of ill-being. Here, the Arbitrator finds that the work accident of 9/19/11 was at least a causative factor in the Petitioner's development of symptoms, and resultant need for surgery.

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

Based on the Arbitrator's findings with regard to accident and causation, as noted above, as well as a review of Px9 & 10, the Arbitrator finds that the Petitioner is entitled to the expenses presented in Px9 and Px10 which are causally related to the accident. However, the Arbitrator denies the bill from Phoenix Physical Therapy. There was no evidence of a referral to this facility from any of the treating physicians, and the report is addressed to the Petitioner's attorney. Thus, this visit and report appear to be related to an independent therapy examination at the request of the Petitioner, and does not constitute reasonable and necessary treatment pursuant to Section 8(a) of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to Arbx1, the Petitioner claims he is entitled to TTD from 10/4/11 through 5/21/12.

At the time of the hearing, the Respondent indicated that the dispute with regard to TTD rests on liability for same, and there is no dispute with regard to the time period being claimed by Petitioner. Given that liability has been found in favor of the Petitioner, the Arbitrator finds that the Petitioner is entitled to TTD from 10/4/11 through 5/20/12. While Petitioner claims TTD through 5/21/12, he testified that he returned to work on that date, and this is not entitled to TTD on 5/21/12.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating was submitted into evidence by either party, and therefore this factor carries no weight in the permanency determination.

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 deputy sheriff at the time of the accident. He returned to that position for a significant period of time before the job was eliminated by the Respondent. Thus, it does not appear from the evidence that his departure from Respondent's employ had anything to do with his injury. It does not appear that the deputy sheriff position was tremendously physical and was more of a desk job, while his current job appears to be much more physical. At the same time, evidence was not presented as to whether the Petitioner had or has other opportunities to work in a less physical position. Based on this evidence, the Arbitrator finds that this factor tends to show a somewhat greater degree of permanency than one who returns to their regular job position.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. No evidence was presented by either party with regard to the impact of the Petitioner's age on his permanent condition relative to the sequelae of the accidental injury. As such, the Arbitrator does not speculate regarding same, and this factor carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that while evidence was presented that the Petitioner is working in a different and more physical job, no evidence was presented with regard to whether his future earning capacity was impacted by the work injury. Thus, this factor tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner appears to have had a very good recovery following surgery, based on Dr. Russell's last report indicating he was doing well and that his neck felt great. The main residual complaint the Petitioner had post-surgery was ongoing numbness in his finger. While the Petitioner complains of soreness and being very tired after working at his current job on a daily basis, he was released to full duty work and has shown an ongoing capability to perform a much heavier physical job than the one he had with Respondent. In general, the Petitioner's testimony is consistent with the medical records, with a solid post-surgical recovery, and this factor carries reasonable weight in the permanency determination.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Denise Goins,

Petitioner,

vs.

Nos. 14 WC 03846
15 WC 07219

Illinois Department of Veterans' Affairs,

18IWCC0734

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

On February 5, 2014, Petitioner filed an application for adjustment of claim, which received case No. 14 WC 03846, alleging that on October 30, 2013, she sustained accidental injuries to the hands, wrists, elbows, knees, left shoulder and person as a whole when she slipped and fell on wet floor. On March 3, 2015, Petitioner filed an application for adjustment of claim, which received case No. 15 WC 07219, alleging repetitive trauma to the hands, wrists and elbows, with the manifestation date of November 22, 2013.

Petitioner, who was 40 years old at the time of the arbitration hearing, testified that she was right hand dominant. Petitioner admitted having high blood pressure since 2006, which was controlled with medication. Petitioner denied being diabetic or a smoker. Petitioner acknowledged having symptoms in her right hand, but not the left hand, before October 30, 2013. The right hand bothered her during the day on certain days when she used it more, and the symptoms progressively became more noticeable. Petitioner mentioned the right-sided symptoms to her doctor, but was not referred to a specialist.

Petitioner further testified that she worked for Respondent since 2003. Initially, she was an executive secretary. Petitioner did not describe her job activities as an executive secretary, other than mentioning writing down meeting minutes every day. In 2012, Petitioner became a human resources associate. Her job duties included "filing, data entry, *** payroll, so a lot of computer entry, typing." She pulled files out of cabinets and boxes, sometimes needing to use force when the files were packed tightly. On Mondays, when she performed filing duties, she would "touch at least 75 to 80 file folders." On cross-examination, Petitioner clarified that was an unusually large number of folders because she had to update annual paperwork. On days when Petitioner did payroll, she mostly did data entry. Petitioner indicated she used a computer mouse with her right hand and typed on a keyboard that rested in a pull-out drawer. Petitioner stated she spent a lot of time doing data entry and looking things up, also stating she was on the computer "on and off." Doing payroll involved "constant data entry." Petitioner tried to enter payroll data daily, and closed it out every two weeks. On a typical day, she spent 30 to 45 minutes entering payroll data. Doing payroll close-out would usually take "most of the morning." On cross-examination, Petitioner clarified that typing and data entry, including payroll, took three to five hours a day. Petitioner also spent a significant amount of time on the phone, handling between five and 15 calls a day, for a total of about an hour a day.

Melanie McReynolds, Petitioner's supervisor, testified that she worked with Petitioner daily. Ms. McReynolds summarized Petitioner's job duties as follows: "60 percent of her job duties is data entry and payroll entry. The rest of the day is answering random phone calls ***, answering e-mails, staff requests." Ms. McReynolds stated Petitioner needed to process 75 to 80 folders only once a month and pull boxes of files only once or twice a year. Daily filing was "very infrequent." On the other hand, Petitioner did data entry daily.

On October 30, 2013, Petitioner slipped and fell on wet floor near the employee entrance, landing on her hands and knees. Petitioner testified she "hit the floor hard" and felt pain in her hands, knees, shoulders and wrists. She reported the accident, but stated she sustained no injury as she understood it. She did not seek immediate medical care. After the accident, Petitioner was "in pain for a couple weeks." The symptoms in the right hand became almost constant, and she developed symptoms in the left hand. Ms. McReynolds, Petitioner's supervisor, testified that Petitioner reported her fall and complained of soreness in her hands and knees. Thereafter, Petitioner would mention stiffness and soreness in her hands every so often.

On November 22, 2013, Petitioner sought treatment at Union County Hospital. The medical records from Union County Hospital show Petitioner sought emergency treatment for bilateral wrist complaints, reporting a sudden onset while at work. X-rays were unremarkable. The attending physician diagnosed wrist sprains.

Petitioner followed up with Dr. Christine Lucas for complaints of soreness in the wrists, among other things. The medical records from Dr. Lucas show that on December 12, 2013, Petitioner reporting slipping on wet floor at work and falling on her hands and knees on October 30, 2013. Regarding Petitioner's upper extremities, Dr. Lucas noted: "She states she is having a constant aching pain in her palms, forearms and going up into her elbows. She is sometimes unable to sleep on her left side due to the pain in the arm there. She freely admits to being a big fan of her smart phone playing games and doing Facebook and if she holds her phone in a certain position for any length of time her hands will start twitching and she has to switch hands. She does do a lot of data entry as part of her job especially when it is around payroll time. She needs to do 3 to 5 hours of data entry and that seems to really worsen her symptoms. At times when she is sleeping the pain will wake her from sleep. *** Her right hand would get numb and goes to sleep prior to this injury and she felt that this was likely related to her occupation and an overuse-type syndrome and she knew that eventually she would need to do something about that but it has significantly worsened this fall." Dr. Lucas noted Petitioner weighed 228 pounds. Dr. Lucas diagnosed bilateral forearm, wrist and hand paresthesias and pain, which she related to "a ground-level fall on a wet tile surface at [the patient's] workplace causing the patient to land on all 4s." Dr. Lucas recommended electrodiagnostic studies and an orthopedic consult.

On January 22, 2014, Petitioner saw Dr. Michael Davis at the Orthopaedic Institute of Southern Illinois on a referral from Dr. Lucas. Dr. Davis noted the following: "She reports that on 10/30/2013, she was at work and was attempting to walk on the floor that has had some water spilled on it ***. She slipped on the floor. Her right leg went out behind her and she reports that she fell landing directly on both knees and both wrists. She had pain, but conservatively managed it. *** She has had a gradual progression over the past several months. Her pain is now a 5 in intensity. It is generally dull, sometimes burning, but it aches if she uses her hands too much. *** She has numbness in her hands more on the left than the right and some activities including writing or using keyboard or mouse a lot seem to exacerbate her right hand symptoms." Dr. Davis noted Petitioner was 5 feet 4 inches tall and weighed 225 pounds. Physical examination was significant for a positive Finkelstein's test and tenderness to palpation in the first dorsal compartment on the right. Light touch sensation was subjectively diminished in the median nerve distribution on the right and slightly in the ulnar nerve distribution. There was tenderness to palpation in the anatomic snuffbox, more on the left than the right. Dr. Davis diagnosed bilateral carpal tunnel syndrome and a right de Quervain's tenosynovitis, and ordered electrodiagnostic studies. The electrodiagnostic studies, performed February 20, 2014, showed a moderate left and a mild right carpal tunnel syndrome. On February 26, 2014, Petitioner followed up with Dr. Davis, who prescribed splints and occupational therapy.

Dr. Davis, an orthopedic surgeon, testified by evidence deposition on August 24, 2017, that Petitioner returned on April 10, 2014, complaining of persistent symptoms in the wrists. Dr. Davis recommended a carpal tunnel release "on her more symptomatic left side." Regarding the right side, Dr. Davis thought it might improve with conservative treatment. Petitioner has not returned since.

Dr. Davis provided the following causation opinion: "I do not think that [the fall] was the sole cause [of the carpal tunnel syndrome]. I do not have electrodiagnostic studies to confirm before and after the fall, but my medical opinion would be that there was probably some component of carpal tunnel syndrome before her fall." Dr. Davis agreed the fall could have aggravated the carpal tunnel condition on the left side and the right side. Regarding the cause of the underlying carpal tunnel syndrome, Dr. Davis opined: "The described work activities are consistent with the development of [bilateral] carpal tunnel symptoms." In formulating his causation opinion, Dr. Davis relied on the history Petitioner provided to him, as well as the history noted by Dr. Lucas. Dr. Davis generally understood Petitioner's job duties to involve writing and using a keyboard or a mouse. When asked about comorbid factors, Dr. Davis acknowledged: "Her body mass index was elevated and she had a history of hypertension." Dr. Davis further acknowledged that Petitioner's gender and age could have played a role in the development of carpal tunnel syndrome.

On November 4, 2014, Dr. Anthony Sudekum, a hand and upper extremity surgeon, examined Petitioner at Respondent's request, noting the following history: "[The claimant] has a history of RIGHT carpal tunnel symptomatology predating *** October 30, 2013. [The claimant] states that on October 30, 2013 she was walking into work carrying Halloween candy and other belongings when she slipped and fell on a wet floor. She states that she landed on her bilateral palms and knees resulting in pain to her knees, hands, shoulders, back. She did not initially seek any medical evaluation or treatment for any injury related to this incident but did fill out workers compensation documents relating to this incident." Petitioner complained to Dr. Sudekum of bilateral hand and wrist symptoms, the right worse than the left. She also complained of right forearm and elbow pain, and left shoulder pain. Dr. Sudekum noted Petitioner was 5 feet 4 inches tall and weighed 225 pounds, corresponding to a BMI of 38.6. Dr. Sudekum obtained repeat electrodiagnostic studies, which were consistent with a mild right carpal tunnel syndrome and no left carpal tunnel syndrome.

Dr. Sudekum reviewed a job description from Respondent, noting the job required working on a computer. Dr. Sudekum then asked Petitioner to describe her job activities, noting: "She states that she spends approximately 80% of her workday at her desk/workstation where she performs a variety of office/clerical tasks including reading paperwork, reading documents on her computer screen, typing, keyboard entry, paperwork, filing, copying, talking on the phone, attending meetings, etc. Her job requires that she be able to type 30 words per minute. She states that she is responsible for payroll and also serves as the workers compensation coordinator for her employer."

Dr. Sudekum diagnosed a preexisting right carpal tunnel syndrome, which he opined was unrelated to the fall on October 30, 2013. Rather, Dr. Sudekum related the right carpal tunnel syndrome to "non-work related risk factors *** including female sex, her age over 37 years, obesity and hypertension and her hobbies and habits including painting, crafts, cooking, housework, scrapbooking and using smartphone for computer games and Facebook."

On June 15, 2017, Dr. Sudekum reexamined Petitioner. Petitioner gave a job history of working as a human resources associate for five years (since 2012) and, prior to that, as an executive secretary for eight years. She gave the same description of her job activities as she did during the initial section 12 examination. Petitioner also reported that since the initial section 12 examination, she had undergone a gastric bypass surgery and lost 100 pounds. She complained of persistent symptoms in the upper extremities, the right side slightly worse than the left, as well as occasional neck pain. Dr. Sudekum obtained updated electrodiagnostic studies, which showed mild bilateral carpal tunnel syndrome, worse on the right. Dr. Sudekum diagnosed mild bilateral carpal tunnel syndrome and possibly cubital tunnel syndrome or other pathologic process, such as bilateral Raynaud's syndrome (spastic vasculopathy affecting blood vessels) or cervical pathology. Dr. Sudekum opined that none of the conditions would be related to Petitioner's job activities, referencing research studies that do not support a causal relationship between clerical activities and the development or aggravation of carpal tunnel syndrome. Dr. Sudekum continued to attribute the carpal tunnel syndrome to nonwork-related risk factors. Dr. Sudekum thought surgical treatment might be appropriate, although not related to Petitioner's work for Respondent.

Dr. Sudekum testified consistently with his reports in his evidence depositions taken February 28, 2017 and September 12, 2017. Regarding the upper extremity injuries Petitioner sustained in the fall, Dr. Sudekum opined "she may have sustained mild contusions of her hands and her wrists," which resolved by the time of his initial examination.

At the time of the arbitration hearing, Petitioner was still working for Respondent in her regular job. Petitioner testified that she continued to suffer from symptoms in her hands and wrists. She noticed the symptoms more in her right hand because she used it more. Petitioner was ambivalent about having surgery, but wanted to resume treating with Dr. Davis.

Having carefully considered the record before us, the Commission gives greater weight to the opinions of Dr. Davis and finds that Petitioner proved, by a preponderance of the evidence, she sustained cumulative trauma to her hands and wrists from her job activities and her fall on October 30, 2013. The Commission therefore affirms the Arbitrator's award of medical expenses in the sum of $4,708.83, with any outstanding bills payable pursuant to the fee schedule, and prospective medical care recommended by Dr. Davis.

18IWCC0734

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

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

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

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

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

NOV 30 2018

DATED:
o-11/01/2018
SM/sk
44

Stephen Mathis

David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that any current conditions of ill-being were caused by her work activities and denied compensation.

Petitioner alleged two separate accidents. One a fall on October 10, 2013, in which she landed on her right hand, and one a repetitive traumatic accident which caused manifestation of a condition of bilateral carpal tunnel syndrome on November 22, 2013. On review, Respondent stipulates to the fall accident on October 10, 2013, but seeks review of the alleged repetitive traumatic accident as well as causation.

Petitioner testified her work involved general clerical activities, including data entry, handling of files, and taking telephone calls. Petitioner also testified that she mostly noticed symptoms in her hands while using her cell phone to play games and accessing Facebook, which

obviously are not work-related activities. Her orthopedic surgeon, Dr. Davis, testified by deposition that all he knew about Petitioner's work activities was that it involved writing and using a keyboard or mouse. He did not know the frequency of the various functions Petitioner performed. He also did not consider the coincidence between her symptoms and her nonwork-related activities on her cell phone. Nevertheless, he opined that her work activities were consistent with development of carpal tunnel syndrome. He also opined that her fall on the right hand could have aggravated a pre-existing condition of carpal tunnel syndrome.

On the other hand, Respondent's Section 12 medical examiner, Dr. Sudekum, reviewed a description of Petitioner's job activities and interviewed her extensively about those job activities. Based on his understanding of Petitioner's job activities, Dr. Sudekum concluded that her work activities did not amount to repetitive trauma and that her bilateral carpal tunnel syndrome was not causally related to those job activities. Dr. Sudekum also noted that while Petitioner's fall could have caused a contusion and/or sprain, it was not of a sufficiently severe nature to contribute to the development of carpal tunnel syndrome. He noted that any injury sustained in that fall had resolved at the time of his Section 12 medical examination. It is also noteworthy that Petitioner did not ascribe her carpal tunnel syndrome symptoms to her fall until two weeks after the fall occurred, putting in considerable doubt any connection between the fall and her carpal tunnel symptoms.

The Arbitrator, and through its affirmation the Commission, determined that the opinions of Dr. Davis were more persuasive than those of Dr. Sudekum. I disagree with that assessment. In my opinion, Dr. Sudekum had a much better and more detailed understanding of Petitioner's work activities than did Dr. Davis. In addition, I subscribe to the general theory that normal clerical activities such as the use of a keyboard, use of a mouse, and regular and substantial hand activities are not alone sufficient to contribute to the development of carpal tunnel syndrome.

Rather, in my opinion to contribute to carpal tunnel syndrome, the activities have to involve forceful repetitive activities, significant prolonged vibration, or prolonged unnatural extension or flexion of the hands/wrists. Petitioner has not proven any of these factors. In addition, Petitioner testified that she had symptoms of carpal tunnel syndrome prior to her fall and she did not relate her symptoms to her fall for a period of weeks. Therefore, I find persuasive Dr. Sudekum's opinion that the fall did not contribute to her carpal tunnel syndrome.

Based on the persuasive opinions of Dr. Sudekum, I would have found that Petitioner did not sustain her burden of proving a repetitive traumatic accident or a causal connection between her work activities and/or fall and her carpal tunnel syndrome, reversed the Decision of the Arbitrator, and denied compensation for that condition. For these reasons, I respectfully dissent.

Deborah L. Simpson

Deborah L. Simpson

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

GOINS, DENISE
Employee/Petitioner

Case# **14WC003846**

15WC007219

DVA/ANNA VETERANS' HOME
Employer/Respondent

18IWCC0734

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

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

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

3067 KIRKPARTICK LAW OFFICES PC
ERIC KIRKPATRICK
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BELLEVILLE, IL 62226

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

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

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

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

APR 2 - 2018

Ronald A. Piccin
RONALD A. PICCIN, ACTING Secretary
Illinois Workers' Compensation Commission

18IWCC0734

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Denise Goins
Employee/Petitioner

v.

DVA/Anna Veterans' Home
Employer/Respondent

Case # **14** WC **3846**

Consolidated cases: **15 WC 7219**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **2/15/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/30/13 & 11/22/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,565.79**; the average weekly wage was **$900.00**.

On the date of accident, Petitioner was **36** years of age, *married* with **1** dependent children.

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

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

Respondent is entitled to a credit if any medical bills were paid by group carrier under Section 8(j) of the Act.

ORDER

THIS ARBITRATOR FINDS PETITIONER HAS PROVEN AN ACCIDENT ON EACH CLAIM FOR THE REASONS DESCRIBED IN THE ATTACHMENT.

THIS ARBITRATOR FINDS PETITIONER HAS SUSTAINED HER BURDEN OF PROVING A CAUSAL RELATIONSHIP BETWEEN THE CARPAL TUNNEL SYNDROME AND THE ACCIDENTS. SPECIFICALLY THE ARBITRATOR FINDS THE UNDERLYING WORK ACTIVITIES TO BE AN UNDERLYING CAUSE OF THE CARPAL TUNNEL (15 WC 7219) WITH THE FALL OF OCTOBER 30,2013 (14 WC 3846) BEING AT LEAST AN AGGRAVATION OF THE PREEXISTING CONDITION OF THE RIGHT HAND AND AN AGGRAVATION OR DIRECT CAUSE OF SYMPTOMS IN THE LEFT HAND THAT NECESSITATED THE TREATMENT AS RECOMMENDED BY DR. DAVIS.

PETITIONER IS AWARDED PROSPECTIVE MEDICAL CARE AS SUGGESTED BY DR. DAVIS.

PETITIONER IS AWARDED MEDICAL EXPENSES IN THE AMOUNT OF $4,708.83. RESPONDENT IS ENTITLED TO A CREDIT FOR ANY AMOUNTS ALREADY PAID WITH ANY OUTSTANDING BILLS BEING PAID PURSUANT TO THE FEE SCHEDULE. RESPONDENT ENTITLED TO AN 8(J) CREDIT FOR ANY AMOUNTS PAID BY PETITIONER'S APPLICABLE GROUP INSURANCE CARRIER.

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

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

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

Signature of Arbitrator

3/26/18
Date

APR 2 - 2018

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

18IWCC0734

This case comes on Petition for Immediate Hearing

Petitioner filed two cases that were consolidated for hearing. Case number 14WC 3846 is for traumatic bilateral carpal tunnel. Case number 15WC 7219 alleges carpal tunnel due to repetitive trauma from work activities. It is Petitioner's position that the bilateral carpal tunnel is related to one or both in combination.

Petitioner agreed she had night time symptoms in her right hand before the fall but did not have symptoms in her left hand before the fall.

Facts of the Traumatic Accident:

Petitioner, age, 40, had worked for the Illinois Department of Veterans Affairs since 2003. She walked into the facility on a stormy and rainy day and slipped on the wet floor near the time clock. The time clock was in the hallway near the entrance used by staff or vendors. The entrance was not used by the general public.

Petitioner fell onto both outstretched hands and knees. She felt pain in her wrists up to her shoulders. She described that basically her entire body was sore from all of her weight landing as it did.

She testified she assumed the pain would ease up. She had bruises on her knees. A month later she still had pain in both knees, both wrists and shoulders. She described the pain was in the base of her hands.

She testified on direct that prior to the fall she had experienced pain and numbness in the right hand on occasion and she felt this had probably been related to her work activities. This is so stated in the medical record of Dr. Lucas who saw her after the accident. She testified her prior symptoms on the right had been some pain and numbness in the right hand at night. Her symptoms on the right worsened after the fall to the point she had pain and numbness "24/7."

She had no symptoms in the left hand before the fall. Since the fall she has had constant symptoms of numbness and tingling.

Petitioner's Job Duties:

Petitioner stated her job duties consisted of data entry, payroll and typing, 5 days per week for 37.5 hours. She also performed filing which consists of grasping/pinching files to pull them from filing cabinets. She physically grabs the files, some of which are harder to pull than others. She stated that on occasion she pulls and replaces up to 75 to 80 files per day.

She spends a great deal of time entering data into a computer. Her keyboard is right above her lap. Her elbow sets below her hands on the keyboard and mouse. Her wrists set on the edge of the desk as she uses the mouse. Her hands are extended backwards as she types. Petitioner demonstrated this to the Arbitrator.

Both hands and wrists have gotten worse since the fall. She has pain in both hands as well as numbness. In order to keep working, she stops and "shakes her hands out." She takes ibuprofen every day. Her symptoms are constant.

She testified she desires to have the treatment suggested by Dr. Davis, her treating orthopedic surgeon.

On cross-examination, Petitioner testified that she put "no injury" on the Tristar report of injury (RE3) because when that was filled out on 10/31/13, the day after the accident, she did not have any visual injuries. She said she considered herself "injured" when the pain didn't go away, and bruising developed on her knees.

She agreed she had been pregnant in 2006; that she had lost 112 pounds in a 2-year period and described she previously had been overweight her entire life.

When she was asked how the fall made her symptoms worse, she said that now she has symptoms on the right that are constant and before they were only at night. She stated again that she had no symptoms in the left hand or wrist until after the fall.

Melonie Reynolds, Petitioner's supervisor testified that only 60% of Petitioner's job is data entry and that the filing to the degree petitioner and described occasionally once per month.

Respondent disputes accident and causation and the need for surgical treatment. In order to avoid redundancy, medical will be described in the causation section of this proposed decision.

Medical evidence:

To avoid redundancy, the medical evidence will be discussed in the causation section of this decision.

Denise Goins v Illinois Veterans Affairs
DA: 10/30/13; 14WC 3846
DA: 11/22/13; 15WC 7219

ISSUES AND DECISION:

ACCIDENT:

Each accident will be discussed separately. This arbitrator finds Petitioner has proven accident on both claims, case number 14WC 3846 and 15WC 7219.

The traumatic accident is clear. Petitioner walked through a doorway used by employees and vendors. She fell on a wet hallway near the time clock. She landed on both hands and knees. There is no indication that this event did not happen. Petitioner's testimony is uncontradicted. Petitioner suffered an accident that arose out of and in the course of her employment. Respondents exhibit 1,2,3, and 4 outline statements consistent with Petitioner's testimony and the medical evidence contains the same history of the fall and how she landed; on her outstretched hands.

As for the work activities, this arbitrator finds those to also arise out of and in the course of her employment. They were the duties of her job. Respondents witness merely disputed the frequency and duration of the activities. The real nature of this issue on the work activities is of causation.

CAUSATION:

It is first necessary to consider the medical evidence.

Petitioner was first seen at the Union County Hospital on November 22, 2013 This note shows a history of complaints in her right and left wrists which she sustained at work. She described the "symptoms/episode began/occurred suddenly." She was given a prescription for ultram. (PE 1)

Petitioner was then seen at Rural Health, Inc.by Dr. Lucas on December 12, 2013. The history reflects she was walking on a tile floor that she did not realize was wet and fell landing on her knees and outstretched hands. The note reflects she began to have quite a bit of pain and went to the emergency department. Petitioner stated the pain got worse the first two weeks after the fall as her whole body just hurt. She had not missed any work due to the injury.

Petitioner was having constant aching pain in her palms, forearms, and into her elbows. The note describes it as a constant ache in both hands. She was sometimes unable to sleep on her left side due to pain in her arm. She stated that she sometimes played games on her cell phone and her hand would start to twitch if she held the phone for length of time and would have to switch hands.

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Dr. Lucas noted that Petitioner did a lot of data entry at her job especially around payroll time when she does 3-5 hours of entry and that tended to worsen the symptoms.

Petitioner described that her right hand would get numb and go to sleep prior to this injury and she felt that was likely related to her occupation and overuse type syndrome. That it had significantly worsened since her fall at work.

Petitioner complained of pain in her knees but that is not a part of this petition for immediate hearing.

Dr. Lucas noted full range of motion at the wrist with tenderness profusely about the wrist. Her diagnosis was bilateral forearm wrist and hand paresthesias and pain. Dr. Lucas requested an orthopedic evaluation.

Petitioner was seen by Dr. Mike Davis, an orthopedic surgeon for the first time on January 22, 2014. Again the history was a fall on to the floor and landing directly on both knees and both wrists. She had stated she treated it conservatively and had had progression in pain over the last several months. Her pain was a 5 in intensity and generally dull but sometimes burning. It ached if she used her hands too much. The numbness in her hands was more on the left than the right and some activities including writing or using the keyboard or mouse at work seem to exacerbate her right-hand symptoms. After examination his impression was bilateral carpal tunnel syndrome with no evidence of cubital tunnel syndrome, and right wrist de Quervain's tenosynovitis. He requested an EMG/nerve conduction and allowed her to continue to work.

The EMG findings on the test of February 20, 2014 indicated moderate right and left median neuropathy at the wrist ---"carpal tunnel syndrome."

February 26, 2014 Dr. Davis noted some improvement with anti-inflammatories and he referred her to occupational therapy and the use of splints at night. He indicated that if she failed conservative treatment surgical intervention may be necessary.

On April 10, 2014 Dr. Davis noted that petitioner had been wearing her braces at night and had completed therapy but she was doing about the same. He stated that in light of her persistent symptoms she elected with carpal tunnel release on the left.

The occupation therapy progress summary dated April 10, 2014 noted petitioner subjected complaints that her right elbow and hand pain would increase with work activities on the computer. Work that required her to hold her hands in one position such as driving or performing haircare would cause cramping in her thumbs and hands.

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Dr. Davis's deposition consisting of 37 pages was introduced as an exhibit. Dr. Davis testified that he reviewed Dr. Lucas's note of December 12, 2013 when he saw her for the first time on January 22, 2014. (Davis depo, p. 6) Dr. Davis testified that his diagnosis on that first visit was carpal tunnel syndrome in both hands as well as tendonitis of the wrist on the right. (Davis depo, p. 9)

His recommendations based on the persistence and duration of her symptoms was to proceed with carpal tunnel release on her more symptomatic LEFT HAND. His prognosis without surgery was that she would continue to be symptomatic with non-surgical treatment and with a small potential for improvement. Her prognosis after recovering from surgery was good.

With regard to her RIGHT HAND and wrist he felt that there was still the possibility for the right side to improve with non-surgical management. The left was more pressing.

On the issue of causation of the carpal tunnel and its relationship to the fall at work he did not think that it was the sole cause. He did not have electro diagnostic studies to confirm before and after the fall, but his medical opinion was that there was likely some symptom of carpal tunnel before her fall. He believed that the fall could have aggravated the underlining condition such that it necessitated the surgery that he was describing on her left side. (Davis depo, p. 14-15)

Dr. Davis was handed what he had previously reviewed, that in Dr. Lucas's medical of December 12, 2013 and asked if he it was the type of report relied on by physicians such as his self and the treatment of patients and he responded that it was. This note played a role in his formation of diagnosis and treatment. He agreed that the report indicated she did not have any left side problems prior to the fall. (Davis depo, p.16-17) Dr. Davis was then asked based on Dr. Lucas's report indicating symptoms in the right prior to the fall, whether the fall played a role in the aggravation of any pre-existing carpal tunnel syndrome on the right side he responded yes, as an aggravation of a pre-existing condition. (Davis depo, p. 18)

Dr. Davis was then asked to take into account the work activities that were described in Dr. Lucas's report of December 12, 2013 and was asked whether based from a reasonable medical certainty those work activities as described could have caused the underlying carpal syndrome. His response was that the work activities were consistent with the development of carpal tunnel syndrome on both the right and the left.

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Respondent had petitioner evaluated three times, once by Dr. Petkovich and twice by Dr. Sudekum. Dr. Sudekum issued multiple reports.

Dr. Petkovich examined petitioner on December 12, 2014 but only for her knees which is not at issue at this time.

A very close look is taken at the evidence and testimony of Dr. Sudekum. Dr. Sudekum evaluated petitioner on November 4, 2014 and June 15, 2017. Each of his reports is 19 pages long and he had addendums to each. Dr. Sudekum evaluated petitioner one time for purposes of determining the causal relationship to the work activities and the carpal tunnel, and the second time to determine the causal relationship between the fall and the carpal tunnel.

Though Dr. Sudekum testified that his reports were not exact, the same is written in each report about the same medical evidence and information solicited from Petitioner. The paragraphs are simply put in different order. The only real exception to each report is that each denies causation for a different reason.

While repetition is not in and of itself is not unusual, in this particular case it brings Dr. Sudekum's credibility into question because of the nature of his incredible charges.

The following was brought out on cross-examination of Dr. Sudekum:

1.) The charge to the State of Illinois for the report of 2014 was $5,000.00;
2.) The charge to the State of Illinois for his report of 2017 was $5,000.00;
3.) His charge for the first the nerve conduction study he did was $1,330.00;
4.) His charge for the second nerve conduction study in 2017 was $1,548.00;
5.) He charged $2,000.00 for the deposition he did in 2014;
6.) He charged $2,000.00 for the deposition he gave again in September 2017;
7.) Dr. Sudekum sees 5 or 6 people per month for medical legal purposes and probably 2 of those are for the State of Illinois.
(RE 10, p. 20-23, 25)

The above totals $17,548.00.

This arbitrator notes nothing was asked about the charges for the two addendums.

Dr. Sudekum testified that this case took him 20 hours of work. (RE 10, p. 23)

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While he claimed he reviewed additional records the second time, those were records from 1999 to 2005 those no additional records were set forth in the second report.

When asked what the charge to be for a one-sided carpal tunnel surgery, incredibly, the doctor testified that his charge would be $3,200.00. (RE 10, p. 24) The average for what he gets paid for a carpal tunnel surgery is $2,500.00 at least. (RE 10, p. 30)

Inquiry was then made of his income from surgery:

1.) He performs an average of carpal tunnel surgeries per week. (RE 10 p31) ($2,500.00 each = $5,000.00).
2.) Taking it a step further, he testified that he does an average of 4 or 5 surgeries per week that range in price from "a couple hundred bucks to several thousand dollars, maybe $10,000.00 being on the high end." (RE 10, p.31)

Assuming then, that Dr. Sudekum does one of the remaining "4 or 5" surgeries at $10,000, and another and does another at $5,000.00, and another at $200.00, the math for surgical income for a week comes to $20,200.00 for five surgeries. ($2,500.00 + $2,500.00 + $10,000.00 + $5,000.00 + $200.00 = $20,200.00)

The comparison is that for a claimed 20 hours medical-legal work for Denise Goins, he made $17,548.00 without taking into account the two addendums, within $3,000.00 of what he makes for 5 surgeries.

In addition to the above, Dr. Sudekum's credibility on the numbers he testified to is suspect. In reviewing his *first deposition* taken on February 28, 2017 in case number 14WC3846 the doctor testified on direct examination that he charges "$2,000.00 the first hour of deposition and then an additional $2,000.00 an hour after that." (2/28/17 Sudekum depo, p. 6)

He testified in September 2017 that he charged $2,000.00 for first deposition. If his testimony in the first deposition is to be believed, he actually charged $4,000.00 for the first deposition. The court reporter stated on page 3 of the 2/28/17 deposition that it started at 3:06 pm and finished at 4:53 – almost two hours.

Dr. Sudekum opined the carpal tunnel was not caused by the administrative duties or the fall at work. Though two depositions were taken, the testimony solicited was essentially the same.

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On page 40 of his deposition he was asked "if this injury was not caused by an acute trauma, is there any additional testing for things of that nature that you would have done for Ms. Goins that you did not do?" The answer was "no."

It is then interesting that when he saw her the second time he chose to perform yet another nerve conduction study at a charge of over $1,500.00 as stated above.

During cross examination he testified that 80% of the folks that he sees for medical legal purposes are at the request of the employers or insurance companies or their lawyers.

He also agreed on cross examination that there were no records he reviewed from 1999 to indicate that there were any symptoms noted regarding either of her hands until the note of December 12, 2013 which gave a history of some prior issues on the right side.

As will be explained below, this Arbitrator finds in Petitioner's favor with regard to causation for the bilateral carpal tunnel syndrome as follows:

Left carpal tunnel syndrome;

This Arbitrator finds that the condition of Petitioner's left hand to be related to the traumatic accident of October 30, 2013. (14WC3846) It is significant that prior to the fall, Petitioner had no complaints or symptoms with regard to her left hand. There were no medical records to suggest that Petitioner had any symptoms in her left hand prior to the fall. Dr. Davis testified that there was a causal relationship. He testified that he did not have a nerve conduction study prior to the fall but opined that if there were such preexisting findings they were aggravated by the fall and the recommendation for the surgery was necessitated by the fall.

Right carpal tunnel syndrome;

This Arbitrator finds that the condition of Petitioner's right hand is related to both the repetitive aspects of her work activities and the fall suffered at work. Petitioner testified, and it is uncontradicted that before her fall she had symptoms of pain and numbness in her right hand on occasion but only at night time. She testified that after the fall her symptoms became progressively worse. Her symptoms became constant and progressively painful.

Dr. Davis opined that the Petitioner's work activities might or could have caused the symptoms of carpal tunnel in her right hand. He also testified that the symptoms failed to respond to physical therapy and that the fall at work aggravated her condition.

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PROSPECTIVE MEDICAL CARE:

Dr. Davis suggested surgery on the left hand. This was the worse of the two hands. His prognosis without surgery was that with conservative treatment and physical therapy having failed, she would not see relief over time. He believed that with surgery her prognosis was good.

Petitioner testified that her condition in the left hand has progressively worsened. She testified that she desires to have the treatment suggested by Dr. Davis.

MEDICAL BILLS:

It is first noted that Dr. Sudekum testified the treatment that Petitioner had received prior to his first examination of her in 2014 was reasonable.

Petitioner submitted medical bills totaling $4,708.83 of which $641.00 remained outstanding. In light of the findings on causation and accident, this arbitrator awards the same to be paid in accordance with the fee schedule. Respondent is entitled to an 8j credit for any bills paid by Petitioner's group carrier.

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

Bessie Joy Kaufhold,

Petitioner,

vs. NO: 13WC022871

Grand & Ashland Tap Inc. d/b/a
Grandbar and the Illinois State Treasurer as ex-officio
Custodian of the Injured Workers'
Benefit Fund,

18IWCC0735

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issue(s) of causal connection, benefit rates, wage calculations, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 30, 2018 is hereby affirmed and adopted.

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

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

18IWCC0735

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

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: NOV 30 2018
SJM/sj
o-11/15/2018
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAUFHOLD, BESSIE JOY
Employee/Petitioner

Case# **13WC022871**

GRAND & ASHLAND TAP INC D/B/A GRANDBAR AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0735

On 5/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bessie Joy Kaufhold
Employee/Petitioner

v.

Grand & Ashland Tap, Inc. d/b/a Grandbar and the Illinois State Treasurer as custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **13WC22871**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the City of **Chicago**, County of **Cook**, on **October 2, 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: **Notice of trial for Respondent Employer and Proof of Insurance**

FINDINGS

On **March 16, 2013**, Respondent-Employer ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's average weekly wage was **$1,212.96.**

On the date of accident, Petitioner was **41** years of age, married with 0 dependent child.

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

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

Respondent-Employer is not awarded any credit for TTD, TPD, maintenance, or for other benefits.

Respondent-Employer is not entitled to a credit under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent-Employer shall pay Petitioner temporary total disability benefits of **$808.64**/week for **23** weeks, commencing March 17, 2013 through August 24, 2013, as provided in Section 8(b) of the Act.

Medical benefits
Respondent-Employer shall pay the medical bills for the reasonable and necessary medical services, which total **$30,734.25**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Permanent Partial Disability with 8.1b language (For injuries after 9/1/11)

Respondent-Employer shall pay Petitioner **$712.55**/week for **175** weeks as Petitioner sustained permanent partial disability to the extent of **35%** loss of use of a person as a whole, pursuant to §8(d)2 of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This finding is hereby entered as to the Fund to the extent permitted and allowed under §4(d) of the Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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

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

Signature of Arbitrator

5/30/18
Date

MAY 30 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTACHMENT TO ARBITRATION DECISION

Bessie Joy Kaufhold
Employee/Petitioner

18IWCC0735

v.

Case No. 13 WC 22871

Grand & Ashland Tap, Inc. d/b/a Grandbar
and the Illinois State Treasurer as Ex-Officio
Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

I. FINDINGS OF FACT

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by the Petitioner-Employee, Bessie Joy Kaufhold, ("Petitioner") and sought relief from the Respondent-Employer, Grand & Ashland Tap, Inc., ("Grandbar") and the Illinois State Treasurer as custodian of the State of Illinois, Injured Workers' Benefit Fund, ("IWBF").

On October 2, 2017, a trial was held and proofs were closed before Arbitrator Brian T. Cronin in Chicago, Illinois. Attorney Jose Rivero represented the Petitioner. The Illinois Attorney General's office represented the IWBF. Respondent-Employer was not present; however, they were represented by counsel, Scott Barber, who only made a brief statement and did not present a defense. Petitioner entered into evidence a certification from the National Council on Compensation Insurance showing that Respondent-Employer was not insured at the time of the injury. [Px.19].

A. **Summary of Petitioner's Testimony at Trial**

On March 16, 2013, Petitioner was 41 years old, married with no dependent children. [Ax.1]. Petitioner was married at the time of the incident; however, her divorce had not yet been finalized. Transcript of Proceedings (hereinafter "T.") 82. Petitioner's highest level of completed education is 12th Grade; however, Petitioner took additional courses at Elgin Community College in electronics, although she never received an associate's degree. [Px.16 and T. 63]. Petitioner did have CDL training at Star Truck Driving School, apprenticeship as a journeyman lineman through Electricians Local 9, and training/licensure as a mortgage broker, although that licensure has lapsed. [T. 63].

Grandbar is owned by Betty Stokes, Petitioner's aunt, and managed by Gene Stokes, Petitioner's cousin. [T. 45]. Grandbar had approximately seven plus employees working the night of the accident and served alcoholic beverages to the public. [T. 56].

Petitioner worked for Grandbar as a cocktail waitress, but was unsure when she had started working there. [T. 55-56]. Petitioner found out about the job through her family and never signed an employment contract. [T. 54]. While working at Grandbar, Gene Stoke acted as Petitioner's boss and would discipline her with regard to getting there early, requesting time off, and moving faster. [T. 12-13]. Petitioner worked from 9:00 p.m. to 4:00 a.m. on Fridays, and from 9:00 p.m. to 5:00 a.m. on Saturdays. [T. 9]. While Petitioner stated she was paid in cash at the end of every night, she could not recall how much her pay rate was, even when presented with her tax returns. [T. 10-12]. Moreover, Petitioner never received a W-2 from Grandbar. [T. 60]. Petitioner identified, as Petitioner's Exhibits 25 and 26, her tax returns for the years 2012 and 2013. [T. 11]. Additionally, Petitioner testified that Grandbar served alcohol, and had sharp

cutting tools and refrigerators. [T. 13]. Petitioner never received any training by Grandbar. [T. 58].

On March 16, 2013, at approximately 3:00 a.m., while Petitioner was working as a cocktail waitress, she approached two customers, a husband and a wife, the latter identified as Vanessa Suarez. [T. 16]. Petitioner asked if they wanted a shot to go with their drinks as the bar would be closing soon. *Id.* They declined, so Petitioner moved past these two customers to the bar where she attempted to get the attention of the bartender, Zita. *Id.* At that time, Vanessa Suarez took a pint glass, broke it on Petitioner's head, and ran it down Petitioner's nose, cheek, and neck. [T. 19]. Initially, Petitioner did not feel pain, but instant wetness. [T. 18]. Petitioner asked the bartender the following: "did this f---ing bitch just throw a drink on me?" *Id.* [Letters deleted.] The bartender responded that Petitioner was bleeding. Petitioner touched her face and saw that there was blood everywhere. [T. 18-19]. Petitioner offered into evidence photographs of Petitioner's face as Exhibit 17. [T. 20]. Petitioner testified that she felt light-headed and fell to the floor. [T. 22].

After Petitioner had been injured, the bartender's husband's friend, a chef, pressed a dirty bar towel to Petitioner's face to stop the bleeding. [T. 23]. After using the restroom with the assistance of others and having a cigarette, Petitioner got into the ambulance with the help of the paramedics. [T. 26-28]. When the paramedic removed the towel, Petitioner felt pain in the left side of her head, temple, and face. [T. 28]. Gene Stokes got in the ambulance and briefly spoke with Petitioner. *Id.* Petitioner asked Gene if he was coming with her. *Id.* Gene responded that he was not, but that he loved her. *Id.*

Petitioner did not return to work for Respondent-Employer after this injury.

B. **Summary of Petitioner's Medical Treatment Based Upon Petitioner's Testimony and Medical Records**

Petitioner was taken to Northwestern Memorial HealthCare on March 16, 2013. [Px.5]. Petitioner was treated for a 4-cm. laceration across her left cheek that was deep. Petitioner had an additional 1-cm. deep laceration above her left eyebrow and a third laceration that was thin, shallow 1.5-cm. and across bridge of Petitioner's nose. Petitioner complained of a headache and had CT scans of her face and brain taken. [Px.5].

The CT scan of Petitioner's face revealed, in pertinent part, that she did not have an acute facial fracture, but rather a large vertical laceration involving the soft tissues overlying the left check extending inferolaterally to the level of the mid left lower mandible, as well as a smaller vertical laceration more posteriorly in the soft tissues overlying the left lateral face, and lastly, a small amount of air overlying the anterior left aspect of the maxillary alveolus that may reflect an additional lactation. [Px.5].

The CT scan of the Petitioner's brain showed no acute intracranial hemorrhage and mild swelling in the extracranial soft tissues overlying the left supraorbital region. Petitioner was discharged later that day. The records of Northwestern Memorial Hospital also indicate that Petitioner had been previously treated for anxiety. [Px.5].

Petitioner was treated at Northwestern Maxillofacial Surgeons, P.C. for her lacerations. [Px.7]. There, Petitioner's lacerations were cleaned and stitched up. On March 22, 2013, Petitioner's sutures were removed and Petitioner returned to Northwestern Maxillofacial Surgeons, P.C. for follow-up visits. Petitioner was told to see her primary care physician/neurologist regarding head trauma and to wait five months before undergoing scar revision surgery. [Px.7].

On April 8, 2013, Petitioner saw her primary care physician Gloria F. Millare, M.D. [Px.8]. Petitioner complained of pain in her face, blinding headaches, tingling and numbness in her left lower jaw, problems with concentration and memory, nightmares, and crying spells. After examining Petitioner, Dr. Millare diagnosed with multiple deep lacerations, head injury with persistent headaches, and post-traumatic stress disorder. Dr. Millare advised Petitioner to take off from work for approximately two months while undergoing treatment and to follow up with plastic surgeon. [Px.8].

On April 25, 2013, Anthony Geroulis, M.D, a plastic surgeon from North Shore Center for Cosmetic Surgery, examined Petitioner and found that her scar appeared to be smooth and level, but that in other areas, the scar appeared to be irregular and not level. [Px10]. He opined that a future scar revision would have to be evaluated further down the line since it takes a good year for a scar to mature. [Px10].

Post-accident, Petitioner saw Karen Lake, LCSW, of Associates in Psychiatry & Coun., on April 18, 2013. [Px1]. Pre-accident, and since 2003, Petitioner had been seeing Karen Lake, LCSW, for therapy for anxiety, depression, and sleep problems. [Px.1, Px.13]. In fact, Petitioner stated she was depressed prior to the accident due to a number of factors. [T. 73-74]. However, Petitioner testified she could not recall how long she had going to therapy prior to the accident or how frequently she had been receiving such therapy. [T. 72-73].

After the accident, Petitioner made numerous complaints to Karen Lake, LCSW including, significant headaches, bad dreams, anxiety, stress, exhaustion, and low self-esteem. [Px.2, Px.3, Px.4]. Petitioner stated that she was also having difficult time concentrating, recalling certain memories, and recalling words. [Px.2, Px.3, Px.4].

Petitioner also began treating with Bindu Gandhiraj, M.D., a psychiatrist, prior to this accident as well. [T. 73]. Petitioner testified that prior to the accident, she saw Dr. Gandhiraj "usually quarterly or twice a year." Id. However, she could not recall when she started seeing Dr. Gandhiraj, but did recall that it was for her condition following the deaths of loved ones and a divorce. [T. 73-74]. While not all of Petitioner's records from past psychiatric treatment were provided, the records due indicate that Dr. Gandhiraj saw Petitioner prior to the accident on January 26, 2013 and February 8, 2013.

On January 26, 2013, Dr. Gandhiraj listed her problems as Major Depressive Affective Disorder, Recurrent Episode Moderate Degree, and Anxiety State, Unspecified. [Px1]. Dr. Gandhiraj also prescribed Klonopin, Lexapro, and Wellbutrin. [Px.1]

On February 8, 2013, which was five weeks before the accident, Dr. Gandhiraj wrote, in the Client Report section of the Clinician Progress Note, the following:

> "Client is a 41 year old female. Client was seen at the office for individual therapy. Client reports feeling anxious, some low mood. Feeling overwhelmed. Client reports that she often "feels like crying." She reports feeling lonely. She is not sleeping well and is waking up frequently. Client reports that she has been having some medical issues lately. She reports that she has been having severe financial issues. She reports that her house has been ordered into foreclosure. She also reports that her divorce is still pending. Plus, now she has to find a new attorney because her current attorney is no longer working her case. Client reports that she still wishes husband did not want a divorce. Client reports that relationship with daughter is showing some improvements. Daughter is being more pleasant while talking with client. Client reports that overall her job is good and she is happy to have a job. However, she reports that there are a lot of work stressors." [Px.1]

After the accident, Petitioner continued to see Dr. Gandhiraj and made new complaints of recurrent nightmares and crying spells; however, Dr. Gandhiraj's course of treatment largely stayed the course; he continued to prescribe similar medication for Petitioner. [Px.2, Px.3, Px.4]. Petitioner also testified that she continues to see Dr. Gandhiraj today and is in the process of setting up another appointment. [T. 80].

On May 3, 2013 and June 3, 2013, Petitioner saw Todd Gephart, M.D., at Northwest Health Care Associates - East Dundee. [Px.11]. Petitioner complained of headaches, disorientation, memory lapses, visual changes, and numbness of the face, and fatigue. A CT scan of Petitioner's brain was negative for intracranial bleed. Petitioner was told to follow up for a neuropsychological evaluation. Dr. Gephart referred Petitioner to Alan G. Shephard, M.D., who examined her and referred her to Beth Borosh, Ph.D. [Px.11].

On September 18 and 19, 2013, Petitioner underwent an evaluation at Northwestern Memorial HealthCare. [Px.6]. D. Mark Courtney, M.D., and Kory Gebhardt, M.D., examined Petitioner's head. The MRI of the brain was found to be unremarkable. Petitioner complained of continued intermittent headaches, difficulty with concentration and focus, work finding difficulties, memory difficulty, sleep disruptions, and increased daytime tiredness. Dr. Courtney, the attending physician, offered the following impression:

> "not totally clear if this is true post concussive syndrome. based on near constant every day HA and duration this seems unlikely. may be some component of post traumatic syndrome of somatic manifestation of anxiety/depression." [Px.6].

On October 15, 2013, Beth Borosh, Ph.D., of Neuropsychology Assessment and Wellness, LLC, conducted a neuropsychological evaluation of Petitioner. [Px.13]. After taking a

history that indicated Petitioner had been seeing a therapist since 2003, and administering various tests, Dr. Borosh found that Petitioner had mild to moderate processing speed impairment and mild naming impairment, and relative weakness in sustained attention, working memory, verbal reasoning, and mental flexibility. [Px.13]. While Dr. Borosh determined Petitioner's profile demonstrates depression, "there is an indication of an element of exaggeration of complaints or a 'cry for help.'" She opined that her clinical profile reveals marked elevations across several scales that suggest the presence of significant distress likely associated with a traumatic event. Ultimately, Dr. Borosh found that Petitioner suffered mild to moderate frontal networks dysfunction and a mild nonspecific naming impairment for which the "differential for this type of profile is quite broad; however, Petitioner's profile likely reflects both post concussive syndrome and psychiatric etiologies." [Px.13].

On June 5, 2014, Petitioner underwent Active FX/Deep FX/ CO2 Resurfacing Surgery for her facial disfiguration. [Px.12].

On November 21, 2014 and December 1, 2014, at the request of Petitioner's counsel, Petitioner presented to Kathy Borchardt, Psy.D., for an independent neuropsychological evaluation. [Px.15]. At that time, Petitioner complained of residual cognitive impairments from her head injury, including word-retrieval deficits, difficulty with sustained concentration, short-term/working memory impairments, and gaps in her autobiographical memory. [Px.15]. After taking a work history and noting that Petitioner had returned to work a month earlier, Dr. Borchardt administered a series of tests to Petitioner. Dr. Borchardt stated the results should be interpreted with caution since there is "significant variability." Dr. Borchardt opined that Petitioner's FSIQ of 80 was an underrepresentation of her true abilities since Petitioner reported that she was an A-B student in college, earned credits toward a college degree, and held a

mortgage broker's license. Dr. Borchardt then wrote: "It is highly probable that her apparent cognitive processing deficits and word-retrieval impairments likely resulted from her traumatic brain injury and depressed her FSIQ score during this neuropsychological evaluation." Dr. Borchardt determined that Petitioner had mild cognitive deficits and was likely to need work-related accommodations upon a return to work. Additionally, Petitioner needed supportive psychotherapy to assist Petitioner with her PTSD and anxiety. Lastly, Petitioner should consider speech therapy to address her significant word-retrieval deficits. [Px.15].

On April 16, 2015, James F. Boyd, M.S., C.R.C., conducted a vocational evaluation of Petitioner. [Px.16]. Petitioner told Mr. Boyd that she periodically worked at a friend's window and door company. At that time, Petitioner's job consisted of replying to emails and scheduling appointments. He wrote that she never worked more than four to six hours. Mr. Boyd found that Petitioner would have difficulty maintaining any level or type of competitive employment at that time. Mr. Boyd stated that vocational test results indicated relative strength in reading comprehension, math computation, auditory comprehension, and keyboarding. However, Mr. Boyd stated that Petitioner's below average visual-motor speed, excessive error rates, inconsistent attention to detail and poor visual problem solving are not compatible with the requirements of any full or part-time jobs in the competitive labor market. [Px.16].

Petitioner testified that because of the incident she has a difficult time sleeping and is continually stressed and anxious. [T. 36]. Petitioner also states that she gets blinding headaches. [T. 43].

Petitioner testified that she was off of work until May 10, 2016. [T. 34]. At that time, Petitioner began working for McHenry County Glass and Mirror. [T.35].

At trial, Arbitrator Cronin viewed Petitioner's scars from approximately six feet away and described the longer scar as a three to four-inch scar running from Petitioner's left eye to jaw and narrowing. [T. 39, 41]. The Arbitrator also observed Petitioner's scars on both her clavicle and nose. [T. 41]. In addition, Petitioner offered into evidence photographs her injuries. [Px.17A, Px.17B].

Petitioner testified that due to the nerve damage from her accidental injury, she experiences pain on the left and right sides of her face. [T. 43] The scars still itch and she has massive, blinding headaches, for which she takes Tylenol turns the lights down low. [T. 43]

II. CONCLUSIONS OF LAW

With respect to issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator finds as follows:

The Arbitrator finds that the Respondent was operating under and subject to the Illinois Workers' Compensation Act as Petitioner's testified that Respondent used sharp cutting tools (820 ILCS 305/3(8)), sold alcoholic beverages for the public for consumption on its premises (820 ILCS 305/3(12)), and operated equipment powered by electricity (820 ILCS 305/3(15). (T. 13).

With respect to issue (B), was there and employer and employee relationship, the Arbitrator finds as follows:

Petitioner testified that Respondent's owners, Betty and Gene Stokes, hired her. (T. 9). Gene paid her at the end of each night and had the capacity to discipline her for arriving late and not working fast enough. (T. 10, 13). Petitioner's testimony is unrebutted. Accordingly, the Arbitrator finds that Respondent controlled Petitioner's work to the degree that an employer and employee relationship existed.

With respect to issue (C) and (D) whether an accident occurred that arose out of her employment with the Respondent and what is the date of accident, the Arbitrator finds as follows:

Petitioner testified that she suffered injuries to her head and face on March 16 ,2013 when she was attacked with a glass by a patron of the Respondent's bar while she was attempting to place a drink order with the bartender. (T. 15-21). The Arbitrator finds that Petitioner's testimony is corroborated by the treating records and consequently finds that on March 16, 2013, Petitioner sustained an accident that arose out of and in the course of her employment by Respondent.

With respect to issue (E), whether timely notice was provided to the Respondent, the Arbitrator finds as follows:

Petitioner testified that Gene Stokes entered the ambulance with her when she was being transported from the scene of the accident to the hospital. (T. 28-29). Furthermore, Petitioner read into the record a text message sent to her by Betty Stokes wherein Respondent admitted to having been informed of the incident by "Hector" the day after the accident. (T. 50). Accordingly, the Arbitrator finds that timely notice was provided to Respondent of the accident sustained by Petitioner.

With respect to issue (F), is Petitioner's condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner offered photographs of the lacerations to her head, face and neck shortly after the accident. [Px.17A]. Petitioner also offered more recent photographs of the lacerations to her head and face. [Px.17B]. The Arbitrator find that the injuries to Petitioner's head, face and neck that he observed at trial are consistent with the photographs displayed in Px.17B.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Ficek,

Petitioner,

vs.
Home Depot,

NO: 13WC 29548

Respondent.

18IWCC0736

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issue(s) of causal connection, temporary disability, permanent disability, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2018 is hereby affirmed and adopted.

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

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

18IWCC0736

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,200.00. 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.

NOV 30 2018

DATED:
SJM/sj
o-11/15/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FICEK, JOSEPH
Employee/Petitioner

Case# **13WC029548**

18IWCC0736

HOME DEPOT
Employer/Respondent

On 3/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

1747 SEIDMAN MARGULIA & FAIRMAN
NIKITAS FUDUKOS
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

4136 ADELSON TESTAN & BRUNDO
MARCY E BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

18IWCC0736

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

Joseph Ficek,
Employee/Petitioner

v.

Home Depot,
Employer/Respondent

Case # **13** WC **29548**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **January 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 8, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,218.76**; the average weekly wage was **$581.13**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to prove a causal connection exists between his current condition of ill-being and the accident (except as noted below) no medical benefits or TTD benefits are awarded.

Respondent shall pay Petitioner compensation of $310.88/week for 10 weeks, because the injuries sustained caused serious and permanent disfigurement of the left arm and left foot, as provided in Section 8(c) of the Act. These are the specific injuries to which causation is found and for which compensation is payable.

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

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

Robert M. Harris

Robert M. Harris, Arbitrator

March 8, 2018
Date

MAR 8 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION OF ARBITRATOR

Joseph Ficek,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 13WC29548
	)	
Home Depot,	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

Petitioner Joseph Ficek testified he currently works for Respondent Home Depot and has been working there since approximately 2012. Petitioner testified he was working at the Home Depot on February 8, 2013, at which point his job title was "Pro Account Salesperson." Petitioner's job duties include working with contractors and builders determining materials needed for projects. On occasion, he goes out on the sales floor. (Tx 12-14)

Petitioner testified that on February 8, 2013 he was injured at work. Petitioner was on the sales floor helping a customer and checking stock when he got up on a ladder. While attempting to walk down from the ladder Petitioner turned and his foot hit the side of the ladder and he fell down three steps of the ladder. Petitioner testified he was approximate 3 ½ to 4 feet off the ground when he tripped on the ladder scraping his left arm and left foot. (Tx 14-19)

Petitioner testified that he drafted an accident report. (PX 14/Tx 19-20).

Petitioner testified that he sought medical treatment for his ankle anywhere from 3 to 6 weeks after his alleged fall. Upon clarification, the petitioner testified that March 25, 2013 was the first time he sought medical treatment. The petitioner was seen at Stroger Hospital on March 25, 2013. Petitioner testified that his arm and wrist area had healed without problem prior to his first visit. Petitioner testified that his foot began to become "ulcerated," and the skin was breaking and opening up, which made him worry there may have been an infection. Petitioner testified the "ulcer" was getting larger so he went to the doctor. (Tx 21-24)

Cook County Health/Stroger Hospital medical records show the petitioner was seen on March 25, 2013. (PX 1). The medical record indicates Petitioner had a history of deep vein thrombosis with pulmonary embolism in February 2007, deep vein thrombosis 1992 after trauma. At the time of his first visit on March 25, 2013, Petitioner complained of left leg redness and pain.

The medical record indicates on examination, sharp areas of erythema on the left leg with mildly increasing local temps. Petitioner was diagnosed with possible cellulitis eczema with superimposed cellulitis. Petitioner was prescribed ointment and told to follow-up in one week. **The medical record does not indicate any open wound, laceration, or ulceration on Petitioner's left ankle. Medical record further does not indicate any trauma or fall Petitioenr suffered. (PX 1, pg. 453).**

Petitioner testified he suffered from deep vein thrombosis in his left leg prior to the date of injury. As a result, Petitioner was taking Coumadin at the time of injury. Medical records further indicate Petitioner will be a lifelong Coumadin recipient due to a history of deep vein thrombosis. (PX 1, pg. 440).

Petitioner testified he followed up at Stroger Hospital on April 1, 2013 and saw a dermatology specialist on the same day. Medical records indicate Petitioner had an ulcer on the left lateral lower extremity. **This is the first notation of ulceration on the ankle.** There is no mention of cause of ulceration or trauma. (PX 1, pg. 431,440).

Petitioner testified he followed up with a vascular surgeon on April 19, 2013. Medical records demonstrate the petitioner was seen at Stroger Hospital again and was again noted to have a small superficial ulceration on the left lateral malleus. At this point, Petitioner was diagnosed with venous insufficiency and a small venous ulceration, healing. **There is no mention in the medical record of injury or trauma to petitioner's left ankle.** (PX 1, pg. 423).

Petitioner testified he continued to receive wound care at Stroger Hospital through September 10 of 2013. Petitioner was seen at Stroger Hospital on the following dates: May 7, 2013 (PX 1, pg. 402), May 14, 2013 (PX 1, pg. 389), June 3, 2013 (PX 1), July 9, 2013 (PX 1, pg. 349).

Petitioner was seen in Stroger Hospital on July 26, 2013. **This is a first medical record where Petitioner claims he fell at work.** In this record, Petitioner indicates he fell at work in March 2013. (PX 1, pg. 339).

Petitioner was seen at Stroger Hospital on August 27, 2013. At that time he indicated he fell from a ladder in February 2013. It was noted Petitioner had a healed ulceration of the left ankle. Petitioner was given a strap for compression and medication and told to follow up in two weeks. The records note Petitioner requested time off for work, however the doctor indicated it would be inappropriate as there was no clear endpoint with venous stasis disease and it would take time to resolve. The doctor indicated the patient was offered a note for light duty work at which point he became agitated and vocally upset. He (Petitioner) refused a light duty note and stated that he'd follow up with his primary care for continued application for Worker's Compensation. (PX 1, pg. 321-322).

Petitioner testified he saw Dr. Ali at Chicago Heart Association on September 9, 2013. During this visit, Petitioner told the physician he sustained an injury at work about a week prior. There was no noted edema in the extremities. The doctor noted chronic venous stasis changes seen in the left ankle. There was no ulceration or inflammation of the skin noted and no edema of

the ankle joint. The doctor noted full range of motion of the left ankle. Patient was diagnosed with: chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity, hemorrhagic disorder due to intrinsic circulating anticoagulants antibodies inhibitors, and venous peripheral insufficiency. The doctor noted the ankle pain was most probably chronic neuropathic pain and advised the petitioner to continue anticoagulation. The doctor noted chronic venous insufficiency was due to chronic DVT. The doctor recommended compression stockings and follow up with his primary care physician. (PX 2).

Petitioner testified he followed up with Dr. Ahmed on September 21, 2013. Petitioner's Exhibit 3 shows Petitioner saw Dr. Ahmed on September 21, 2013 at which time he indicated he needed a primary care doctor. At this time, Petitioner indicated he could not bear weight on the left foot. (PX 3, pg 007). Handwritten notes from Dr. Ahmed are mostly illegible.

On September 22, 2013, Petitioner was admitted to St. Mary of Nazareth Hospital. Medical records indicate the petitioner had history of DVT approximately 18 years ago after an incident and a repeat DVT in 2007 at which time he was noted to have pulmonary embolism. The left lower extremity was noted to have blue/purple discoloration and some skin thickening centrally which extends towards posterior leg. Minimal swelling was noted in the left ankle. It was noted the skin was intact and there were no open wounds. (PX 10).

Petitioner was seen by Dr. Vais on September 24, 2013 at St. Mary of Nazareth Hospital. The MRI was reviewed and showed increased T2 signal in the bone marrow of the fifth metatarsal. It was noted there is mild erythema and induration of the extremities. Petitioner was diagnosed with left ankle cellulitis on a background of chronic stasis dermatitis. Possible osteomyelitis of the left fifth metatarsal, which is somewhat unusual given the fact that his pain is mostly on the lateral malleus, and chronic venous insufficiency with a history of an ulcer healed about a month ago. (PX 7, pg. 30).

On September 27, 2013 Petitioner was again seen by Dr. Ahmed. It was noted that the ulcer of the left ankle had resolved. Petitioner's discharge diagnosis was contact dermatitis and painful left ankle. Petitioner had received consult by an infectious disease, orthopedic surgery and podiatry. (PX 7, pg. 23). Petitioner was discharged.

Petitioner testified he was told to stay off work and let his foot heal. Petitioner testified he was told to be off work from September through December.

Petitioner was seen by Metro Infectious Disease Consultants on October 18, 2013. It was noted there was improvement in Petitioner's left ankle and no evidence of active infection. He was recommended to finish his prescribed medication then no further antibiotics. Petitioner was diagnosed with venous stasis dermatitis, with history of deep vein thrombosis. Petitioner was recommended referral to a vein clinic. (PX 3, pg. 14).

Dr. Joba testified via deposition. (PX 6). Dr. Joba testified he is a doctor of podiatric medicine and at the time of the first visit with Petitioner he was a practicing podiatrist for four years. The doctor noted Petitioner was complaining of pain in his left ankle, with some erythema.

Dr. Joba last saw Petitioner in November 2014. Dr. Joba's ultimate diagnosis was edema pain and venous insufficiency. Dr. Joba clarified the venous insufficiency means the arteries and veins responsible for moving blood are not working properly and not taking blood to and from the heart correctly. Due to this insufficiency, blood starts circulating and pooling in lower extremities causing swelling and pain. Dr. Joba testified the venous insufficiency is related to the pain and swelling the claimant had on November 4, 2014. Dr. Joba further clarified there are several causes of venous insufficiency and risk factors including chronic standing, smoking, and trauma. Dr. Joba further testified he does not know the exact cause of claimant's venous insufficiency. Dr. Joba testified based on claimant's history, the fact that he had a history of deep vein thrombosis, the fact that he's a smoker, and the fact that he might be standing for extended period of times can all cause venous insufficiency. The doctor noted venous insufficiency is usually a chronic condition.

On cross-examination, Dr. Joba noted Petitioner's diagnosis of edema, venous insufficiency, pain in limb are all conditions commonly seen in a patient who has a history of deep vein thrombosis and is a cigarette smoker. Further, venous stasis is another diagnosis commonly seen in persons with history of deep vein thrombosis. Dr. Joba testified it is common for ulcers to develop in the area where venous stasis occurs as well as common for ulcers to develop in the area of the lateral malleus. Dr. Joba confirmed the lateral malleus is the area Petitioner is complaining of ulcers in this case. Dr. Joba finally testified that venous stasis can cause nerve pain. (PX 6).

Petitioner was seen by Dr. Ahmed on November 23, 2013 (PX 3). Petitioner testified at this time that the doctor ordered petitioner to return to work.

Petitioner testified he was examined by Dr. Ernest Chiodo in February 2014 at the request of Respondent. Dr. Chiodo testified via deposition (RX 1). Dr. Chiodo testified regarding his significant and voluminous curriculum vitae as well as his extensive experience. Dr. Chiodo testified that he examined Petitioner and reviewed significant medical records as well as imaging studies (the actual films) in anticipation of his report and addendum reports. Dr. Chiodo testified Petitioner provided a history of falling off a four-step ladder, causing injury to the ulnar aspect of his left wrist, and the lateral malleus of the ankle. Dr. Chiodo testified this history was not consistent with any medical records.

On examination, Dr. Chiodo noted a brownish discoloration of claimant's left ankle with no current ulceration or laceration of the left ankle. Dr. Chiodo further noted there was no scar consistent with laceration, no swelling, normal gait, and normal blood flow (but he still noted venous stasis). Dr. Chiodo testified regarding venous stasis indicating it is a condition where blood does not properly flow back through the venous system causing problems like ulcers. Dr. Chiodo testified Petitioner has a history of deep vein thrombosis in the left leg. Dr. Chiodo noted the findings on his exam were consistent with venous stasis involving the left leg consistent with the known history of two DVT and resultant pulmonary embolism because of DVT of the left leg. Dr. Chiodo diagnosed Petitioner with left leg venous stasis with skin discoloration due to left venous stasis and venous stasis ulcer of the left lower extremity because of prior history of deep venous thrombosis. Dr. Chiodo noted these were chronic conditions and these conditions pre-existed any fall at work that may have occurred on February 8, 2013. Dr. Chiodo opined Petitioner was suffering from diabetes.

When asked about Petitioner's current condition of ill being, Dr. Chiodo indicated a fall at work with claimed laceration would not explain burning pain in his extremity. Dr. Chiodo clarified that nerve pain is not related to any fall at work and could not provide a mechanism given the circumstances in this case where laceration of the skin of the lateral malleus would cause him to have this type of nerve pain. Dr. Chiodo opined there is no pathophysiological mechanism that would explain nerve pain like this. Dr. Chiodo testified regarding the cause of the current condition of claimant's venous stasis that Petitioner's past history of deep venous thrombosis is the basis for Petitioner's condition.

Dr. Chiodo was asked about the claimed laceration from February 2013 whether that was a cause of the venous stasis or ulcerations. Dr. Chiodo testified that whether or not there was a laceration in February 2013 did not impact or cause Petitioner's current condition of ill being. **Dr. Chiodo testified he based his opinions on the fact that the March 25, 2013 medical record from Stroger Hospital did not show any laceration, ulceration or open wound of the left ankle. Dr. Chiodo explained that if there was a laceration in February 2013 it had fully healed by March 25 of 2013. Dr. Chiodo testified that if there was later an ulceration, which medical records show only after March 2013, it was not caused by any potential fall or injury at work.**

Dr. Chiodo testified clearly that venous stasis is in no way related to the claimant's work at the Home Depot. The doctor found the petitioner to be at MMI prior to March 25, 2013 due to the fact that there was no ulceration or laceration to the petitioner's left ankle on his March 25, 2013 visit.

On cross-examination, Dr. Chiodo further clarified that he was not testifying whether or not there was a laceration in February 2013; however, if there was, it had fully healed and resolved by March 25, 2013 due to the medical records from that date (not indicating any such laceration).

Petitioner testified he still presently has tingling and the movement is not the same as his right ankle. Petitioner testified he continues to take medication and he is still working today. Petitioner testified he is not as mobile as he used to be. Petitioner testified that the ulcers on his left ankle took three to four years to close up, which is not supported by the medical records. (Tx 36-39)

Petitioner's left and right ankles were examined at the trial setting. Petitioner's left ankle showed a dark area with a bruise on it. Petitioner's right ankle and leg were viewed for comparison and noted to have discoloration/darkened areas on the skin. (Tx 40-42)

Petitioner testified on cross-examination that Coumadin does not cause bruises. Petitioner testified that he drafted the report indicating there was internal bleeding on the arm and a scratch on the left foot on the date of injury. Petitioner testified that he scratched his left arm but on the report only indicated internal bleeding and no scratching. Petitioner further confirmed that the report he drafted did not discuss any blood being drawn from the ankle or arm. (Tx 44-50). Petitioner could not explain why he did not identify a laceration or bloody ankle in his drafted witness statement.

Petitioner testified he has not seen a doctor in 2 ½ years. Petitioner testified the last time he saw a doctor, he was told to follow up but he did not follow up with such a physician. Petitioner further clarified the medication he is presently on is in no way related to this claimed accident. Petitioner is not currently taking any pain medication, rather only Coumadin for his pre-existing deep vein thrombosis. (Tx 51-54)

Petitioner testified that he is working in a full duty capacity, with no work restrictions. Petitioner testified that he goes to Stroger Hospital approximately once a month for anticoagulants. Petitioner further testified that he has communication issues with his physicians, nurses, and physical therapist. Petitioner was unable to recall the names of the doctors, physical therapists or and nurses with whom he had communication issues.

Petitioner testified he always felt like he was rushed in his doctors' appointments. Petitioner felt the doctors and physicians were taking full advantage of his insurance. Petitioner further testified that the medical records for his treatment could or may be incorrect, but gave no specific examples. Petitioner had a language problem with his physicians, but he never made note of it to his attorney. Petitioner testified he hired an attorney for his workers' compensation case in September 2013. (Tx 54-62)

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (C), WHETHER AN ACCIDENT OCCURRED ARISING OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT ON FEBRUARY 8, 2013, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOW:

It is Petitioner's burden to prove each element of his case by a preponderance of the credible evidence. It is not the burden of Respondent to disprove any issue. Rather, the burden lies with Petitioner, his testimony, character and evidence entered onto the record at the time of trial. *Rambert v. Indus. Comm'n.* 133 Ill App. 3d 895, 87 Ill. Dec. 836, 477 N.E.2d 1364, 1369 (1985).

An accident arises out of employment if the employee was performing acts instructed by the employer, or acts which the employee might reasonably be expected to perform. *Nabisco Brands v. Indus. Comm'n (Prendergast),* 266 Ill. App. 3d 1103, 1106, 204 Ill. Dec. 354, 357, 641 N.E.2d 578, 581 (1994).

Petitioner testified that he was helping a customer, climbing up a ladder on February 8, 2013 when he fell from the ladder scraping his left forearm and left ankle. Petitioner offered no medical evidence which described what specific injury may have resulted from this accident on February 8, 2013; however, Petitioner's unrebutted testimony provides sufficient evidence to demonstrate that an accident took place on February 8, 2013.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (F), WHETHER PETITIONER PROVED A CAUSAL RELATIONSHIP EXISTS BETWEEN THE ACCIDENT SUSTAINED AND HIS CURRENT CONDITION OF ILL-BEING, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

In a workers' compensation case, the claimant has the burden of proving, by a preponderance of the evidence, some causal relation between the employment the claimed injury and current condition of ill being. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 63, 541 N.E.2d 665, 669, 133 Ill. Dec. 454 (1989).

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). "[C]laimant has the burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

It is the Commission's function to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4, 31 Ill. Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 590 N.E. 2d 78, 82 (1992).

As indicated *supra*, Petitioner bears the burden of proving each element of his case by a preponderance of credible evidence. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470 (4th Dist. 1987). In order to meet this burden, a Petitioner must "produce competent evidence of objective conditions and symptoms to support [a] claim." *Nunn* at 477. Where a claimant has a pre-existing condition, whether it is aggravated or accelerated is a question of fact for the Commission. *Caterpillar Tractor Co. v. Indus. Comm'n*, 92 Ill. 2d 30, 36-37 (1982). Furthermore, in questions involving causation, the parties need not necessarily submit a medical opinion in order to prove causation. **However, "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* at 507, citing to *Interlake Steel Co. v. Indus. Comm'n*, 136 Ill. App. 3d 740 (1985). In this case, the Arbitrator finds that "the question is one within the knowledge of experts only and not within the common knowledge of laypersons." Based upon the evidence submitted by the parties, the Arbitrator finds that the evidence submitted by Petitioner is not sufficient to prove that it is more probable than not

that his current condition of ill-being is related to the February 8, 2013 accident. Respondent's evidence is more credible and weighty than Petitioner's evidence.

Regarding the conflicting expert medical testimony which ultimately decides this case, all expert testimony, whether scientific or not, must have an adequate foundation in order to be admissible. An adequate foundation must be laid establishing that the information upon which the expert bases his opinion is reliable.

It is fundamental and elementary that an expert's opinion is only as valid (as to weight and credibility) as the basis and reason for the opinion. An expert must give some reason for his opinion.

The Arbitrator has been presented with divergent medical opinion evidence regarding the causal relationship between Petitioner's condition of ill-being and his accident. It is within the purview of the Commission to accord the proper weight to these conflicting opinions.

The Illinois Supreme Court has held that the weight accorded an expert's opinion must be measured by the facts supporting the opinion and the reason given for the opinions. If the expert's opinion lacks a factual basis, the opinion deserves little weight. An expert's opinion cannot be based solely on guess, surmise or conjecture. *Doser v. Savage Manufacturing and Sales, Inc.*, 142 Ill. 2d 176, 195-196 (1990).

While it is true that expert testimony couched in terms of probabilities or possibilities based on assumed facts is admissible, this rule does not lessen the need for a reasonable degree of certainty. *Brown v. Chicago Northwestern Transportation Co.*, 162 Ill. App. 3rd 926, 037-38 (Ill. App. 1st Dist.1987). The *Brown* Court held that, "...the doctor's response, **'It's possible'**, to a question concerning the necessity of surgery in the future was **"too speculative"** to support an award for future medical expenses. *Brown*, 161 Ill. App. 3rd at 938. Similarly in this case, Dr. Joba's opinions couched in terms of mere "possibility" are not grounded in a reasonable degree of certainty and are "too speculative" to support his opinions regarding causation.

Additional case law supports the finding and conclusion that Dr. Joba's opinions are too speculative. The Appellate Court, Industrial Commission Division, has held that a physician's opinion that "Repeated bending **may well have** caused her condition of ill-being..." **was equivocal with regard to causation.** *McRae v. Industrial Comm'n*, 285 Ill. App. 3rd 448, 451-453, 674 N.E. 2d 512, 515-516 (Ill. App. 5th Dist. 1996). The Court emphasized that **the physician "could not say repeated bending at work did in fact cause the injury..."** *McRae*, 285 Ill. App. 3rd at 453. Very significantly, the Appellate Court further held that, "...the Commission was not required to accept this equivocal and ambiguous opinion as undeniable truth that claimant's condition was indeed caused by repeated bending and lifting at work. Moreover, the Commission was at liberty to discount the credibility of this statement because it was made 14 months after claimant's alleged injury." *Ibid.*

Lastly, and also very significant, the *McRae* **Court also held that implicit in the physician's expert opinion that claimant's work "may well have" caused her condition of ill-being, "is that claimant's work may well <u>not</u> have caused the condition."** *Id.*, at 516.

The McRae case is directly on point. It's holdings directly attack the weight and credibility of Dr. Joba's "equivocal and ambiguous" opinions on causation, which also were offered some 25 months after Petitioner's injury.

Petitioner claims his current condition of ill being, including venous insufficiency causing venous stasis and venous stasis ulcers of the left leg, are related to his work accident of February 8, 2013. To support his claim, Petitioner offered his testimony, along with medical records and deposition of Dr. Joba, records of Dr. Ahmed, records from Dr. Vias, Stroger Hospital records and St. Mary of Nazareth records. Respondent offered medical reports and the deposition testimony of its examining expert Dr. Ernest Chiodo.

It is undisputed that Petitioner has a longstanding history of deep vein thrombosis to his left leg, clearly unrelated to and pre-dating this claim. Petitioner has been participating in anticoagulation therapy for several years and the evidence shows he will likely have to continue this treatment for the rest of his life.

The evidence reveals that Petitioner offered no medical records outlining any trauma to his left ankle for more than 7 weeks. Petitioner was seen at Stroger Hospital on February 19, 2013 for his follow-up anticoagulation treatment, yet, inexplicably, there is no mention of any ankle laceration, pain or injury seen in those records. (PX 1, pg. 468).

Petitioner was seen again on March 19, 2013 at Stroger Hospital for another round of anticoagulant treatment and again he inexplicably did not complain of any issues with his ankle or forearm nor are any such injuries noted in these records. (PX 1, pg. 463).

The first office visit record discussing his left ankle was on March 25, 2013 at Cook County Hospital. The records from this office visit and physical examination indicate Petitioner complained of ankle pain and erythema (redness), with no laceration, open wound or ulceration noted or indicated at that time. Inexplicably, there is also no mention of any work injury or trauma during this office visit. (PX 1, pg 453). Medical records do not mention any work injury until July 26, 2013, at which point the hospital indicated Petitioner fell in March and developed an ulcer. (PX 1, pg 339).

Petitioner sought treatment with a vascular specialist in August of 2013 who noted a healed ulceration to the left ankle. The vascular surgeon indicated that Petitioner requested an off work slip which was denied, due to the chronic nature of the disease and there being no formal endpoint for venous stasis. Petitioner then became agitated and vocally upset with the vascular surgeon when a light duty work slip was offered. (PX 1, pg. 321).

Petitioner's treating podiatrist, Dr. Joba, testified via deposition that Petitioner suffered from edema pain and venous insufficiency. (PX 6) Dr. Joba first saw Petitioner on September 23, 2013 (PX 6, p. 09). Dr. Joba testified that Petitioner complained of pain in the left ankle, he had some erythema and he had an injury at work about six months prior (PX 6, p. 010). Dr. Joba testified that **"It's <u>possible</u> that Petitioner had a laceration that had healed"** (PX 6, p. 010). X-rays taken on that date only indicated some swelling, which "**could be** from chronic venous problem." (PX 6, pp. 011-12). Dr. Joba's impression was only "history of DVT and some cellulitis

(infection) of the left ankle." (PX 6, p. 012). Dr. Joba was **unable** to offer an opinion "I cannot offer specifically") regarding where the bacteria (causing the cellulitis) came from. (PX 6, p. 015). Dr. Joba could not answer these causation questions because he admitted that he was not involved in the Petitioner's treatment during this six-month period (PX 6, p. 013).

Dr. Joba next saw Petitioner on September 25, 2013 (PX 6, p. 016). The MRI showed "some kind of a reading that suggested something wrong with the fifth metatarsal." (PX 6, p. 017).

Dr. Joba next saw Petitioner on September 26, 2013 (PX 6, p. 018). The impression was "cellulitis/dermatitis." (PX 6, p. 018). A new left foot MRI showed findings that could be due to normal variation or a remote trauma and some degenerative changes. (PX 6, p. 018-019). Tests showed negative DVT.

Dr. Joba next saw Petitioner on November 4, 2013 (PX 6, p. 019-020). The impression was pain and swelling of the left ankle, and he later modified that testimony to indicate "edema, pain, and venous insufficiency." (PX 6, p. 023). . (PX 6, p. 020). There was no cellulitis present (PX 6, p. 022-023). Dr. Joba testified Petitioner had told him that he had pain and swelling since his fall at work (PX 6, pp. 020-021).

Dr. Joba was asked what caused the venous insufficiency. Dr. Joba answered; there are a lot of risk factors that can cause venous insufficiency, for example, chronic standing, smoking, if the valves in the veins do not work properly. Trauma can cause venous insufficiency too. (PX 6, p. 024). History of infection "can happen." (PX 6, pp. 024-025),

Significantly, when asked to offer an opinion as to what caused Petitioner's venous insufficiency, Dr. Joba stated he "wouldn't know exactly" because different risk factors can cause the insufficiency. (PX 6, p. 025).

Upon further questioning as to whether Petitioner's trauma to his left ankle could have been a factor to this venous insufficiency, Dr. Joba **first** indicated that venous insufficiency is usually a chronic condition (indicating he was clearly reluctant to indicate that trauma could have caused his venous insufficiency) and then Dr. Joba eventually testified that stated that venous insufficiency **"could"** be caused by trauma. (PX 6, p. 027).

On cross-examination, Dr. Joba clarified that venous insufficiency and venous stasis commonly occur in persons with DVT, and ulcers commonly occur in limbs with venous stasis. Dr. Joba further clarified that it is common for venous stasis ulcers to occur in the area of the lateral malleus. (PX 6, p. 031-032). Finally, Dr. Joba confirmed that the chronic condition of venous stasis can possibly cause nerve pain. (PX 6, pp. 034-035).

Dr. Joba testified that the only two conditions that were consistent with infection when he examined Petitioner were tissue redness and pain, which are the same conditions consistent with venous stasis (PX 6, pp. 034-035).

Significantly, Dr. Joba testified that he did not review any medical records from March to June of 2013 (PX 6, p. 036). This places Dr. Joba at a distinct disadvantage in

relation to Dr. Chiodo, as Dr. Chiodo did review these records and he made important and considerable use of them at his deposition as a basis in formulating his expert opinions. This factor adds great weight to Dr. Chiodo's opinions.

Petitioner's treating medical records, including from Dr. Ahmed and Dr. Vais **do not indicate** Petitioner's injury at work on February 8, 2013 caused his condition of venous stasis, venous insufficiency or ulcers of the left lower extremity.

Petitioner's treating medical records, including from Dr. Ahmed and Dr. Vais **do not offer an opinion** that Petitioner's injury at work on February 8, 2013 caused his condition of venous stasis, venous insufficiency or ulcers of the left lower extremity.

Therefore, based on a thorough review of the applicable case law and the facts, the Arbitrator finds and concludes that Dr. Joba's opinions merit very little weight and credibility, are discounted and do not support a finding of causation. The Arbitrator resolves the conflicts found in the expert medical evidence opinions in favor of Dr. Chiodo.

On the other hand, the Arbitrator affords and assigns greater weight and credibility to the opinions of Respondent's examining expert Dr. Chiodo. Beyond the very relevant and significant fact that Dr. Chiodo reviewed more medical records than Dr. Joba (thereby making him more informed) Dr. Chiodo is objectively far better qualified and credentialed as an expert in the medical, scientific and (significantly) forensic fields than Dr. Joba (who is only a podiatrist with only four years of practice experience) to offer causation opinions. The Arbitrator highlights that Dr. Chiodo has the following relevant credentials (not considering his M.S, in Threat Response, MBA and law degrees): Doctor of Medicine, Master of Public Health, Master of Science in Biomedical Engineering and Master of Science in Occupational and Environmental Health Sciences. Dr. Chiodo has also completed his class work at Oxford towards his degree of Master of Science in Evidence Based Medicine. He is also specialty resident-trained in Diagnostic Radiology and Internal Medicine. Dr. Chiodo is triple-board certified in Internal Medicine, Occupational Medicine, and Public Health and General Preventative Medicine. Dr. Chiodo is a Certified Industrial Hygienist, Graduate Toxicologist and epidemiologist. Lastly, Dr. Chiodo has been specially trained to determine causation due to an environmental or occupational exposure or circumstance.

Dr. Chiodo testified regarding Petitioner's venous stasis, venous insufficiency and ulceration of the left ankle (Resp. Ex. No. 1). Dr. Chiodo testified that Petitioner's condition of ill being including venous stasis, venous insufficiency and ulceration of the left ankle are not related to his claimed work injury of February 8, 2013. Dr. Chiodo testified that he would not opine whether there was an injury on February 8, 2013, as he did not have any medical records to identify an injury, but that even if there were an injury, **it had resolved prior to the March 25, 2013 visit to Stroger Hospital. Dr. Chiodo explained in detail that the March 25, 2013 medical record from Stroger Hospital showed detailed examination of Petitioner demonstrated left lower extremity sharp area of erythema, and that the record in no way implied or stated any ulcer, laceration or open wound existed on that date.** (Resp. Ex. 1, pp. 21-23).

Dr. Chiodo offered other explanations for the venous stasis and venous insufficiency but noted that there was no relation between a claimed wound in February to Petitioner's current condition. Dr. Chiodo indicated that the claimed injury of a laceration/open wound suffered in February was completely resolved by March 25, 2013, and any subsequent treatment was unrelated to the work for Respondent.

Dr. Chiodo opined that Petitioner's nerve pain condition is a peripheral neuropathy "in my opinion most likely to diabetes mellitus", an opinion based on Petitioner's history of pain in his lower extremities. Resp. Ex. 1, pp.21-23. Dr. Chiodo opined that that nerve pain is not related to the fall but rather "the explanation is to a high likelihood is diabetes mellitus." Resp. Ex. 1, pp.22-23.

Dr. Chiodo testified and explained that Petitioner's condition of venous stasis is related to his past history of two deep venous thrombosis. Resp. Ex. 1, p. 24.

Dr. Kyoto also testified that it is his opinion that Petitioner did not have cellulitis in his lower extremity any time after the work accident of 2013. This is based on his evaluation and workup in the medical records. Dr. Chiodo further testified that there was nothing records it was consistent with Petitioner having a venous stasis. The records of Cook County Hospital are not consistent with any laceration causing the problem because it was no laceration of the skin. If there was a laceration of skin causing cellulitis you would expect there to be a continued laceration. So clearly anything to happen to work even if there was a laceration that didn't cause a problem because it healed if you did have a laceration and had healed by the date of the accident of February 25, 2013. Dr. Kyoto further noted that an ulceration is not a laceration. They look completely different and that's consistent with venous stasis. You would not typically see an ulceration with cellulitis.

Dr. Chiodo further testified that as of March 25, 2013 Petitioner did not present with anything consistent with a work-related injury. Further, at no time in the records that he reviewed did Petitioner present with anything consistent with a work-related injury. Dr. Chiodo further testified that the records from Cook County Hospital for March 25, 2013 do not indicate any sign of any laceration on the skin. Dr. Chiodo reviewed these records at his deposition. Under review of systems the records indicated sharp areas of erythma on the left leg with mild increase in local temperature but there was no indication of any laceration or indication of any ulceration. That would've been a significant finding that would have been recorded in the records. Nowhere in the records does Dr. Chiodo find the word ulcer or laceration. Dr. Chiodo again confirmed that Petitioner's venous stasis has nothing to do with his claimed work incident. The venous stasis is related to the to the prior deep venous thrombosis. The eventual venous ulcers also are related to the venous stasis and the DVT.

Dr. Chiodo testified that the records indicate that if Petitioner did have any abrasion or laceration of the skin over the left malleolus it had clearly healed by March 25, 2013 as his records do not indicate any such condition being present. Dr. Chiodo also agreed that Petitioner did develop an ulcer as indicated in the Cook County Hospital records dated April 1, 2013. This means that Petitioner clearly developed ulcers well after the claimed injury so he developed this after they saw him in March 25, 2013. And an ulcer could develop pretty rapidly. Dr. Chiodo also confirmed

that the ulcer which appeared on or about April 1 again has nothing to do with the February work injury.

Dr. Chiodo questioned how does Petitioner have a problem due to laceration of his ankle at work but then he is no manifestation of any ulceration or laceration March 25 then he claims that April 1 is the manifestation of his work condition which Dr. Chiodo indicated does not flow. Dr. Chiodo then again confirmed that the Cook County Hospital records do not indicate that the physicians diagnosed cellulitis on March 25 but rather it was part of his differential diagnosis. Petitioner never had cellulitis based upon the medical records. Petitioner never had osteomyelitis based upon the medical records and imaging studies.

Dr. Chiodo testified that to an absolute certainty the ulceration later on had nothing to do with work because he didn't have any abrasion, any laceration or any ulceration of the skin when he was seen on March 25, 2013. So anything that may or may not have happened with that letter had nothing to do with his later problems.

Dr. Joba's testimony relied on hypothetical situations wherein Petitioner suffered a trauma and an open wound. But Dr. Joba testified that he did not review medical records for the period between February and March of 2013. Significantly, Dr. Joba did not review any medical records which demonstrated any open wound or injury following the claimed work injury in February 2013.

There are no medical records which show an open wound to Petitioner's left ankle following the accident. Medical records from March 25, 2013 at Cook County Hospital show no laceration, ulceration or open wound. Due to this lack of evidence, Petitioner failed to prove causation and any injury Petitioner may have suffered to his left ankle on February 8, 2013 has not been proven and has long since resolved.

Petitioner has not met his burden of proof by a preponderance of the credible evidence. Petitioner's own treating podiatrist did not provide credible causation opinions with a proper foundation. None of the treating physicians were able to provide causation opinions sufficient to outweigh Dr. Chiodo's clear and decisive opinions, based on a thorough review of the medcial redcords, pacing him at a distinct advantage . As such, the Arbitrator finds Dr. Chiodo's medical opinions more persuasive, and finds that the petitioner's current condition of ill being is unrelated to petitioner's work accident of February 8, 2013.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (J), WHETHER THE MEDICAL SERVICES PROVIDED WERE REASONABLE AND NECESSARY AND WHETHER RESPONDENT HAS PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

"[T]he employer shall provide and pay 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 necessary to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a).

Petitioner has not proven that his condition of ill-being as of his March 25, 2013 visits to Cook County Hospital is related to his work accident of February 8, 2013. Petitioner did not submit any bills for payment between February 8, 2013 and March 25, 2013. The Arbitrator finds that Petitioner's condition had resolved prior to March 25, 2013 and any treatment from that day forth is not related to his work injury. As the bills from March 25, 2013 forward were not necessary to cure or relieve the effects of the accidental injury, the submitted bills are not awarded.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING DISPUTED ISSUE (K), WHETHER TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

To be entitled to a temporary total disability award under the Act, an injured employee must provide not only that he or she did not work but also that he or she could not work. *Lukasik v. Indus. Com. of Ill.*, 124 Ill. App. 3d 609, 614, 80 Ill. Dec. 416, 419, 465 N.E.2d 528, 531 (1984).

Petitioner has failed to meet his burden of proving that his condition of ill-being from March 25, 2013 forward is causally related to his work accident. Petitioner submitted no off works slips for the period between February 8, 2013 and March 25, 2013. Any work restrictions imposed beyond March 25, 2013 are unrelated to claimant's work accident and therefore not compensable. TTD for the claimed period of September 22, 2013 through December 3, 2013 is denied.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING THE NATURE AND EXTENT OF PETITIONER'S INJURY, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner sustained an accident at work on February 8, 2013. Petitioner testified that he scraped/cut his forearm and his left ankle. Therese are the only injuries for which causation is found and therefore the only injuries regarding which permanency shall be awarded.

The Arbitrator viewed Petitioner's injuries. Regarding the scrapes/cuts to Petitioner's forearm and left ankle, the Arbitrator awards 10 weeks of compensation for serious and permanent disfigurement pursuant to Section 8(c) of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: March 8, 2018

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHERINE BELL,

Petitioner,

vs.

NO: 17 WC 9218

18IWCC0737

CHICAGO PUBLIC SCHOOLS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical, and temporary total disability benefits (TTD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on January 10, 2017. The Commission finds that Petitioner's cervical spine, right shoulder, and right arm conditions were causally related to the accident. The Commission also finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the January 10, 2017 accident, including prospective medical by way of an epidural injection and a functional capacity evaluation (FCE). The Commission further finds that Petitioner is entitled to TTD benefits from January 11, 2017 through February 28, 2018.

The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the

matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1) As of January 10, 2017, Petitioner testified that she had been employed by Respondent for 17 years. (T.11). On that date, Petitioner's job title was "porter"; she worked 40 hours a week, 10 months out of the year. (T.11). Petitioner identified Petitioner's Exhibit 11, which was a pay stub for the period of January 8, 2017 to January 21, 2017. (T.11; PX11).

2) Petitioner testified as to her accident on January 10, 2017:

> I had stock come in that day, which I have on Tuesdays and Thursdays; and I was putting away my stock, which was frozen and dried goods; and I was putting up a box of frozen chicken legs, which I bent down and came up with the box to put in the freezer; and as I bent down and came up with the box, I felt a sharp pain in my arm go up to my shoulder, and I dropped the box. (T.12).

3) Petitioner reiterated to the Arbitrator that after picking up the box, she felt a sharp pain that went up to her right shoulder and to her neck. (T.13). The boxes weighed approximately 50 to 75 pounds. (T.13). Petitioner testified that her manager, Gloria McIntosh, had witnessed the accident. (T.14). Petitioner completed an accident report with the principal, V.S. Thompson, and then worked the remainder of her shift. (T.14). Petitioner stated that when she went home, she felt a little pain in her shoulder and arm, she took some medicine, and laid down. She felt worse the next day. (T.15).

4) On January 11, 2017, Petitioner sought treatment with Dr. Arnulfo Vielgo. (T.15; PX1). The medical record stated, "has pain from right side of neck down to right shoulder and right arm with associated paresthesias of right arm and right hand x last 3-4 days." The history further indicated that Petitioner had pain under her right arm, she had difficulty raising her right arm, and that Petitioner did not have a recent injury. (PX1). Petitioner denied that this was the history reported to Dr. Vielgo; she testified that she informed Dr. Vielgo: "I was at work, and I had stock come in that day and I was doing some heavy lifting; and I told him that I picked up the box, and I felt a pain in my arm, and I dropped the box." (T.15-16). Petitioner was diagnosed with cervical radiculopathy; the medical record stated that x-rays of the cervical spine taken on January 11, 2017 revealed arthritic changes at C6-7, but otherwise they were unremarkable. Dr. Vielgo suggested that Petitioner consider physical therapy and an MRI of the cervical spine if her symptoms worsened. (T.16; PX1).

5) In a later follow-up appointment with Dr. Vielgo, on February 23, 2017, Dr. Vielgo noted, "patient seeing me today to discuss her previous visit with me on January 11, 2017 . . . at the time of this particular visit patient claims that she had stated that she was injured at work prior to the onset of her pain but was so much in pain she forgot to mention this." (PX1).

6) Petitioner presented to Advocate Medical Group on January 17, 2017; the medical record stated that Petitioner reported a pinched nerve was causing her arm pain. The right arm pain was radiating from her shoulder, and "pt states her hand and knuckles has been swelling up with pain- denies injury." Petitioner apparently received a cortisone injection the week prior, but her pain was presently worse. Petitioner was given a Lidocaine patch and referred to pain management. (PX1).

7) Petitioner returned to Advocate Medical Group on January 31, 2017; the medical record stated that Petitioner was there for an initial visit for carpal tunnel symptoms in her right hand, and that Petitioner's pain was worse since the January 10 injury to her right arm. The medical record further indicated that Petitioner had had these symptoms intermittently for the past five years. (PX1). Petitioner had previously completed an MRI of the cervical spine on January 24, 2017. (T.18; PX1; PX3). The impression demonstrated minimal disc osteophyte at C4-5 with minimal impression on the ventral aspect of the thecal sac without spinal stenosis centrally or foraminal narrowing; significant herniation at C5-6 paracentral to the right; there was a broad-based C6-7 herniation with an associated foraminal component projecting cephalad [toward the head or anterior end of the body]; both herniations were compressing the cervical cord without associated myelomalacia or cord edema. (T.18; PX1; PX3). An x-ray of the right shoulder, completed on January 16, 2017, was normal. Petitioner was diagnosed with cervical radiculopathy and carpal tunnel syndrome. Dr. Shri Agrawal suggested Petitioner see a neurosurgeon. (PX1).

8) On February 23, 2017, Petitioner followed-up with Dr. Vielgo; Dr. Vielgo recommended that Petitioner undergo a CT scan of her cervical spine. (T.19). Petitioner completed the CT scan on March 21, 2017. (T.19; PX1; PX4). The impression indicated mild lower cervical degenerative disc disease at C5-6 and C6-7.

9) Petitioner testified that her primary care physician, Dr. Carol Hayes-Sharpley, had referred her to neurosurgeon, Dr. Ryan Trombly; Petitioner consulted with Dr. Trombly on March 7, 2017. (T.18; PX1). Dr. Trombly noted that Petitioner injured herself at work on January 10, 2017 while lifting 75 pounds of chicken legs. He reviewed the MRI of the cervical spine from January 2017, and noted a right C6-7 disc bulge, a moderate right paracentral disc at C5-6, and moderate impingement of the ventral cord. Dr. Trombly diagnosed Petitioner with cervical radiculopathy, and suggested that she wear a cervical collar and take oral steroids. If the pain persisted, Dr. Trombly recommended an anterior cervical discectomy and fusion (ACDF). (PX1). Petitioner underwent physical therapy at Physiotherapy and ATI. (T.20; PX5). A medical note, dated March 31, 2017, stated that

Dr. Trombly had reviewed the CT scan of the cervical spine, and that there were no findings requiring emergent surgery. (PX1; PX4).

10) On August 22, 2017, Dr. Trombly recommended surgery. "Yes because he said the nerve was weakening – the damage in my arm, the muscles in my arm." (T.20). Petitioner testified that Dr. Trombly ordered a comparison MRI to check for any additional damage. (T.21). Petitioner completed the MRI on September 18, 2017; the impression indicated right paramedian herniated disc with annular fissure at C5-C6; no significant change since prior study; there was also a tiny broad-based subligamentous disc protrusion at C6-C7 improved as compared to prior study of January 24, 2017. (PX2; PX7).

11) Respondent sent Petitioner for a Section 12 examination with Dr. Julie Wehner on November 9, 2017. (T.21; RX1). The parties did not obtain Dr. Wehner's evidence deposition, but agreed to enter the Section 12 report into evidence. (T.37-38). Dr. Wehner's history of injury was consistent with Petitioner's testimony; she noted that after picking up the box of chicken legs, Petitioner felt a pop in her right shoulder, and the pain shot to her head. Dr. Wehner examined Petitioner and noted that her neck range of motion was normal; her reflexes, including biceps, triceps and brachial radialis were symmetric, but caused pain; Petitioner had giveaway weakness in the entire right arm with decreased sensation in the entire right hand. Dr. Wehner reported that Petitioner was using her right hand to use her phone and manipulate the doorknob and her purse without difficulty or pain behaviors. There was no edema or atrophy, but Phalen's test produced dorsal wrist pain and Tinel's test at the wrist caused tenderness but was not positive. (RX1).

12) Dr. Wehner reviewed the diagnostic images completed for the cervical spine, as well as some images related to Petitioner's prior history of low back issues. Dr. Wehner further detailed in her report the medical records she reviewed for this claim; they were consistent with the evidence in the record. (RX1).

13) Dr. Wehner opined:

> Because her subjective complaints of decreased sensation in the entire hand and the giving way weakness are nonfocal, and she has a normal neck range of motion, it is difficult to reconcile her clinical exam with the radiographic findings. It is difficult to reconcile the radiographic findings in a specific distribution with the nonfocal clinical exam. (RX1).

14) However, Dr. Wehner stated that the recommended arthroplasty at C5-6 and C6-7 would be reasonable based on the radiographic findings, if they specifically correlated with her clinical findings. Dr. Wehner diagnosed Petitioner with cervicalgia and right radiculopathy, noting however that the clinical exam was nonfocal. Dr. Wehner also based

her causal connection opinion on the fact that the initial medical records failed to indicate that Petitioner had injured herself at work. (RX2).

15) Dr. Wehner believed that Petitioner's treatment by way of pain medication and physical therapy had been reasonable and necessary, but unrelated to the January 10, 2017 injury. She stated that Petitioner could return to work with restrictions of no lifting more than five pounds with her right arm, and no overhead work; Petitioner was not at maximum medical improvement (MMI). Dr. Wehner recommended that Petitioner receive an epidural injection, and an EMG to rule out carpal tunnel syndrome. She also stated, "If Ms. Bell wished to return to work without surgical intervention and this is considered a work related injury, then an FCA should be performed." (RX2).

16) Petitioner followed-up with Dr. Trombly on December 26, 2017; Dr. Trombly responded to Dr. Wehner's Section 12 examination in his medical note:

> Evaluation with Dr. Wehner asserts that although MRI from Jan 24, 2017 confirms right sided disk herniation at C56 and C76, the claimant has hand numbness and 'it is difficult to reconcile her clinical exam with the radiographic findings.' However, on exam Ms. Bell has clear right weakness in wrist extension and triceps, which correlate with C56 and C67 disk herniations and C6 and C7 nerve roots, respectively. The patient states that Dr. Wehner did not examine triceps and wrist extension strength specifically. therefore I disagree with the assertion of Dr. Wehner. The findings on exam correlate well with the radiographic findings and also the history of right arm pain after lifting at work. Furthermore, the assertion of Dr. Wehner that the current complaints are not causally related to a date of accident of 1-10-2017, despite an event that happened at work with subsequent right arm pain and MRI taken 2 weeks later showing acute right-sided disk herniations at C56 and C67, is truly hard to justify. (PX2).

17) Dr. Trombly further opined:

> [T]he lifting event from work on 1-10-2017 caused acute right arm pain, and that MRI taken two weeks later confirmed C56 and C67 right sided disk herniations; and that chiropractic and PT since that time have not alleviated the severe right arm pain; and that the motor weakness demonstrated on exam in the C6 and C7 distribution is a direct result of this work related injury and the acute disk herniations; and also that if the claimant were to return to work before the disk herniations can be repaired she would be placed at unnecessary risk of further injury and further loss of neurologic

> function; and that the appropriate medical treatment is to perform cervical arthroplasty at C56 and C67.
>
> Dr. Wehner asserts that 'the standard does not usually indicate a 2-level arthroplasty and usually indicates than an arthroplasty is a 1-level procedure.' Much recent evidence supports 2-level arthroplasty, and FDA-approval of 2-level arthroplasty suggests that it is known to be safe and effective. (PX2).

18) As of the date of arbitration, Petitioner testified that she continued to feel pain even with medication. (T.25).

> My pain is in my right arm, my hand. Sometimes I have pain shoot down my leg to the toes where I have to have throbbing in my toes. My neck and my shoulder is keeping me from doing a lot of things that I want to do with this right hand. I'm mainly using my left hand; and mainly, when I lay down to go to sleep, I'm in pain because of the position that I have to lay in. (T.26).

19) Petitioner was presently taking Gabapentin and Tizanidine. (T.30). Petitioner intended to proceed with surgery in the near future. (T.25). Petitioner confirmed that no doctor has prescribed surgery for her right shoulder or right hand. (T.32).

20) Petitioner testified on cross-examination that she never had any previous injury to her neck or right shoulder. (T.28). She also did not have any subsequent injury to her neck or right shoulder following the January 10, 2017 accident. (T.28).

21) As to her work status, Petitioner stated that Dr. Hayes-Sharpley had kept her off work from the date of her first office examination to the present. (T.23; PX2; PX10). Petitioner testified that she provided the off-work slips to Respondent. (T.23). Petitioner's benefits were terminated on December 7, 2017. (T.24). She has not received money from any other source, and has not worked for any other employer since December 7, 2017 to the present. (T.24-25).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on January 10, 2017. The Arbitrator stated that Petitioner's trial testimony was self-serving, lacked credibility, was contradicted, and there was no credible evidence to support her claim. Specifically, the Arbitrator noted that the alleged sole witness to Petitioner's accident did not testify at arbitration, and the accident report was not offered into evidence; without this evidence, the Arbitrator stated there was nothing in the record to corroborate Petitioner's testimony as to her injury. The Arbitrator also noted that the initial medical records failed to mention a work injury; the Arbitrator further found suspect Petitioner's testimony that she had told Dr. Vielgo about the work accident.

The Commission finds that the same evidence called for by the Arbitrator to corroborate Petitioner's testimony regarding the accident, is the same evidence that Respondent could have offered to rebut Petitioner's claim that she sustained a work-related accident on January 10, 2017. This evidence, if available, was within Respondent's custody and control.

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. 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.* The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.*

In the case at bar, the Commission will not speculate on evidence not offered at arbitration. Here, Petitioner's unrebutted testimony was that she had been putting away stock comprising of frozen and dried goods, as she does on Tuesdays and Thursdays. After picking up a 50 to 75 pound box of frozen chicken legs on January 10, 2017, she felt a sharp pain in her right arm, right shoulder, and neck. Respondent offered no evidence to the contrary, no evidence to dispute Petitioner's job duties, as described, and no evidence demonstrating that her work activities on January 10, 2017 were not connected with or incidental to the employment. Therefore, the Commission finds that Petitioner met her burden of showing, by a preponderance of the evidence, that she suffered a disabling injury which arose out of and in the course of her employment on January 10, 2017.

The Commission further finds that any discrepancy within Dr. Vielgo's January 11, 2017 office visit note was clarified by Petitioner, who testified that she had informed Dr. Vielgo about her accident on that date. Any issues of credibility were sufficiently rebutted by Petitioner's testimony and by the evidence in the record. The office visit note from Advocate Medical Group, dated January 31, 2017, revealed that Petitioner had presented with carpal tunnel symptoms and radicular pain following a right arm injury "this month at work." The Commission notes that the

timeline and nature of Petitioner's complaints as presented in the medical records are consistent with Petitioner's testimony as to her injury on January 10, 2017. As such, the Commission finds that Petitioner sustained a work-related accident on January 10, 2017. The Arbitrator's Decision relative to the issue of Accident is hereby reversed.

The Commission further finds that Petitioner's neck, right shoulder, and right arm conditions are causally related to the accident. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982). Petitioner testified on cross-examination that she never had any previous injury to her neck or right shoulder. She also did not have any subsequent injury to her neck or right shoulder following the January 10, 2017 accident.

Following the January 10, 2017 accident, Petitioner experienced immediate pain in her right shoulder, right arm, and neck. The next day, on January 11, 2017, Petitioner sought treatment with Dr. Vielgo for her complaints of worsening pain and paresthesias in her right arm and hand. X-rays and an MRI were ordered, Petitioner was given a cortisone injection and Lidocaine patch, and she was referred to physical therapy and pain management.

X-rays of the cervical spine demonstrated arthritic changes at C6-7, but otherwise they were unremarkable. The MRI of the cervical spine, dated January 24, 2017, revealed significant herniation at C5-6 paracentral to the right; there was a broad-based C6-7 herniation with an associated foraminal component projecting cephalad [toward the head or anterior end of the body]; both herniations were compressing the cervical cord without associated myelomalacia or cord edema. An x-ray of the right shoulder, completed on January 16, 2017, was normal. Petitioner next consulted with neurosurgeon, Dr. Ryan Trombly; he reviewed the MRI, as well as the March 21, 2017 CT scan of the cervical spine. Dr. Trombly found nothing in the diagnostic imaging that required emergent surgery. Dr. Trombly had ordered a repeat MRI of the cervical spine which was completed on September 18, 2017; there were no significant changes since the prior study, and the disc protrusion at C6-7 had improved.

Given these findings, the Commission finds that Petitioner's condition as it relates to the cervical spine, right shoulder, and right arm to be causally related to the January 10, 2017 work-related accident. The Commission further notes that while the medical records refer to a possible carpal tunnel injury, the Commission does not find this condition to be causally related to the January 10, 2017 accident. Not only does Petitioner fail to claim or address this condition, but the medical evidence does not support a causal relationship. No physician opined that Petitioner's alleged carpal tunnel syndrome was causally related to the January 10, 2017 accident. Petitioner's treatment thus far has been centered on her cervical spine, which according to Dr. Trombly was the source of Petitioner's right arm pain and weakness.

Based on the evidence in its entirety, the Commission finds Petitioner credible, and that the record supports Petitioner's position that she sustained an accident arising out of and in the

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course of her employment on January 10, 2017, and that her cervical spine, right shoulder, and right arm condition are causally related to this work injury.

As such, the Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's Exhibit 8 and 9. Respondent offered no evidence to rebut the reasonableness and necessity of the bills.

The Commission further awards the epidural injection and the functional capacity evaluation as recommended by Dr. Wehner. However, the Commission finds that Petitioner is not entitled to the arthroplasty at C5-6 and C6-7 as recommended by Dr. Trombly. The Commission relies on Dr. Wehner in this regard, who found that Petitioner's clinical exam could not be reconciled with the radiographic findings of the cervical spine.

The Commission additionally awards TTD benefits to Petitioner from January 11, 2017 through the date of hearing, February 28, 2018. The medical evidence demonstrates that Petitioner was off work due to her work-related condition during this time period.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 2, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $368.80 per week for a period of 59 1/7 weeks, from January 11, 2017 through February 28, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $14,964.63 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibit 8 and 9 pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $4,629.02 for amounts paid under its group health plan under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the epidural injection and the functional capacity evaluation as recommended by Dr. Wehner.

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 other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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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.

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

DATED: DEC 4 - 2018
MJB/pm
O: 11-05-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

BELL, KATHERINE D
Employee/Petitioner

Case# **17WC009218**

CHICAGO PUBLIC SCHOOLS
Employer/Respondent

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

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

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

0059 BAUM RUFFOLO & MARZAL LTD
V ANDREW MARZAL
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0559 CHICAGO PUBLIC SCHOOLS
MICHAEL COHEN
ONE N DEARBORN ST SUITE 900
CHICAGO, IL 60602

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STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KATHERINE BELL,
Employee/Petitioner

Case # 17 WC 9218

v.

Consolidated cases: _____

CHICAGO PUBLIC SCHOOLS,
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 M. Harris, Arbitrator of the Commission, in the city of Chicago, on February 28, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 10, 2017**, Respondent was operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$28,824.10**; the average weekly wage was **$553.20**.

On the date of accident, Petitioner was 52 years of age, with 1 dependent children.

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

Respondent shall be given a credit of **$14,464.63** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,464.63**.

Respondent is entitled to a credit of **$4,629.02** under Section 8(j) of the Act.

ORDER:

PETITIONER FAILED TO PROVE SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON JANUARY 10, 2017. THEREFORE, HER CLAIM FOR COMPENSATION IS DENIED. ALL OTHER ISSUES ARE MOOT (EXCEPT EARNINGS).

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

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

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

Robert M. Harris

Robert M. Harris — March 29, 2018

Arbitrator — **Date**

APR 2 - 2018

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

Regarding disputed issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds the following facts and conclusions of law as detailed below. Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent on January 10, 2017. Petitioner's trial testimony was self-serving and lacked credibility, her trial testimony was contradicted and there was no credible evidence to support her claim.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro v. The Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). "'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Id.* at 203. "The 'arising out of' component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* at 203. Furthermore, a claimant must prove a compensable accident beyond a preponderance of the evidence, defined as "evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not." *Black's Law Dictionary* (6th ed. 1999). This is the evidence which is more "credible and convincing to the mind." *Id.*

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07,

459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

Applying the law to the case facts, Petitioner testified she was employed as a lunch room porter for the Chicago Public Schools for 17 years. She worked 10 months a year, 40 hours per week. She testified that her paystub, PX 11, was true and accurate. Petitioner testified that on January 10, 2017, while working in the kitchen, she felt a pain in her right arm while she was lifting a case of frozen chicken legs weighing 50-75 pounds. She bent down and came up with the box and sharp pain up her right shoulder to her neck. She dropped the box. The boxes were stock and ranged in weight from 50-75 lbs. Petitioner testified she continued working but went home later in pain in her right shoulder and arm. Petitioner testified she felt worse the next day.

Petitioner testified this accident was witnessed by her Manager, Gloria McIntosh. **However, inexplicably, McIntosh did not appear as a trial witness to provide any testimony to corroborate Petitioner's self-serving testimony that McIntosh witnessed this event.** The Arbitrator draws the inference that McIntosh's testimony would damage Petitioner's case. Nor did Petitioner offer any written statement by McIntosh to support her claim.

Petitioner specifically testified that an accident report was written up by her Principal, V. S. Thompson, and McIntosh was indicated as a witness in this report. However, inexplicably, **this accident report was <u>not</u> offered into evidence**. The Arbitrator draws the inference that this accident report (if it even exists) would damage Petitioner's case. Therefore, Petitioner's trial testimony regarding a key issue (that an accident report was created) was not corroborated.

Further, Thompson also did not appear as a trial witness to provide any testimony to corroborate Petitioner's testimony in support of her accident claim and the purported accident report. Nor did Petitioner provide to the Arbitrator any written statement from Thompson to support her accident claim. The Arbitrator draws the inference that Thompson's testimony would damage Petitioner's case.

On the following day, January 11, 2017, Petitioner sought medical care from her primary care physician, Arnolfo Vielgo, M.D. at Advocate Medical Group (AMG; PX 1 and PX 2). There is no dispute that the record entries of that visit do not contain any history of any work accident sustained on the prior day, January 10, 2017 (or on any other date). The indicated reason for the visit ("History of Present Illness") was that Petitioner "has pain from right side of her neck down to right shoulder and right arm with associated paresthesias of the right arm and right hand **X last 3-4 days.**" (PX, p. 147). Very significantly, **these records further indicate "no recent injury"** (PX 1, p. 147).

Also of great significance bearing on the issue of accident and Petitioner's credibility is that Petitioner specifically testified that she told Dr. Vielgo about this work accident at her January 11, 2017 office visit. But Dr. Vielgo disputes this assertion (see below).

X-rays of the cervical spine were also taken on January 11, 2017 (PX 1, p. 151). The "Clinical Indication" was **"Pain, no trauma."** There was no mention of any work injury or accident. X-rays of the cervical spine were taken also on January 11, 2017 (PX 1, p. 153). The "Clinical Indication" was **"Right shoulder pain."** There was no mention of any work injury or accident.

Petitioner offered no testimony or explanation as to why the separate X-rays taken on January 11, 2017 also make no mention of any trauma or accident. Apparently, Petitioner did not ask the radiologists who wrote the x-ray reports to change their records as she did with Dr. Vielgo.

Petitioner again visited Advocate Medical Group on January 13, 2017 with Dr. Carol Hayes-Sharpley (PX 1, 144-146). **The "Reason for Visit" makes no mention of any work injury** (...patient here today for a follow-up management of from right arm pain states still having pain seen 2 days ago.") Apparently, Petitioner did not ask this doctor to change her records.

Petitioner again visited Advocate Medical Group on January 17, 2017 with Dr. Patrice Burch (PX 1, 140-143). **The "Reason for Visit" again makes no mention of any work injury** (...patient here today for a chief complaint of [blank] pt saw her primary last month-states she has a pinched nerve and that's why arm is hurting-pt states her hand and knuckles has been swelling up with pain-denies injury.") **To the contrary, as was shown, this note indicates "denies injury." This is the third such similar treating medical records entry.** Apparently, Petitioner did not ask this doctor either to change her records.

The Arbitrator chooses to accept that these treating medical records accurately reflect what Petitioner actually told her treating medical providers – and specifically and especially that **Petitioner denied any trauma or injury**. One such entry ***might*** be in error, but not three, each worded slightly differently, with different providers, which strongly suggest these three entries were not merely "copy-and-paste" entries made in haste and sloppy error.

Later medical records do begin to show entries more related to an actual "accident" (but not all specifically mentioning an accident sustained at work).

The next note from Advocate Medical Group dated January 19, 2017 does indicate "shoulder injury and pain" but again makes no mention of any work injury and includes erroneous facts. Petitioner was seen at AMG in Rheumatology on January 31, 2017 (PX 1, p. 3). The History was, "…CTS symptoms in RT hand, Pain worse since injured on RT arm on 10th Jan." "PCP Acute Care Note" from February 10, 2017 indicates "Patient refeered [*sic*] here for CTS but has injured her arms this month at work as well new radicular pain…" The "Clinical Indication" for the cervical MRI makes no mention of any trauma or work injury. Advocate Medical Group "PCP Acute Care Note" from February 20, 2017, "History of Present Illness" indicates "F/U with shoulder injury – work related injury 1-10-2017 (pt. picked up 50-7olb frozen chicken parts, felt pop in r shoulder with pain)."

Purportedly at around this time, Petitioner somehow "discovered" that Dr. Vielgo had not recorded in his records her claimed on-the-job injury during her prior January visits. No evidence was introduced to explain how or why this was "discovered."

On the visit of February 23, 2017, Petitioner saw Dr. Vielgo to discuss this problem of the absence of any accident history (PX 1, p.111). Dr. Vielgo did not seem enthusiastic about this visit and Petitioner's request for him to change his records. Dr. Vielgo's record indicates, "patient seeing me today to discuss her previous visit with me on January 11, 2017. At that time, she was seen and evaluated for radicular-type neck and right shoulder pain radiated down the right UE and under right arm. At the time of this particular visit patient claims that she

stated that she was injured at work prior to the onset of her pain but was in so much pain, **she forgot to mention this.** Support staff chief complain notation and my clinical notes didn't mention this alleged injury but now patient believes that this alleged injury is the cause of her symptomatology... She is asking me today if I can change my clinical notes on her Jan 11 2017 visit to mention her alleged work injury." (PX 1, page 111.) There is no comment or explanation as to why she was in "so much pain" that she could provide an otherwise detailed history to the doctor but somehow fail to mention a work accident history - but was able to mention "no recent injury." Further, at this January 11, 2017 visit, the pain was indicated as "moderately severe" with no indication that this pain level impaired her ability to discuss everything else in detail. Yet further, her psychiatric exam showed that her "judgement not impaired" and she had "normal attention span", findings not indicative of such severe pain as to render her unable to recall a history of a work injury allegedly sustained only the day prior. Quite peculiar and not credible. The doctor also did not comment on that.

Dr. Vielgo further went on to indicate in the Plan portion of the report, "I had a long discussion with Patient that I will not change my clinical notes on January 11, 2017 to reflect or alleged work injury as this is now a permanent record. However I told her that I will include this information about her alleged work injury on today's clinical notes as she appears sincere and I do not have any reason to believe that she is malingering or providing any misinformation." (P X 1, p. 114).

The Arbitrator strongly emphasizes that Dr. Vielgo's above note directly contradicts Petitioner's trial testimony on a very key point: Assuming we believe Dr.

Vielgo, Petitioner told Dr. Vielgo at the time of this particular visit on February 23, 2017 that she stated to him during at her prior visit on January 11 that she was injured at work prior to the onset of her pain but she was in so much pain at her visit, **she forgot to mention this work accident to Dr. Vielgo.** In other words, Petitioner, in her own words to Dr. Vielgo on February 23, 2017, "forgot" to tell Dr. Vielgo at her January 11, 2017 visit that she was injured at work. **However, this statement directly contradicts Petitioner's (self-serving) trial testimony**, where she specifically testified that at her January 11, 2017 visit she told Dr. Vielgo about her work accident. But at her February 23, 2017 visit, she said she forgot to mention this accident to him on January 11. **Only one version can be correct; therefore, Petitioner was not truthful either at trial or with Dr. Vielgo.**

Even further, this obvious and problematic contradiction was not addressed – let alone explained away – at trial. Petitioner seeks to have this Arbitrator use and adopt Dr. Vielgo's records to support her claim, the same records that contradict Petitioner's trial testimony. The Arbitrator finds and concludes that Dr. Viego's records actually **rebut Petitioner's claims and call Petitioner's credibility into serious question.**

Lastly, and just as significant, Dr. Vielgo's February 23, 2017 notes and commentary regarding the absence of any work accident history does **not** address the very significant issue of why his notes do indicate **"no recent injury" and pain "X 3-4 days"** - both statements which rebut Petitioner's claims. The entry of pain for the past 3-4 days also suggests it is accurate and that, therefore, she had pain before the alleged date of injury, raising another problematic issue.

The Arbitrator reasonably assumes that the doctor did not randomly insert these two entries into his notes, but rather he accurately recorded what Petitioner actually told him.

Dr. Vielgo does not explain or discuss this very important issue in his February 23, 2017 records and apparently Petitioner did not ask him to do so. Significantly, and inexplicably, Petitioner never asserted that these two specific medical records entries are erroneous. These two entries actually corroborate each other and support the doctor's records which indicate nothing about any work accident.

Based on the above, the Arbitrator finds and concludes that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent on January 10, 2017. All other issues are therefore moot and need not be addressed (except for earnings)

Regarding disputed issue (G), what where the Petitioner's earnings?

The Respondent stated on the record that pursuant to its claim adjuster's calculation, the average weekly wage is in the amount of $516.87. Respondent offered no written documentation of this.

Petitioner testified that her rate of pay is $13.83 per hour and that she worked 40 hours a week. Petitioner calculated that her average weekly wage is in the amount of $553.20. The paystub indicates that her bi-weekly pay rate was $1,106.15. **The bi-weekly payrate of $1,106.15 divided by 80 hours of work is $13.83 per hour.** Petitioner identified as an exhibit her paystub for January 10, 2017, which verifies those earnings. (Pet. Exh. #11). Petitioner further testified that she is paid as are the teachers. This is on a 10-month school year.

Based upon *Washington District 50 Schools vs. the Illinois Workers' Compensation Commission, et al*, 394 Ill App 3d 1087, 917 NE 2d 586, 334 Ill December 760 (2009) and *Elgin Board of Education School District U-46 vs. Illinois Workers' Compensation Commission and Linda Weiler*; 409 Ill App 3d 943 (2011), the correct computation under Section 10 of the Act is based upon the 10 months of school earnings rather than on 12 months. The Arbitrator finds that the average weekly wage is $553.20.

Based on the above, Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent on January 10, 2017 and therefore her claim for compensation is denied.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: March 29, 2018

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

Angela McKillip,
Petitioner,
vs.

NO: 15WC 38230

18IWCC0738

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 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 $63,700.00. 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: DEC 4 - 2018

Michael J. Brennan

o112018
MJB/jrc
052

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKILLIP, ANGELA
Employee/Petitioner

Case# **15WC038230**

UNITYPOINT HEALTH
Employer/Respondent

18IWCC0738

On 12/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

4134 VanDERGINST LAW PC
JOHN H WESTENSEE
4950 38TH AVE
MOLINE, IL 61265

2119 CALIFF & HARPER PC
STEVEN L NELSON
506 15TH ST
MOLINE, IL 61265

18IWCC0738

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

ANGELA McKILLIP
Employee/Petitioner

v.

UNITYPOINT HEALTH
Employer/Respondent

Case # **15** WC **38230**

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, IL**, on **1/5/17**. 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 _____

18IWCC0738

FINDINGS

On **7/18/14**, 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 **$25,690.11**; the average weekly wage was **$494.06**.

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

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

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

Respondent 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 $39,221.90, as set forth in Petitioner`s exhibit 5, 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 $329.37/week for 25 5/7 weeks, commencing 4/20/15 through 10/15/15, 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 **$296.44**/week for a further period of **53.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **25% loss of 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.

Michael K. Nowak, Arbitrator

11/27/17
Date

ICArbDec p. 2

DEC 12 2017

FINDINGS OF FACT

Petitioner is claiming an Accident that occurred on 7/18/14 when she tripped over a sprinkler head on her way in to work that morning, injuring her left knee.

Petitioner testified that on 7/18/14 she was employed as a cook for Respondent, a hospital/medical center complex. At approximately 5:15 that morning, she was on her way into work. After parking in the parking area designated for employees, she was walking on the sidewalk toward the entrance door that she intended to use. Her intended path took her past the emergency room entrance doors. She was walking to the far left side of the sidewalk but never stepped off the sidewalk. She walked on the far left of the sidewalk to avoid sensors that would cause the ER doors to open if she walked on the middle or right side of the sidewalk. While so walking she tripped over a malfunctioning sprinkler head located next to the sidewalk, that was sticking up out of the ground several inches. Petitioner fell, landing on the cement sidewalk on her knees, primarily injuring her left knee.

Photographs of the scene were provided by the Petitioner showing Petitioner's intended path into work and the proximity of the sprinkler head to the sidewalk (Pet.Ex.#6).

Petitioner testified that after ascertaining what had caused her to fall, she continued on in to work, reported her fall and injuries to her supervisor, and filled out a work repair order on the sprinkler head. She subsequently had a discussion with the maintenance man who confirmed that the sprinkler head was broken. Eventually the sprinkler head was moved from that location. Petitioner's testimony was unrebutted.

Petitioner testified that she initially assumed that she had just scraped her knee and would recover but when she continued to be symptomatic, she went to Human Resources and asked to see a doctor. Human Resources referred to Occupational Health where she came under the care of Dr. Patricia Dunbar beginning 9/30/14.

Medical records of Occupational Health show that when Petitioner presented to Dr. Dunbar on 9/30/14 she gave a history of falling to her knees on concrete after tripping on a raised sprinkler head on her way into work on 7/18/14. She reported that her right knee symptoms had dissipated but she was continuing to have catching and persistent increasing pain in the left knee. X-rays showed decreased joint space medially, degenerative changes and a loose body posteriorly. Dr. Dunbar felt that the exam showed focal findings suggestive of meniscal pain. She prescribed therapy, work restrictions, a knee brace and anti-inflammatory medication. (Pet.Ex.#1).

Medical records show that Petitioner continued to treat with Dr. Dunbar until 10/29/14. Records for that office visit show that the Petitioner's condition was deteriorating and Dr. Dunbar referred her to an orthopaedist specialist, Dr. Tuvi Mendel. (Pet.Ex.#1).

All of Dr. Dunbar's office records indicate that her treatment of the Petitioner's left knee was related to the accident of 7/18/14 (Pet.Ex.#1).

On 1/27/15 Respondent sent Petitioner to Dr. Waqas Hussain for an examination pursuant to section 12 of the Act and Dr. Hussain opined that there was no causal connection.

Prior to offering surgery, Dr. Mendel stated in his office notes for 4/7/15 that the Petitioner had failed conservative care. Further, while he did recommend weight loss Petitioner was having a difficult time with that due to her knee discomfort. He noted that she was continuing to complain of pain 2 to 6 on a scale of 1 to 10 that she localized to the anterior and anterolateral aspect of her knee, as well as medial joint line pain. (Pet.Ex.#2b). Dr. Mendel offered and performed surgery on 5/7/15. Petitioner underwent left knee surgery consisting of a partial medial and lateral meniscectomy, patellofemoral compartment chondroplasty, lateral release, and arthroscopically-assisted open medial placation. She continued under Dr. Mendel's care until he released her to return to work 10/16/15. (Pet.Exs.#2a-2c).

In summary, Petitioner fell on 7/18/14 and injured her left knee. She immediately reported the accident. She denied any treatment, complaints or injuries to her left knee prior to the fall. Medical treatment began 9/30/14 with Dr. Dunbar, a doctor selected by the Respondent. Respondent initially accepted the injury and paid benefits until 1/27/15 when Respondent sent Petitioner to Dr. Waqas Hussain for an examination pursuant to section 12 of the Act and Dr. Hussain opined that there was no causal connection. Petitioner's treating orthopaeic surgeon, Dr. Tuvi Mendel, was not a doctor selected by the Petitioner but was rather a referral from the initial doctor that Respondent had selected. In Dr. Mendel's opinion the fall of 7/18/14 aggravated an underlying pre-existing condition which necessitated arthroscopic management.

CONCLUSIONS

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

Respondent's position is that the fall did not arise out of and in the course of the Petitioner's employment, contending that the Petitioner had removed herself from the course of her employment. Respondent offers the Illinois Third District Appellate Court case of *Danielle Hanson vs. Trinity Express Care*, 3-12-0989WC, in which injuries sustained by employee Hanson were found to have not arisen out of the course of her employment. Employee Hanson was injured when, after arriving at her work desk, she discovered that she had left her computer passwords in her car. Claimant proceeded to her car to retrieve the passwords by retracing her steps and exiting the building through the employee exit but then did not use the sidewalk but rather took a direct route to her car by crossing over the sidewalk, walking across a grassy area to a retaining wall and jumping down to a grassy area below. On her way back to her desk she injured her left knee when she attempted to climb up the retaining wall. The Arbitrator found in favor of Hanson but was reversed by the Commission, and the reversal was upheld by both the Circuit Court and the Appellate Court on the basis that Hanson's injuries resulted from her voluntary decision to take an increased personal risk by taking the shortcut to her car as jumping off and on a retaining wall as opposed to using the sidewalk provided by Respondent for its employee's ingress and egress.

The fact situation of *Hanson* is not similar to the facts of the case at hand in that Petitioner McKillip did not deviate off the sidewalk. After parking in the designated parking area, she was walking on the sidewalk of

Respondent's premises toward the door she would enter to go to her work station, when the defective sprinkler head tripped her and caused her to fall.

In summary, on the morning of 7/18/14, after parking in the employee designated parking area, Petitioner proceeded to walk her customary route into the building to begin her shift, by walking on the left side of the sidewalk, close to the grass but not walking on the grass itself, when a malfunctioning sprinkler head, that should have been underground but was, in fact, protruding from the ground, caught her left foot, causing her to trip and fall, landing on her knees on the cement sidewalk, and causing injuries to her left knee.

Based upon the foregoing and the record taken as a whole, Arbitrator finds that on 7/18/14 the Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent.

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

Petitioner sustained a left knee injury on 7/18/14 as the result of a fall on her way into work when she tripped over an exposed sprinkler head. She testified that she reported the accident and injuries to her supervisor that same morning. These facts are unrebutted.

In denying liability Respondent is relying upon the report of Dr. Waqas Hussain, dated 1/27/15. In Dr. Hussain's opinion the Petitioner's symptoms were due to pain from her preexisting arthritis, not the fall of 7/18/14. Dr. Hussain also did not agree with the surgery proposed by Dr. Mendel, feeling that the Petitioner would benefit from other avenues of conservative care and weight loss. (Def.Ex.#3)

With regard to causal connection Dr. Mendel provided a narrative report stating that in his opinion the fall aggravated Petitioner's underlying pre-existing condition which necessitated the arthroscopic management. However, he did not feel that Petitioner's eventual need for a total knee replacement was related to the fall. (Pet.Ex.#2d)

The Arbitrator finds the opinions of Dr. Tuvi Mendel more persuasive than the opinions of Dr. Hussain in this case.

Based upon the foregoing and the record taken as a whole, Arbitrator finds that Petitioner's current condition of ill- being, including the surgery that she underwent on 5/7/15, is causally related to the accident of 7/18/14.

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 initially accepted this claim and paid medical benefits up to the 1/27/15 report of Dr. Waqas Hussain and thereafter terminated benefits. After benefits were terminated Petitioner processed the bills through her spouse's group medical insurance, which has asserted a lien.

Petitioner is claiming entitlement to payment of medical bills totaling $39,221.90. (Pet.Ex.#5).

Respondent referred Petitioner to Occupational Health, where she was first seen by Dr. Patricia Dunbar 9/30/14. After conservative care failed Dr. Dunbar referred the Petitioner to orthopaedist Dr. Tuvi Mendel in

October of 2014. (Pet.Ex.#1). Petitioner began treating with Dr. Tuvi Mendel of Orthopaedic Specialists on 11/7/14. Dr. Mendel offered and performed surgery on 5/7/15. She continued under Dr. Mendel's care until he released her to return to work 10/16/15. (Pet.Exs.#2a-2c). Surgery was performed 5/7/15 at Trinity Medical Center following pre-op testing on 4/24/15 which included an EKG read by Dr. Snyder (Pet.Exs.#4a&4b). Petitioner also had one office visit with her family doctor, Dr. David Gannon, on 2/4/15 during which she complained of left knee pain (Pet.Ex.#3). This was the Petitioner's only medical provider choice.

Based upon the foregoing and the record taken as a whole, Arbitrator finds that Petitioner is entitled to payment of her bills as submitted at trial for reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act, including reimbursement of her out of pocket payments, with the exclusion of any medical bills incurred for treatment of Petitioner's left ankle.

Respondent shall pay reasonable and necessary medical services of $39,221.90, as set forth in Petitioner's exhibit 5. 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?

Petitioner is claiming that she is entitled to TTD benefits for the 25-5/7 week period 4/20/15 through 10/15/15 (Arb..Ex.#1). Petitioner testified that she was off work beginning with April 20th, 2015, and that she was released to return to work on October 16th, 2015. Respondent agreed to the TTD dates but denied liability (Arb.Ex.#1).

Medical records show that when Petitioner saw Dr. Mendel on 4/7/15, the doctor offered surgery and she agreed (Pet.Ex.#2b). On 4/13/15 Petitioner requested that Dr. Mendel complete FMLA paperwork so that she could be off work for three months beginning 4/22/15 and he complied (Pet.Ex.#2c). On 5/7/15 Petitioner underwent surgery (Pet.Ex.#4a). Work slips signed by Dr. Mendel dated 7/22/15 and 9/2/15 show that he kept the Petitioner off work until 10/16/15 (Pet.Ex.#2c).

Based upon the foregoing and the record taken as a whole, Arbitrator finds that Petitioner is entitled to payment of 25-5/7 weeks of TTD benefits for the period 4/20/15 through 10/15/15.

Respondent shall pay Petitioner temporary total disability benefits of $329.37/week for 25 5/7 weeks, commencing 4/20/15 through 10/15/15, 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 neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed by Respondent as a cook. Petitioner testified that when she contacted the Respondent to return to work with her medical release on 10/16/15 she was told that her job had been filled and that she had 30 days to find a new job within the system. In that Petitioner was a cook and Respondent is a hospital/medical center she was unable to locate a position with Respondent and then drew unemployment. She testified that she looked for work within her restrictions but the only work that she could find was a job caring for seniors. She worked the senior care job for about four months between May and September of 2016 but was unable to tolerate it and had to quit. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at time of hearing and 46 years old on the date of accident. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner had begun working for Respondent, a hospital/medical center complex, in July of 2010 as a cook. She denied any accidents, treatment or complaints regarding either of her knees prior to the accident of 7/18/14. On 5/7/15 Petitioner underwent left knee surgery, specifically a partial medial and lateral meniscectomy, patellofemoral compartment chondroplasty, lateral release, and arthroscopically-assisted open medial plication (Pet.Ex.#4b). Petitioner also had hardware in the form of retained sutures removed from the ankle, which was not work-related (Pet.Ex.#4b). Post-operative diagnoses were left knee pain with internal derangement, medial and lateral meniscus tears, patellofemoral subluxation, status post lateral ligament reconstruction, retained hardware painful due to sinus tarsi pain (not related to this accident) (Pet.Ex.#4b). Petitioner was restricted off work before and after the surgery from 4/20/15 through 10/15/15, a total of 25-5/7 weeks. Dr. Mendel gave her permanent restrictions of no lifting over 20 pounds, and sit and stand as needed. At her last office visit of 9/2/15, prior to being released to return to work by the treating surgeon, Dr. Mendel noted that Petitioner was continuing to have significant pain and dysfunction, that X-rays showed moderate medial compartment and significant patellofemoral wear, that he felt that she had failed injections, arthroscopy, anti-inflammatories and physical therapy, and that while she was young for a total knee replacement she would return to see him if she elected to proceed surgically. Petitioner testified that she has recently returned to Dr. Mendel for further care as she is having more knee pain. She testified to residual complaints of pain and swelling in her knee; inability to extend or flex her left leg; difficulty and increased pain with bending, stooping, walking and kneeling; she avoids stairs as they increase her symptoms. Dr. Mendel had told her that the next step would be a total knee replacement, which is confirmed in Dr. Mendel's office records for 9/2/15 (Pet.Ex.#2b). 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 25% loss of use of the left leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rowdy Burris,

Petitioner,

vs. NO: 14WC 29156

State of Illinois/Choate Mental Health Center,

Respondent.

18IWCC0739

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, 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).

Per the agreement of the parties, the December 15, 2017 arbitration hearing related to issues involving the cervical spine only. All issues relative to the lumbar spine were deferred to a later date. Accordingly, the Commission has affirmed and adopted the Decision of the Arbitrator as it relates to the cervical spine. No finding has been made relative to the lumbar spine.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2018 is hereby affirmed and adopted.

18IWCC0739

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

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

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

No bond or summons required for State of Illinois cases.

DATED: DEC 4 - 2018
o112018
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BURRIS, ROWDY
Employee/Petitioner

Case# **14WC029156**

SOI/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0739

On 3/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62946

0558 ASSISTANT ATTORNEY GENERAL
SHANNON RIECKENBERG
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAR 5 - 2018

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

18IWCC0739

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

ROWDY BURRIS
Employee/Petitioner

v.

Case # 14 WC 29156

Consolidated cases: _____

STATE OF ILLINOIS / CHOATE MENTAL HEALTH CENTER
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 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 cervical condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$608.32**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

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

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

ORDER

The Petitioner has failed to prove by the preponderance of the evidence that his cervical condition of ill-being is causally related to July 29, 2014 accident.

No benefits are awarded with regard to the cervical spine.

The parties have stipulated that the December 15, 2017 hearing was exclusively directed to issues involving the Petitioner's alleged cervical spine condition, and that all issues related to the lumbar spine are deferred by agreement.

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

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

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

Signature of Arbitrator

March 2, 2018
Date

MAR 5 - 2018

STATEMENT OF FACTS

On 7/29/14, the parties stipulated that the Petitioner sustained accidental injuries to the lumbar spine which arose out of and in the course of his employment with the Respondent. Based on the Respondent's accident documentation (Rx1 to Rx4) and various medical reports in evidence, this occurred when he was moving furniture down some stairs. The parties also agreed on the record that any issues that may exist regarding the Petitioner's lumbar spine are deferred with regard to the 12/15/17 hearing, and that the current hearing is limited to the issues of causal connection, medical expenses and prospective medical treatment involving the cervical spine. The parties have also agreed on the record that, as of the date of hearing, all due and owing temporary total disability benefits have been paid by Respondent with no underpayment or overpayment.

The Petitioner testified that he began to have cervical spine problems approximately one or two weeks prior to his second post-accident lumbar surgery, which occurred on 8/31/16. He did not testify to any specific date that this occurred. He testified that, as to his low back: "I was in so much pain that it had my body in a strain, like a tension, and all I was doing was pulling myself up out of bed. And when I got to the edge of the bed, I had a pain run up the back of my ear and the side of my face and down my (right) arm. And since then, it's went into my left arm." The left arm will go numb all the way to his hand.

Petitioner testified that he was on his back on the edge of his bed, took hold of a dresser he had at the edge of the bed and hurt himself with the strain of pulling himself up to get his feet on the floor. He testified his body was in a "ball of tension" and in "tremendous pain", and that trying to protect his back when he was getting up is what caused his neck and arm symptoms. He testified the dresser was somewhat above his bed level, and he grabbed it with his right hand while his arm was at an approximate 90 degree angle at the elbow in order to pull himself up.

On cross exam, Petitioner testified he was on the right side of the bed when he pulled himself up with the dresser. He now rolls to his right to get out of bed, and does so carefully or he will feel increased pain down his arms. As to how long he had been pulling himself out of bed using the dresser, Petitioner testified: "for a while." He agreed he could have exited his bed on the left side.

The records in evidence reflect that the Petitioner treated with Dr. Jones' office on numerous occasions for his lumbar condition after the work accident and prior to the onset of cervical symptoms. (Px3). As noted, the Arbitrator's focus in this case is the cervical spine. The Arbitrator notes that in his review of the medical records in evidence, there is no indication of neck or arm complaints in Dr. Jones' records until September 2016.

On 7/29/14, an Initial Workers' Compensation Medical Report was completed by Petitioner's physician, referencing a lower back strain occurred that day. (Rx4). On 1/26/15, the Petitioner underwent an L1/2 microdiscectomy with L2 hemilaminectomy and medial facetectomy and foraminotomy at L1/2 and L2/3 with Dr. Jones. The diagnosis was L1/2 disc herniation with an extruded fragment and severe lateral recess stenosis. (Px3).

On 12/3/15, Petitioner attended a Section 12 examination at the Respondent's request with Dr. Robson. The doctor opined the reported 7/29/14 accident was an aggravating factor in Petitioner's low back pain, L1/2 and L4/5 herniations and bilateral lumbar stenosis at L5/S1. He determined that the surgical procedure and injections were reasonable and necessary treatment. There were no noted cervical complaints or cervical examination. (Rx5).

The records subsequent to that date reflect ongoing low back and/or radicular-type complaints until a second lumbar surgery that took place on 8/31/16. This second surgery involved an L4/5 hemilaminectomy, foraminotomy, facetectomy and microdiscectomy with excision of scar tissue. (Px3).

On 9/16/16 or 9/20/16, Petitioner presented to Dr. Jones with both neck and low back pain. This was the first reference the Arbitrator saw in the medical records to cervical symptoms. Dr. Jones' assistant Angela Arnold indicated Petitioner's cervical pain was improving, but at the same time stated: "Unfortunately, he is also having worsening posterior neck pain and right upper extremity pain which radiates into the hand and sounds like an acute cervical radiculopathy." While a cervical MRI was planned, Petitioner could not yet obtain one due to the recent lumbar surgery. Nothing was indicated as to a date of cervical onset or any alleged cause for such onset. (Px3).

On 10/25/16, Petitioner returned to Dr. Jones for cervical and lumbar spine pain. The cervical symptoms were severe and noted to be "chronic non-traumatic." The Arbitrator notes that Dr. Jones' standard reports tend to repeat the same history at each visit as to symptoms and status, before sometimes later in the report noting more specific findings from that date. At this visit, the note states that Petitioner reported being unable to tell how much pain he had due to being on pain medications. The report goes on to state: "Prior to surgery he was trying to get out of bed and due to the pain in his back and leg he pulled himself out of bed with his right arm trying to take the weight off of his back and got pain in his neck and down his right arm." Due to a lack of improvement with conservative treatment, Dr. Jones recommended an MRI of the cervical spine to determine if surgery was indicated. (Px3).

On 11/14/16, Petitioner began physical therapy with Elite Physical Therapy as referred by Dr. Jones. (PX3). The therapy was to address his low back pain, radiating into his lower right extremity, and the notes do reflect history of neck pain as well. This treatment continued through 2/3/17, with a total of 32 visits. None of these records appear to show any treatment to the cervical spine or upper extremities. (Px4).

On 1/3/17, Petitioner returned to Dr. Jones with complaints of both cervical spine and lumbar spine pain. For the cervical spine, he noted significant neck and right arm pain. Dr. Jones noted the symptoms were "chronic traumatic." He was in therapy for the cervical and lumbar spines. Petitioner's right arm pain continued. A cervical MRI was again prescribed. (Px3).

On 2/15/17, Petitioner underwent an MRI of his cervical spine, and the impressions included severe neural foraminal narrowing at C4/5 on the right and C5/6 bilaterally, along with moderate to severe narrowing at C3/4 and C6/7, both on the left. There was also mild to moderate spinal canal narrowing at C4/5 and mild narrowing at C5/6 and C6/7. Mild grade 1 retrolisthesis was present at C4 on C5 and suggestion of a muscle spasm. (Px3).

On 3/7/17, Petitioner returned to Dr. Jones for complaints of both cervical spine and lumbar spine pain. Cervical symptoms were noted to be chronic and non-traumatic. Petitioner described his symptoms as worse and severe, including being discomforting and aching. He indicated only short-term benefits from physical therapy. A referral was offered for cervical epidural steroid injections, as well as piriformis injections for the continued leg discomfort. (Px3).

On 4/13 and 4/27/17, Petitioner presented to the Pain Management Center for piriformis injections in the lumbar spine. It was noted that Dr. Jones's assistant PA Arnold had also requested an evaluation of neck pain and possible cervical epidural, but that workers' compensation was denying any cervical interventions. (Px5).

On 7/11/17, the Petitioner was re-examined by Dr. Robson at the Respondent's request related to his cervical spine complaints. Petitioner reported he had no history of neck pain prior to 7/29/14, and did not report any neck pain at the

time of the accident. Petitioner stated: "the first time he had persistent neck pain was a couple days prior to his second back surgery in August of 2016 when he was pulling himself out of bed while at home." Petitioner reported this caused severe neck and radiating right arm pain, pain in the side of his right ear and face, and that this had progressed into numbness on the left side. He also noted some right shoulder pain. Petitioner had a reduced cervical range of motion and tenderness to palpation. Neurologic exam was essentially normal. Dr. Robson reviewed the 2/15/17 cervical MRI films, noting a central and right sided C4/5 disc protrusion producing foraminal narrowing, a central C5/6 disc protrusion producing bilateral foraminal narrowing, and a left C6/7. Dr. Robson opined that the 7/29/14 injury was not the "prevailing factor" in the Petitioner's development of neck pain, noting his review of the records didn't indicate any complaints of neck pain until he was trying to get out of his own bed at home a couple of days prior to his second lumbar surgery. He states that "there is no possible way to link his cervical spine complaints to the date of injury of 7/29/14." Dr. Robson diagnosed cervical spondylosis with multiple herniations from C4 to C7, and indicated that he might need further cervical treatment, possibly surgery, due to his degenerative condition. (Rx6).

On 7/21/17, Petitioner returned to Dr. Jones for complaints of both cervical spine and lumbar spine pain, and Petitioner reported he was worse in both areas. Dr. Jones noted he had degenerative changes in the neck and back which could lead to significant pain. Regarding the lower body, Dr. Jones believed Petitioner might be suffering from piriformis syndrome. (Px3).

On 9/1/17, Petitioner returned to Dr. Jones for complaints of both cervical spine and lumbar spine pain. Dr. Jones noted that the Section 12 medical examiner did not believe that the neck injury was related to the back injury, and that cervical treatment would therefore continue based on these findings, assumedly meaning outside of workers' compensation coverage. Given worsening symptoms and pain that was now in the left arm, Dr. Jones prescribed a repeat cervical MRI. Due to ongoing back pain, lumbar MRI was also recommended. (Px3). At some point around this time, as Petitioner testified, Dr. Jones generally issued separate reports for the cervical and lumbar conditions.

On 9/21/17, the parties obtained the deposition of orthopedic surgeon Dr. Robson. Other than what he had previously noted in his report, his testimony essentially indicated that he saw no way that the Petitioner's cervical condition could be connected to the 7/29/14 accident given that the Petitioner had no cervical complaints until approximately two years after that accident, and given the onset was due to getting out of bed "awkwardly" at his home in August 2016. His MRI showed an "insidious degenerative process" that had probably been ongoing for many years, possibly even before the 7/29/14 accident, and "I didn't see that any injury even made this condition symptomatic or aggravated it." In his opinion, any cervical treatment would not be related to the accident. (Rx7).

On 9/26/17, the parties took the deposition of neurosurgeon Dr. Jones. Dr. Jones testified that he recalled speaking with the Petitioner about his cervical complaints on the day of his second lumbar surgery, 8/31/16, prior to the start of surgery. He testified that the Petitioner at that time described the onset as occurring when he went to get out of bed using his arm in some way because of the pain in his back. Dr. Jones testified he wasn't sure how the Petitioner was pulling himself since he wasn't present at the time, but that Petitioner reported that this is when his neck and arm pain began. He also testified: "if I'm remembering correctly, I think he brought it up to me in the hospital before his second surgery at L4/5. . . And I usually don't remember these things, but, of course, with this it kind of sticks out in your mind." (Px6).

Dr. Jones advised Petitioner that even if he did something to is neck, chances were that it would go away with time. He testified that, even assuming it was a herniated disc, "80% of them go away on their own anyway, so we would do some physical therapy and stuff after." He agreed he did not document this conversation in his records until his 10/25/16 note. He believed that the Petitioner had therapy for both the back and neck after the 8/31/16 surgery based on his 1/3/17

note indicating improvement with therapy, though he still was reporting significant neck and arm pain. It appeared that the Respondent was denying authorization of his recommended cervical MRI. (Px6).

After reviewing the 2/15/17 cervical MRI, Dr. Jones testified that he C4/5 and/or C5/6 could explain the Petitioner's right arm symptoms. C4/5 was "pretty degenerated", and he had severe C4/5 and C5/6 foraminal stenosis bilaterally ("it wouldn't take much probably to push him over the edge"). The current recommendation is for epidural injection. but he has findings that may eventually lead to surgery, though fusion is unlikely unless there was instability. He agreed he saw no large disc herniations or instability, and that most of what he saw on the MRI was degenerative in nature, though he indicated Petitioner could have some smaller herniations. Dr. Jones had no legal opinion in the case, but testified that the Petitioner's story was that he was getting out of bed in an abnormal way by pulling himself up mostly with his upper body due to severe back pain, "so its related in that way. . . let me put it that way." Given no evidence of prior cervical complaints, but a preexisting degenerative condition, "if this was anything, it would be an exacerbation of a pre-existing condition." He believes the Petitioner's symptomatic complaints "unless he was really good at getting on Google and coming up with this stuff on his own." (Px6).

On cross examination, Dr. Jones agreed he didn't know the date when the Petitioner alleges he tried to pull himself out of bed and hurt his neck. He agreed that his assistant Angela didn't note anything about the bed incident when she saw him on 9/16/16, but Jones reported this when he himself next saw Petitioner on 10/25/16. He agreed he didn't ask Angela to document it. His specific diagnosis was degenerative disc disease at C4/5 and C5/6 with severe foraminal stenosis and central canal stenosis. Dr. Jones could not identify an acute injury on the cervical MRI, but reiterated his opinion that it would be an exacerbation injury, as he did not see the "whopper" herniation he expected to see, and compared Petitioner's injury to a whiplash type of injury where "you know, you get this stirred up and then you just can't get rid of it." The doctor agreed the degenerative findings were longstanding, but that Petitioner had reported no pain prior to the incident getting out of bed. (Px6).

On 8/26/16, a Physical Examination form was completed by a Dr. Smith. When asked, "Do you have any problem that would interfere with your ability to do this job?" the answer entered, apparently from Petitioner, indicated "Yes" and "Low back pain." Nothing was indicated regarding the cervical spine. (Rx8). On 8/31/16, a History and Physical Examination Update form was completed by Dr. Jones at Herrin Hospital in anticipation of surgery. At his deposition, Dr. Jones testified he sees his surgical patients prior to starting the operation to make sure nothing had changed symptomatically. He agreed that if Petitioner had been experiencing cervical spine issues on that date, it probably should have been indicated on that form. When asked why they weren't, Dr. Jones stated, "I mean we basically just sign it. We don't do much with it", and that he normally would only indicate "big stuff" on the form that could potentially interfere with the surgery itself. (Px6; Rx9).

On 10/20/17, Petitioner returned to Dr. Jones for complaints of cervical spine pain. Cervical x-rays showed evidence of diffuse cervical spondylosis with loss of lordosis and severe degenerative changes at multiple levels, most significantly at C4/5 and C5/6 with anterior osteophytes complexes, and Dr. Jones noted evidence of possible foraminal narrowing. Petitioner was again prescribed as MRI, and physical therapy was added. (Px3).

On 11/27/17, Petitioner returned to Dr. Jones, noting his insurance was continuing to deny cervical MRI. Dr. Jones noted all conservative treatment had been completed. Noting he couldn't determine if there are any concerns about central canal stenosis or worsening foraminal stenosis "which may be contributing to his increasing difficulty with posterior neck pain and upper extremity pain and paresthesias", Dr. Jones stated that the MRI was needed to determine the Petitioner's treatment plan as he had exhausted conservative treatment. (Px3).

Petitioner underwent a cervical MRI on 12/11/17, and the impression was: neuroforaminal narrowing at C4/5 on the right, C5/6 bilaterally, and C6/7 on the left. Compared to 2/15/17 films, stenosis had progressed at left C6/7. There was moderate to severe narrowing at C3/4 on the left, and at C6/7 on the right which had slightly progressed. Also noted was mild to moderate spinal canal stenosis at C4/5, mild at C5/6 and C6/7. Mild grade 1 retrolisthesis was present at C4 on C5 and suggestion of muscle spasm. (Px3).

In his testimony, the Petitioner noted the recent cervical MRI, and that he wants to continue treating for the cervical spine with Dr. Jones. Petitioner testified he has not gone hunting since prior to the 7/29/14 accident. He testified that he "piddles" with antique cars, but isn't able to do much. He remained off work at the time of the hearing due to his lumbar spine.

On cross examination, the Petitioner denied any prior cervical/neck problems. His initial symptoms were in the right arm, and the left arm symptoms started maybe a week later. There was no specific activity that triggered the left arm symptoms. He initially testified that he first discussed the incident getting out of bed with Dr. Jones on the day he had his lumbar surgery, after he had gone to post-surgical recovery. He then testified he discussed it "Very little at that time when I was in the hospital, but I have since then, yes." He testified he initially would discuss his neck during his low back visits: "In the beginning, it was kind of when I was in for my lower back, we would talk about it, but that's no longer. I can't do that now. We don't do that now." Now, his lumbar and cervical conditions are being addressed separately by Dr. Young.

CONCLUSIONS OF LAW

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

Petitioner's alleged injury to his cervical spine occurred at his home in August of 2016. The alleged injury occurred at a time Petitioner was off work and receiving TTD for an accepted injury to his lumbar spine. No specific date of this alleged cervical injury was provided. At trial, Petitioner indicated the injury occurred a week or two prior to his 8/31/16 surgery. In his deposition, Dr. Robson's report indicates the injury occurred only a couple days before the surgery. Dr. Jones testified that the two discussed it the day of the second lumbar surgery, but he was unable to say when the alleged incident of getting out of bed occurred. A discussion between Dr. Jones and Petitioner about a neck injury was not documented in Petitioner's medical records until 10/25/16. Petitioner discussed cervical complaints with Dr. Jones' PA Arnold on 9/16 or 9/20/16, but nothing was documented with regard to how or when those symptoms began at that time or in the 10/25/16 report of Dr. Jones.

Respondent's Exhibits 8 and 9 from 8/26/16 and 8/31/16, respectively, do not contain any mention of cervical spine pain or an injury of any kind. Throughout the reports of Dr. Jones, Petitioner's cervical issues are characterized as chronic and non-traumatic, which is supported by the findings on both of Petitioner's cervical MRIs. The actual cervical pathologies noted appear to be degenerative and longstanding, which is acknowledged in Dr. Jones' testimony, as well as that of Dr. Robson.

There were no witnesses to the alleged incident. The incident occurred at the Petitioner's home, not at work. Petitioner did not report and could not recall the date upon which the alleged incident occurred. At no time from the date of accident through August 2016 is there any indication of cervical complaints, or that the cervical spine was injured at the time of the original accident.

As noted, both Dr. Jones and Dr. Robson agree that Petitioner's degenerative issues in his cervical spine likely preexisted even the 7/29/14. Dr. Jones believes Petitioner's attempt to pull himself out of bed constituted an exacerbation of this degenerative condition. However, Dr. Jones did not testify as to how the Petitioner's attempt to get himself out of bed somehow injured his neck. He testified that he did not know what the Petitioner's specific alleged mechanism of injury was, and thus it is difficult to understand how he therefore commented on causation in a persuasive way. Neither his reports nor those of Dr. Robson reference any specifics as to exactly how the Petitioner reported he was trying to get out of bed or how such activity may have anatomically impacted the cervical spine. It appears he relied on a chain of events type of analysis – i.e., the Petitioner had no neck symptoms, an event occurred, and he then developed symptoms. However, his inability to describe how the neck may have been injured via the described activity is lacking in the testimony of Dr. Jones. Taking this along with the fact he did not know when the actual incident occurred results in his opinion not being persuasive to the Arbitrator by the preponderance of the evidence.

Dr. Robson and Dr. Jones both indicated that the abnormal findings on cervical MRI did not reflect an acute injury. Dr. Jones testified that he was expecting to see a large herniation to support Petitioner's ongoing complaints but did not. Dr. Robson opined that it was not possible for Petitioner's action of getting out of bed to be linked to his work injury of 7/29/14.

The Arbitrator finds that the preponderance of the evidence does not support a causal connection between the 7/29/14 accident, and resulting lumbar condition, and the Petitioner's current cervical condition. As such, with regard to the cervical spine, benefits are denied. As noted above, any findings regarding the lumbar spine have been deferred.

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

Based on the Arbitrator's findings with regard to cervical causation, medical expenses related to cervical and upper extremity treatment are denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to cervical causation, prospective cervical treatment is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eugene Mazur,

Petitioner,

vs.

NO: 13 WC 29524

City of Chicago,

Respondent.

18IWCC0740

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(s) of causal connection and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

18IWCC0740

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

DATED: DEC 4 - 2018
SJM/sj
o-11/15/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAZUR, EUGENE
Employee/Petitioner

Case# **13WC029524**

CITY OF CHICAGO
Employer/Respondent

18IWCC0740

On 3/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
KEVIN REED
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS) 18IWCC0740
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Eugene Mazur
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13** WC **29524**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **October 25, 2017 and January 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 18, 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 **$90,415.99**; the average weekly wage was **$1,738.75**.

On the date of accident, Petitioner was **56** 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 **$67,400.16** for TTD, **$0** for TPD, **$215,614.92** for maintenance, and **$0** for other benefits, for a total credit of **$283,015.08**.

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

ORDER

Respondent shall pay Petitioner permanent and total disability benefits of $1,159.17 per week for life, commencing December 23, 2017 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.

#001 George J. Andros

Signature of Arbitrator

March 15, 2018

Date

Findings of Fact and Conclusions of Law 13 WC 029 524

In regards to "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 the following facts:

Petitioner sustained a lifting injury on April 18, 2013. He was evaluated at Mercy Works that day and saw Dr. Dragisic, his family physician, on April 19, 2013. Dr. Dragisic noted a "massive right inguinal hernia 10 +cm circumference…" and referred Petitioner to Dr. Vossoughi, a general surgeon. (PX7) (PX1).

On July 31, 2013 Petitioner had surgery at Little Company of Mary Hospital by Dr. Vossoughi. This surgery was a hernia repair. (PX2).
Petitioner was returned to the care of Dr. Dragisic for follow-up care and returned to work. (PX10 pages 13 and 14). Dr. Dragisic is board certified in family practice with a fellowship in pain management. (PX10 pages 4-5). Subsequent to surgery, Dr. Dragisic imposed restrictions on Petitioner's work activities. (PX10 @ p. 19).

Petitioner testified his employer requested a functional capacity evaluation which was completed August 12, 2014. The conclusion of the therapist was that the evaluation showed Mr. Mazur was unable to return to work as a machinist based on the job description provided by the employer. Mr. Mazur's physical demand level was limited to sedentary duty. Mr. Mazur provided consistent effort. (PX3). The Arbitrator notes Petitioner had a work-related knee replacement for which a decision of the Commission has been entered and is currently the subject of a 19(h) and 8(a) Petition. See: 07 WC 38141.

Petitioner testified he conducted a self-directed job search, providing Respondent with job search logs on a weekly basis beginning April, 2014. He further testified he was referred for formal vocational rehabilitation after a period of time looking for work on his own without success. This referral was to Vocamotive. (PX6).
Petitioner was evaluated by Kari Stafseth, CRC at Vocamotive on February 12, 2015. Ms. Stafseth referred Mr. Mazur for vocational testing to Steven M. Blumenthal who prepared a report dated March 20, 2015 in which he noted Petitioner's vocational assets and vocational liabilities. (PX4).

Petitioner testified he applied for more than 2,000 jobs and received no job offer. Vocamotive provided periodic reports on Petitioner's progress from February 16, 2015 through December 12, 2017. (PX6, PX11). Petitioner demonstrated a very high level of diligence and commitment to the vocational rehabilitation process.
Respondent submitted a June 27, 2017 Labor Market Survey report. (RX1). This report was prepared by Kari Stafseth, CRC, the Certified Rehabilitation Counselor, working with Mr. Mazur at Vocamotive. Ms. Stafseth concluded that the Labor Market Survey indicated Petitioner has the physical capabilities to perform positions identified within the survey and that the potential wages were mostly between $11.00 and $17.00 per hour. (RX1). (Page 1)

Petitioner testified he contacted the employers listed on the Labor Market Survey and received no offers of employment. In her final report, dated December 12, 2017, Ms. Stafseth reported the file "had been closed at the direction of the account." (PX11). For many months prior to this decision to end vocational rehabilitation efforts, Kari Stafseth, CRC, had concluded her reports with the following opinion:

> *"Mr. Mazur began participating in job search services around June 11, 2015. Since this time, he has been looking for work on a weekly basis with the assistance of Vocamotive staff. Given Mr. Mazur's advanced age, limited experience, and time in vocational rehabilitation, it is the opinion of Ms. Stafseth that continuing the additional services will not yield any job offer."* See, November 8, 2017 Vocamotive report. (PX11).

The Arbitrator notes that Dr. Dragasic testified a causal connection exists between Petitioner's work accident and his current condition of ill-being. He further testified he ultimately adopted the restrictions outlined in the functional capacity report (PX3) dated August 12, 2014 which was not received by Dr. Dragasic until sometime in 2016 according to his testimony. It appears the doctor adopted these restrictions as permanent in 2017 when Petitioner's counsel solicited Dr. Dragasic's opinion. (PX10 @ 23).

A person is considered totally disabled when he is not able to perform services except those for which there is no reasonably stable labor market. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 397 N.E.2d 804 (1979). If a claimant's physical disability is limited in nature so that he is not obviously unemployable, then the burden of proof is on Petitioner to establish the unavailability of work. Id. Here, Petitioner has demonstrated a diligent but unsuccessful attempt to find work on his own and with the vocational assistance of Vocamotive. Ms. Staphseth has repeatedly advised that based on his age, physical restrictions, experience, education and training, Petitioner is unlikely to find work.

Given these factors, Petitioner has demonstrated by a preponderance of the evidence that he is permanently and totally disabled based on the "odd-lot" theory of permanent and total disability pursuant to Section 8(f) of the Act. See: *Alano v. Industrial Commission*, 282 Ill.App.3d 351, 668 N.E.2d 71, 217 Ill. Dec. 836 (1996).

Kari Staphseth, CRC, stated the Respondent determined further efforts at vocational rehabilitation should end December 11, 2017. (PX11). Accordingly, Petitioner's entitlement to permanent total disability benefits begins December 12, 2017.
Maintenance benefits were due through December 11, 2017.

The Arbitrator adopts the above as material findings of fact.

In conclusion, based upon the totality of evidence, the Arbitrator finds the Petitioner at bar is permanently and totally disabled under the Workers Compensation Act, as amended.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

18IWCC0741

vs.

No. 11 INC 00533

Denny Crone and Lori Runyon, Individually and d/b/a Denny's Tree & Gutter Service,

Respondents.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brought this action by and through the office of the Illinois Attorney General against the above-captioned Respondents, alleging violations of section 4(a) of the Illinois Workers' Compensation Act (the Act). Proper and timely notice was given to all parties. An insurance compliance hearing on the merits was held before Commissioner Stephen Mathis on April 11, 2018, in Urbana, Illinois. Respondents did not appear at the hearing despite being properly served with notice of said hearing on February 1, 2018. (PX 2). After considering the entire record and being advised of the facts and law, the Commission finds that Respondents knowingly and willfully violated section 4(a) of the Act and shall pay a penalty of $500.00 per day for 939 days, plus the sum of $68,148.34, which represents the payout from the Injured Workers' Benefit Fund (the Fund). (PX 16).

Petitioner alleges that Respondents, who were in an extra hazardous business and subject to section 3(8) of the Act requiring workers' compensations insurance, knowingly and willfully lacked workers' compensation insurance coverage for a period of 939 days, from May 7, 2009 to December 2, 2011. During that time period, two of Respondents' employees sustained work-related injuries. Paul Mennenga filed a workers' compensation case against Respondents and the Fund alleging a date of accident of June 9, 2009. See *Mennenga v. Denny's Tree Service*, 10 WC 10138. James Chase filed a workers' compensation case against Respondents and the Fund alleging a date of accident of June 6, 2011. (PX 15). The *Chase* case was ultimately dismissed. (PX 15).

18IWCC0741

The *Mennenga* case was tried before Arbitrator Edward Lee on January 27, 2016, and it was determined that: Denny's Tree Service was operating under and subject to the Act; Mr. Mennenga was an employee of Denny's Tree Service; and Denny's Tree Service owed permanent partial disability benefits of $206.67 per week for 100 weeks representing 20 percent disability to the person as a whole, temporary total disability benefits for 40 5/7 weeks, and medical expenses of $54,084.47. (PX 11.) The Fund ultimately paid out $68,148.34. (PX 16).

On April 11, 2018, Respondents did not appear for the insurance compliance hearing. Petitioner called as a witness Michael Cummins, a compliance investigator for the Commission. Mr. Cummins testified that in the course of his investigation, he determined that Denny Crone and Lori Runyon were the owners of Denny's Tree & Gutter Service. Mr. Cummins further determined that Respondents' business was automatically subject to the provisions of section 3 of the Act because it involved the use of motorized vehicles and moving blades. Mr. Cummins's search of the insurance database maintained by the National Council on Compensation Insurance (NCCI) revealed that Respondents were uninsured from May 7, 2009 to December 2, 2011. (PX 3). Mr. Cummins continued his investigation to determine whether Respondents were self-insured under the Act and received a certification from Maria Sarli-Dehlin of the Commission's Office of Self-Insurance Administration indicating there was no certificate of approval to self-insure issued by the Commission. (PX 6). Lastly, Mr. Cummins testified that in February of 2018, he personally served Lori Runyon with notice of this hearing. Ms. Runyon confirmed her identity and understanding of the allegations against Respondents. Ms. Runyon stated she would share the notice with Denny Crone, who lived at the same address.

The Commission concludes that Respondents knowingly and willfully violated the insurance requirements of section 4(a) of the Act. Respondents did not appear to provide any defense for the fact that they operated an extra hazardous business for 939 days without the mandated coverage. The Commission hereby assesses a penalty of $500.00 per day for 939 days, equaling $469,500.00. In addition, Respondents are liable to pay $68,148.34, which represents the payout from the Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents Denny Crone and Lori Runyon, Individually and d/b/a Denny's Tree & Gutter Service, pay to the Illinois Workers' Compensation Commission the sum of $537,648.34 pursuant to section 4(d) of the Act and section 9100.90 of the Commission Rules. Pursuant to Commission Rule 9100.90(f), payment shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission. Payment shall be mailed or presented within 30 days after the final order of the Commission or the order of the court on review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

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

DEC 4 - 2018

DATED:
d-11/01/2018
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

SCOTT APPELHANS,

Petitioner,

vs. NO: 09 WC 025867

CITY OF CHICAGO,

Respondent.

ORDER

The Amended Petition for Penalties and Attorney Fees Pursuant to Section 19(k) and Section 16 ("Petition"), after being continued from time to time as the parties attempted to resolve the issue concerning the agreed-upon Medicare Set-Aside Agreement ("MSA"), came to be heard by Commissioner Kevin W. Lamborn on May 19, 2016. Both parties represented by counsel. At issue was Petitioner's allegation that Respondent's failure to deposit funds into the account as contemplated in the MSA constituted unreasonable and vexatious behavior and warranted sanctioning. The Commission, after consideration of the parties' pleadings presented to and arguments made before Commissioner Lamborn, as well as the pertinent law, declines to award the sought-after penalties and fees.

It is axiomatic for penalties and resultant attorney fees to be awarded under the Act a showing must be made of a respondent or a person or an entity under respondent's control acted in a manner that caused an unreasonable or vexatious delay of payment or intentional underpayment of compensation. In this case, no such behavior on Respondent's part was shown. To the contrary, the Commission finds Respondent's actions to be measured and in harmony with its responsibilities to Petitioner.

The parties entered into a Settlement Contract in January 2013 that included the aforementioned MSA. The purpose of the account created by the MSA was and continues to be to provide Petitioner with funds necessary to pay for possible future medical treatment related to his compensable injury, so that Petitioner would not have to pay for any such treatment out-of-pocket. To this end, the parties agreed that Respondent was to pay into the account created by the MSA the total sum of $195,977.56,

with the initial payment into the account to be made within sixty (60) days from the date the Settlement Contract was approved with additional payments being paid of the subsequent twenty-four years. The Settlement Contract was approved by Arbitrator Robert Williams on January 22, 2013. Respondent failed to make any of the negotiated and agreed-upon payments.

Taken on its face, Petitioner makes a compelling argument as to why the penalty under Section 19(k) and the attorney fees under Section 16 should be awarded. Respondent agreed to fund the MSA per the terms of the rider to the Settlement Contract but, to date, hasn't. It is clear from the record and uncontested by Petitioner, however, that Respondent has proactively attempted to comply with the terms of the Settlement Contract. It presented the MSA to Medicare for approval. When Medicare rejected the MSA as being inadequate to cover Petitioner's future medical needs, Respondent sought to appeal Medicare's decision, in part, by securing an assessment of Petitioner's future medical needs from Petitioner's primary care physician. Respectful of the nature of the physician-patient relationship between Petitioner's primary care physician and Petitioner, Respondent attempted to secure this assessment through communication with Petitioner's attorney. Most significantly, while attempting to fulfill its obligations under the MSA, Respondent has not abandoned its obligations under Section 8(a) of the Act and continues to pay the medical expenses related to Petitioner's compensable injury.

Respondent's continued payment of Petitioner's compensable medical expenses while still attempting to resolve the concerns of Medicare ensures that Petitioner hasn't been and isn't harmed by the non-existence of the account contemplated under the MSA. To the best of the Commission's understanding, Petitioner has not had to use his own funds to pay for any compensable medical treatment.

The Commission finds, under the facts particular to the instant case, Respondent's failure to fund the account created under the MSA, to date, does not constitute either an unreasonable or a vexatious delay of payment of a benefit and, therefore, denies Petitioner's for Penalties and Attorney Fees Pursuant to Section 19(k) and Section 16.

No bond for removal of this cause to the Circuit Court is required as the Commission has not entered an award for the payment of money. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 5 - 2018
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marla Hawkins,
Petitioner,

vs.

NO: 12 WC 35797

Georgetown-Ridge Farms
Cusd #4,
Respondent,

18IWCC0742

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 14, 2016 is hereby affirmed and adopted.

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

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

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

DATED: DEC 6 - 2018

o112718
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAWKINS, MARLA
Employee/Petitioner

Case# **12WC035797**

GEORGETOWN RIDGE FARM CUSD #4
Employer/Respondent

18IWCC0742

On 12/14/2016, 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 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

2674 BRADY CONNOLLY & MASUDA PC
NOAH P HAMANN
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

18IWCC0742

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marla Hawkins
Employee/Petitioner

v.

Georgetown Ridge Farm CUSD #4
Employer/Respondent

Case # **12** WC **35797**

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 **McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **11-17-16**. 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 **9-11-12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being N/A causally related to the accident.

In the year preceding the injury, Petitioner earned **$24,515.58**; the average weekly wage was **$612.89**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

PETITIONER HAS FILED TO PROVE AN ACCIDENT ARISING OUT OF HER EMPLOYMENT. ALL BENEFITS ARE DENIED.

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

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

D. Dylan McEnerney

Signature of Arbitrator

12-12-2016
Date

DEC 14 2016

FINDINGS OF FACT

Petitioner worked as a teacher's assistant for Georgetown Ridge Farm CUSD #4. (Tr. 12). She worked at the district's middle school. (Id.). On September 11, 2012, she testified that her husband dropped her off at the south parking lot of the middle school, which was where he normally dropped her off. (Tr. 13). She entered the eastern door of the south parking lot, which the Arbitrator notes is depicted on the right side of respondent's exhibit 4 and a close up photo of the entrance is noted in respondent's exhibit 6. (Tr. 14-15).

The petitioner testified that while descending a flight of stairs to enter the building, she caught one of her feet and fell onto her left knee. (Tr. 18-19). She was wearing sandals. (Tr. 16). The petitioner is not sure which one of her feet became caught, but she suspects it was her right foot given that she landed on her left knee. (Tr. 19). The petitioner testified that she believes she landed in a way that her left knee and left leg above the knee hit the steps. (Id.).

Petitioner testified that she was able to get herself into the building, where she was given assistance by co workers. (Tr. 21). She was eventually transported to a local emergency room for medical care. (Tr. 22). It is undisputed that the petitioner fell.

Direct Exam of Petitioner

On direct examination petitioner testified that she traversed the steps where she fell twice per day. (Tr. 17). The weather conditions on the date she fell were pleasant. (Id.). There was no moisture on the ground. (Id.). At trial she denied any history of dizziness or balance issues. (Id.).

She testified that there were no foreign substances on the ground when she fell. (Tr. 18). She testified that the toe of her sandal became caught in the sidewalk "somewhere, at some place…at the top of the steps," causing her to fall. (Id.).

She testified that before the date of the fall, she noticed "some problems" with the sidewalk next to the stairs, "but nothing drastic." (Tr. 15).

Petitioner testified that on the date of accident she was carrying her purse and a grocery bag. (Tr. 16). Inside of the grocery bag was cereal that she gave to students she tutored in the mornings. (Id.). She testified that she was not required to provide the cereal to the students. (Tr. 17). The cereal did not obstruct her view of the sidewalk or the stairs on the morning of the fall. (Id.).

On September 18, 2012 the petitioner gave a recorded statement to Brad Sandner, who works for the workers' compensation insurance carrier. (Tr. 18). A written transcript of that recorded statement was offered into evidence as respondent's exhibit 8. Audio of the recorded statement was offered into evidence as respondent's exhibit 7. Petitioner does not refute the transcript or the audio. (Tr. 49).

When the petitioner presented to the emergency room she saw the school superintendent, Mrs. Neal. (Tr. 23). Mrs. Neal was at the hospital for an unrelated injury to a student. (Id.). According to the petitioner, Mrs. Neal advised the petitioner to bill her treatment to workers' compensation insurance. (Tr. 24). The petitioner testified that none of her medical bills have been paid by workers' compensation insurance. (Id.).

The petitioner denied any history of left knee or left leg problems before September 11, 2012. (Tr. 25).

The petitioner testified that she did not improve with physical therapy, surgery or pain management treatments, which consisted of injections and medications. (Tr. 25-28). Petitioner testified that after taking medications such as Cymbalta, she developed side effects including high blood pressure and listlessness. (Tr. 28). She does not like taking medication. (Tr. 29).

The petitioner testified that she intended to keep working, but she retired early. (Tr. 30). She was 59 years old on the date of accident. (Arb. Ex. 1). She testified that retirement has negatively impacted her finances. (Tr. 30).

She testified that since the accident she is less active. (Tr. 31). She tries to perform activities for enjoyment such as cooking, working in her yard and volunteering. (Id.). She can still perform most tasks, but not as much as she could prior to the date of accident. (Id.).

She testified that her home is two stories. (Tr. 32). She moved her bedroom downstairs following the accident due to difficulty with stairs. (Id.). She now sleeps on a couch so she can elevate her left leg. (Tr. 33). She testified that her daily pain is rated six or seven out of ten when she is active. (Tr. 34). At rest, is approximately four out of ten. (Id.). She testified that when it rains or when it is cold her left leg gets stiff. (Id.).

Cross Exam of Petitioner

On cross-examination the petitioner testified that she's not sure which part of her body she landed on when she fell. (Tr. 37).

The petitioner testified that she initially treated with Dr. Paul Plattner, but that she changed care to Dr. Robert Gurtler, in part, at the advice of her attorney. (Tr. 40).

The petitioner testified that she reviewed the respondent's exhibits. She agreed that photos of the school and the accident site, marked as exhibits one through six, are accurate. (Tr. 40-41).

She testified that there are three parking lots at the school, one to the east, one to the west and one to the south. (Id.). Photos of the parking lots are marked as respondent's exhibits one through four. The petitioner testified that each of the parking lots is open to employees and members of the general public who would visit the school. (Tr. 41). She was not required to park in any specific parking lot. (Tr. 42). She chose to park in the south parking lot because it was the closest to her classroom. (Tr. 43). She parked there for her convenience. (Id.).

Each parking lot has at least one entrance into the building. (Id). The petitioner testified that she was not required to use any specific entrance into the building. (Id.).

The petitioner testified that the east parking lot has a few stairs and a handicap ramp for entrance into the building. (Tr. 44). The stairs and the ramp off of the east lot rise into the building. (Rx3).

The petitioner testified that the west entrance has no steps to enter the building. (Tr. 44).

The south parking lot has two entrances into the building. (Tr. 44). The petitioner testified that a photo of the two entrances to the building from the south parking lot is accurately depicted in respondent's exhibit 4. The entrance to the left in respondent's exhibit 4 was not used by the petitioner on the date of accident. (Id.). The petitioner testified that the entrance on the left of respondent's exhibit 4, is shown close up as respondent's exhibit 5. That entrance, which the petitioner did not use, has no steps into the building. (Tr. 45-46). It does have a small concrete landing. (Id.). The petitioner did not use that entrance because it required her to walk a little farther to her classroom than the other south entrance. (Tr. 46).

The petitioner did use the entrance that is shown on the right side of respondent's exhibit 4, which is off of the south parking lot. (Tr. 46). A close up of the entrance used by the petitioner on the date of accident is depicted in respondent's exhibit 6. (Id.). The petitioner testified that the entrance she used on the date accident was not locked as a matter of practice. (Tr. 47). The entrance she used led into the school kitchen. (Tr. 15). The petitioner testified that, in part, she used that entrance because she would start her day by getting a cup of coffee from the kitchen. (Tr. 57). She used this entrance for her convenience. (Tr. 43).

The entrance where the petitioner fell is open to members of the general public such as delivery people, volunteers who worked in the kitchen or parents who would access the school gymnasium. (Tr. 47-48).

The petitioner testified during cross examination that she does not know how she fell. (Tr. 49-51). She testified that she caught her foot on something, but she does not know what. (Id.).

She indicated that it is possible she simply caught her shoe on the concrete and not a defect. (Tr. 52). The petitioner testified that carrying the box of cereal likely did not cause her to fall. (Tr. 54).

The petitioner testified that she was never given any work restrictions by a doctor that led her to retire. (Tr. 54-55). She made the decision to retire on her own. (Tr. 55-56). She testified that when she tendered her resignation, her supervisor, Lisa Gocken, tried to keep the petitioner as an employee and that the petitioner was offered other positions. (Tr. 56). The petitioner declined. (Id.).

Re-direct Examination of the Petitioner

On redirect examination the petitioner testified that there was crumbling sidewalk next to the step. (Tr. 57). She testified that crumbling sidewalk is something she could have caught her foot on. (Tr. 57-58).

Re-cross Examination of the Petitioner

During re-cross examination the petitioner testified that she does not know what she caught her toe on. (Tr. 59).

Direct Examination of Respondent's witness Lisa Gocken

Lisa Gocken testified on behalf of the respondent. (Tr. 60). She worked as the principal at the petitioner's school. (Tr. 61). She was the petitioner's direct supervisor on the date of accident. (Tr. 62).

She testified that employees are not told where to park or which entrance to use to enter the building. (Tr. 62-63).

Ms. Gocken testified about the two entrances off of the south parking lot that are depicted in respondent's exhibits four, five and six. (Tr. 63). According to Ms. Gocken the entrance shown on the left side of respondent's exhibit 4, and in the close up picture marked as

respondent's exhibit 5, is the entrance the petitioner did not use on the date of accident. (Id.). That entrance does not have any steps into the building. (Tr. 45-46). Ms. Gocken testified that if the petitioner had entered the school through that entrance she would have walked down a small hallway to a main hallway where the petitioner's classroom was located. (Tr. 63-64). That entrance did not require the petitioner to ascend or descend any stairs into the building or once inside of the school. (Id.).

Ms. Goeken testified about the entrance the petitioner did use on the date of accident, which is shown on the right side of respondent's exhibit 4 and in a close up marked as respondent's exhibit 6. (Tr. 64). To enter the building through that entrance, the petitioner had to descend stairs. (Id). Once inside of the building the petitioner would have entered through the school kitchen/cafeteria. (Id.). After getting her cup of coffee, the petitioner would then walk up a flight of stairs. (Id.). Once at the top of the stairs, the petitioner's classroom was approximately the second door. (Id.).

Cross Examination of Lisa Gocken

Ms. Gocken testified that she took the photos marked as respondent's exhibits one through six. (Tr. 65). She testified that she took the photos between three and six weeks prior to trial. (Id).

Ms. Gocken was asked about the west entrance, which is depicted in respondent's exhibit two. She testified that said entrance is locked during school hours. (Tr. 66). The same is true of the east entrance, which is marked as respondent's exhibit 3. (Tr. 67). She testified that the entrance used by the petitioner on the date of accident, marked as respondent's exhibit 6, typically was not locked. (Id.).

Ms. Gocken testified that the south entrance, which was used by the petitioner, is normally used by teachers and staff. (Tr. 67). Ms. Gocken testified that most visitors use the front door of the school, which is not off of the south entrance. (Tr. 68).

Ms. Gocken testified that the condition of the sidewalk depicted in the respondent's exhibits does not depict to the condition of the sidewalk on the date of accident. (Tr. 68-69). She testified that the concrete which supported the railing for the steps shown in respondent's exhibit 6 does show some chipped concrete. (Tr. 69). Ms. Gocken then testified that she was sure that there was some chipped concrete in different places on the sidewalk leading up to the stairs on the date of accident. (Id).

Re-Direct Examination of Ms. Gocken

During redirect examination Ms. Gocken testified that while visitors should use the front door, if they were lost and looking for a parking lot, they could park in the south lot. (Tr. 71). She testified that anybody who attempted to enter through the entrance used by the petitioner would be able to enter the building. (Id.). Ms. Gocken testified that delivery people used to the entrance the petitioner used. (Id). Ms. Gocken also testified that volunteers for activities or individuals who knew the building well would also use the entrance used by the petitioner.

Recorded Statement

The petitioner gave a recorded statement on September 8, 2012, to Bradley Sandner of the Sandner Group, which is the workers' compensation carrier involved in this matter. The petitioner testified that the recorded statement is accurate. (Tr. 18). In the recorded statement the petitioner was asked if there were any defects to the stairs where she fell and the petitioner stated "not to my knowledge. I go down them everyday. I've never had a problem, so." (Rx7, pg. 5)

Medical Treatment

On the date of accident the petitioner presented to the emergency room at Provena United Samaritans Medical Center. (Px1). She complained of left knee pain. She was noted to have an abrasion to her left knee. No complaints were made concerning the petitioner's left quadriceps muscle. The record reflects that the petitioner tripped over her sandal.

An x-ray was taken of her left knee that showed effusion and a possible fracture of the proximal lateral tibia and distal lateral femur. (Px2). She was referred to Dr. Paul Plattner. (Px1).

Petitioner was first seen by orthopedic surgeon, Dr. Paul Plattner, on September 13, 2012. (Px4). That record states that the petitioner fell at work after catching her toe on a step, falling onto her left knee. She reported that her knee took the brunt of her injury. There is no mention of the petitioner falling onto her quadriceps or thigh area. Dr. Plattner recommended crutches and an MRI.

On October 2, 2012, the petitioner underwent an MRI of the left knee at Carle Clinic. (Px5). That study showed a complex fracture of the proximal tibia and large knee joint effusion.

When the petitioner returned to Dr. Plattner on October 5, 2012, he diagnosed her with a fracture of the proximal tibia. (Px4). He opined that the fracture would heal on its own. He recommended she treat with rest, ice and compression. He prescribed crutches and restrictions of no bending. The record indicates that the patient wanted a second opinion at the advice of her attorney and specifically that the patient wanted to be seen by Dr. Gurtler. (Px4). The petitioner testified at the time of trial that Dr. Gurtler was recommended by her attorney. (Tr. 40).

On October 16, 2012 the petitioner began treating with Dr. Robert Gurtler. (Px6). This record does not go into depth about the circumstances of the petitioner's fall. Dr. Gurtler reviewed the petitioner's MRI and opined that the petitioner was going to develop osteoarthritis in the lateral compartment of her left knee and that she eventually would need a total knee replacement. In the meantime she would participate in physical therapy, which was performed at Carle Clinic. (Px8).

Petitioner did not significantly improve with physical therapy. When she returned to Dr. Gurtler on November 13, 2012, she was noted to have a palpable defect to the distal and

quadriceps tendon. (Px6). She had difficulty extending her knee. Dr. Gurtler suspected that she had a quadriceps tendon rupture of the left knee. Surgery was recommended.

On November 16, 2012 the petitioner underwent a left quadriceps repair surgery for the diagnosis of a left quad rupture. (Px10). Post operatively the petitioner participated in physical therapy at Carle. (Px11).

Post operatively the petitioner did not make strong gains. She continued complaining of pain along the medial and lateral aspect of her knee according to the January 24, 2013 follow up visit with Dr. Gurtler's office. (Px6). She also complained of weakness to her left quadriceps muscle and an inability to perform flexion or aggressive knee extension.

After attempting continued physical therapy and conservative care, on June 10, 2013 the petitioner underwent a left leg nerve conduction study with Dr. Rong Chen. (Px13, 14). The study was normal.

Over time, an updated MRI of the petitioner's left knee was performed on April 17, 2013. (Px5). That study showed no evidence for meniscal or collateral ligament tears. On June 18, 2013 an MRI of the lumbar spine showed L5-S1 spondylolisthesis, no central spinal canal stenosis and mild lower lumbar loevoscoliosis. (Id.).

On February 3, 2014, Dr. Gurtler authored a report to petitioner's attorney. (Px16). In the report he causally connected the petitioner's condition of ill being to the work accident. He indicated that the petitioner would need crutches for the rest of her life and that she would likely need to work sitting jobs. He also indicated that she likely would need a total knee replacement at some point in the future.

The petitioner was last seen by Dr. Gurtler on April 24, 2014. (Px6). At that time, the record states that the petitioner's quad was still not working and that she had been evaluated by

neurology with no explanation. He suspected possible RSD, but indicated he did not treat that condition. He recommended pain management.

The petitioner has been treated by pain management physician Dr. Shaberra Rauther since January 8, 2015 for complaints of left thigh pain and left knee pain. (Px17). Dr. Rauther assessed the petitioner with possible CRPS. On February 25, 2015 she performed a left sided lumbar sympathetic nerve block, which was followed up with a repeat injection on March 18, 2015. The injections provided no long term relief. Since then Dr. Rauther has treated the petitioner with Cymbalta and Lidoderm patches. The petitioner was last seen by Dr. Rauther in September 2016.

The petitioner also continues to follow up with her primary care provider Dr. Jatin Rana for some pain management. (Px19). She most recently saw Dr. Rana on July 28, 2016 for refills of Norco and Lidoderm.

Causation Opinions

Respondent obtained records review reports from orthopedic surgeon, Dr. David Fetter, dated July 29, 2013 and November 27, 2013. (Rx9, 10). Dr. Fetter opined that the petitioner's only injury as a result of the fall was a lateral tibial plateau fracture of the left knee. He did not find that the petitioner's quadriceps rupture was causally related to the work accident nor does he feel that the petitioner's surgery was related to the work accident. He is of the opinion that the petitioner only required immobilization, six to twelve weeks of non or minimal weight bearing followed by a rehab program of 12 weeks. Dr. Fetter's deposition was taken on May 21, 2014.

Dr. Fetter's opinions are contrasted by the opinions of Dr. Gurtler. He opines that the petitioner fractured her lateral tibial plateau and that she also ruptured her left quadriceps muscle as a result of the fall. He authored a narrative report dated February 3, 2014. His deposition was taken on April 24, 2014. (Px30).

CONCLUSIONS OF LAW

A claimant bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. 820 ILCS 305/2 (West 2002). Both elements must be present 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).

Arising out of the employment pertains to the origin or cause of a claimant's injury. William G. Ceas & Co. v. Industrial Comm'n, 261 Ill. App. 3d 630, 636, 633 N.E.2d 994, 199 Ill. Dec. 198 (1994). An injury "arises out of" employment when "the injury has its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." Id. As a general rule, "an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts she was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incidental to her assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties." Caterpillar Tractor Co. V. Industrial Comm'n, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667, 133 Ill. Dec. 454 (1989).

In order to determine whether a claimant's injury arose out of her employment, we must first categorize the risk to which she was exposed. The risks to which an employee may be exposed are categorized into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, and (3) neutral risks that have no particular employment or personal characteristics. Illinois Consolidated Telephone Co. v. Industrial Comm'n, 314 Ill. App. 3d 347, 352, 732 N.E.2d 49, 247 Ill. Dec. 333 (2000).

Falling while traversing stairs is a neutral risk and the injuries resulting therefrom generally do not arise out of employment. Illinois Consolidated Telephone Company, 314 Ill. App. at 353. An injury resulting from a neutral risk does not arise out of the

employment. Caterpillar Tractor Co., 129 Ill. 2d at 59. However, an exception to noncompensability under the Act exists where the requirements of the claimant's employment create a risk to which the general public is not exposed. Id. "The increased risk may be qualitative or quantitative, such as where the claimant is exposed to a common risk more frequently than the general public." When analyzing a neutral risk, the increased degree of risk to the claimant may be either qualitative (*i.e.*, when some aspect of the employment contributes to the risk) or quantitative (*i.e.*, when the employee is exposed to the risk more frequently than members of the general public by virtue of the employment. Adcock v. Illinois Workers' Compensation Comm'n, 2015 IL App (2d) 130884WC, 395 Ill. Dec. 401, 38 N.E.3d 587.

Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling. Nabisco Brands, Inc. v. Industrial Comm'n, 266 Ill. App. 3d 1103, 1107, 641 N.E.2d 578, 204 Ill. Dec. 354 (1994).

In this case, the claimant did not present any evidence explaining the cause of her fall. She testified that she does not know why she fell. Specifically, trial testimony was as follows:

> Q. Is it fair to say that you don't know how you fell?
> A. Well, no, not really.
> Q. Okay.
> A. **I caught my foot *on something***. I know that that happened. I don't just get to the top of the stairs and decide you're going to fall down and something happened that caused me to fall. I've never fallen, you know, in my life. I know that I'm older, and I realize that people, you know, fall down when they get older, but that isn't what happened. I mean, I absolutely did something to make myself, you know, to cause the fall.
> Q. But do you know what got caught?
> A. My -- the toe of my shoe was caught. It was an accident. The toe of my shoe was caught, and I went forward.

Q. In reading your transcript, you were asked specifically: Did your shoe get caught on any defect? And I think you responded that either you weren't sure or that it didn't. Is that still a fair statement?
A. **Well, something caused me to fall and, you know, that's pretty much about all I can tell you.** I just didn't stand there and fall down. **I wish I could be more clear** without -- but at the time that I spoke with him, I was on some medication. That may have had something to do with my thinking, and I'll be real honest with you, my whole -- during this whole thing, I was worried death about the school. That's why I didn't want to do workmen's comp. I didn't want to do insurance. That's why I knew how much that would cost, and it was -- I was very concerned that they were going to have to pay a lot of money, and I knew what kind of financial place they were in at that time, and that's the truth. I don't know what else to tell you other than something caused me to fall -- catch my toe and -- of my shoe, not really my toe, of my shoe and made me fall.
Q. Again, if I'm putting words in your mouth, stop me.
A. I will tell you, yes.
Q. **If you tripped over, say, a chunk of concrete that was missing or, you know, a branch that was in your way, you would remember that, correct?**
A. After I thought about it, **I think I probably would remember** it because I --
Q. Sorry.
A. Continue.
Q. **And you don't recall anything like that, correct?**
A. **I recall catching my toe on** ***something*** involved.
Q. **I guess my question is: What is the something you caught your toe on?**
A. **I don't --** ***something on the sidewalk.*** At first I thought it was just a crack on the sidewalk. At first I wasn't a hundred percent sure if it were like a deep pocket in the sidewalk or it was just a crack. I mean, you're walking down the sidewalk and caught your toe in the crack of the sidewalk. I didn't know that, but I know that I caught my toe on something on the toe of my shoe. I just didn't stand there and fall. ***Something happened that could have caused it. I'm not sure what the default was or if it was just a crack or if it was just my shoe catch on the concrete, but something made me fall down the stairs.***
Q. ***So it is possible that your shoe just caught on the concrete, correct?***
A. ***I don't know. I mean, yes.*** (Tr. 49-52)***[emphasis added]***

While the petitioner clearly caught the toe of her sandal on something and fell, there is no clear testimony or evidence indicating on what she caught her sandal.

Additionally, she testified that weather did not play a role in the fall. She offered no testimony that she was in a rush. She testified that while she was carrying cereal in her hands, she was not required to bring cereal to the school by her employer and importantly, carrying the cereal did not cause her to fall.

Importantly, the medical records also illustrate the fact that the petitioner did not know how she fell. The initial medical record from the emergency room on the date of accident reflects that the petitioner tripped on her own sandal. (Px1). The next medical record in her history is from Dr. Plattner on September 13, 2012. (Px4).

The petitioner did not show that qualitatively she was performing an employment related task when she was injured. She was not performing any task for her employer. She was walking like any member of the general public. Likewise, qualitatively she presented no evidence she used the stairs in question more than a member of the general public. The entrance she used was open to the general public. The door she entered through was the only door at the school that was unlocked all day. The petitioner has the burden of proving that her injury arose out of her employment. See *Ghere v. Industrial Comm'n,* 278 Ill. App. 3d 840, 847, 663 N.E.2d 1046, 215 Ill. Dec. 532 (1996). She has not met her burden.

The Arbitrator recognizes the petitioner suspects she tripped over concrete, but for the Arbitrator to agree with the petitioner, he must speculate concerning the cause of the fall. There is some evidence that there was crumbling concrete near where the petitioner fell. However, the issue is whether that constituted a defect or hazard. The Petitioner initially said in her direct testimony that while there were some problems with the sidewalk next to the stairs, it was "nothing drastic." When she gave her recorded statement just one week after her fall, she said that she was unaware of any defects in the condition of the stairs. She clearly had an opportunity at that time to tell the insurance representative about the crumbling walk but did not. (RX 8) While Mrs. Goeken did testify on cross examination that she was sure that the sidewalk had a chip in different places, the Arbitrator is mindful of the context in which that testimony was given. She was first shown a picture of the stairs and asked about chips in the concrete standards supporting the railing. The chipping noted on the standards had nothing to do with the

petitioner's fall. She was then asked about chipping on the walk. She was not asked to indicate on the photograph where the chipping was nor how extensive it was. She only said it was chipped through wear and tear.

The petitioner is asking the Arbitrator to decide, through circumstantial evidence, that she fell because the toe of her sandal caught on some chipped concrete on the sidewalk next to the steps and that said sidewalk's condition at the time constituted a risk or hazard not present on normal sidewalks used by the general public. Circumstantial evidence can only support an inference which is reasonable and probable, not merely possible. Mann v. Producer's Chemical Co., 356 Ill. App. 3d 967, 974, 827 N.E.2d 883, 293 Ill. Dec. 2 (2005). Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn. Carter v. Azaran, 332 Ill. App. 3d 948, 961, 774 N.E.2d 400, 266 Ill. Dec. 294 (2002).

In her proposed decision, the petitioner cites a number of cases to support her position. The common factor in all of those cases, however, is the proven existence of a defect or hazard which was causally linked to the petitioner's accident. In Bommarito v.The Industrial Commission, 82 Il. 2d. 191 (1980), the petitioner fell because he stepped in a hole. In Litchfield Healthcare v. The IWCC, 349 Il. App. 3d 486 (5th. 2004), photographs showing a height discrepancy of an inch and a quarter where the fall occurred were offered and conceded to by the respondent. The two other cases were Rule 23 decisions, but in both there was clear evidence of a defect or hazard. As noted above, in the instant case, the existence of a defect has not been sufficiently proven.

Based on the evidence in the record, the claimant cannot show more than a mere possibility that she tripped over defective concrete as the cause of her fall, and, thus, there is no

reasonable certainty that the claimant's injury stemmed from a risk associated with her employment.

Because the petitioner did not present any evidence establishing the cause of her fall, she has failed to prove that her injury arose out of her employment.

The claim is denied and all other issues become 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN JACOBSEN,

Petitioner,

vs.

NO: 14 WC 000292

ILLINOIS DEPT. OF EMPLOYMENT SECURITY,

Respondent.

18IWCC0743

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of benefit rate, temporary total disability, medical expenses, permanent partial disability and vocational rehabilitation, 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 is a wheelchair-bound quadriplegic who was employed by the Illinois Department of Employment Security for approximately eight to nine years when he sustained a work-related accident while exiting his work station. On May 6, 2008, Petitioner's left foot caught while exiting his cubicle, and Petitioner sustained a fracture of the left femur. Petitioner sought orthopedic care for treatment of the fracture, which included wearing a full leg brace and a long leg cast. Petitioner underwent several cast changes in order to protect him from the development of skin ulceration, a potential risk due to his quadriplegia. However, even with precaution, Petitioner developed a pressure sore on his hip where the cast ended. Petitioner met his burden of proof that he sustained a work-related accident on May 6, 2008. Following appropriate orthopedic treatment, Petitioner's fracture healed, and he was released from treatment for his fracture as of September 16, 2008. Petitioner's orthopedist released him to full duty work at that time, though noted Petitioner may require further treatment due to the pressure sores from his cast. Petitioner resumed treatment on October 22, 2008, for a pressure sore related to the position of his cast. Petitioner received care related to his pressure sore on his hip on and off through March 9, 2009.

Dr. Ingberman, Respondent's Section 12 physician, was more persuasive than

Petitioner's treating physician in her opinion that there is no additional increased risk of recurrent ulceration compared to his risk for the same prior to the 2008 fracture. The Commission finds that Petitioner had reached maximum medical improvement as to his leg fracture and associated disability as of December 20, 2008, the date he was discharged from the wound care clinic. The Arbitrator's award for temporary total disability benefits is modified down to reflect the maximum medical improvement date of December 20, 2008. The Arbitrator failed to indicate a benefit rate for Petitioner's temporary total disability award. The Commission corrects the benefit rates and awards Petitioner the sum of $600.80 per week for a period of 27 5/7 weeks, from May 6, 2008 through September 16, 2008, and from October 22, 2008 through December 20, 2008.

Petitioner returned for follow-up care regarding the same pressure sore for which he had treated following his leg fracture, in February of 2009. Petitioner sought care for approximately one month, and his last visit was on March 9, 2009. The Commission awards medical treatment through March 9, 2009, as there were some recurring ulcerations and necessary palliative treatment through that time. The Commission affirms the Arbitrator's award for medical benefits.

The Commission finds that Petitioner's condition related to his fractures and pressure sores resolved, and that Petitioner's current condition of ill-being is not related to Petitioner's work-injury, but rather to his pre-existing condition of quadriplegia. The Commission therefore modifies the Arbitrator's award from 10% loss of the person as a whole, to a 15% loss of use of the left leg. The Arbitrator incorrectly awarded the average weekly wage amount of $901.20 as the permanency rate. The Commission additionally corrects the benefit rate to the correct amount of $540.72 per week.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.80 per week for a period of 27 5/7 weeks, from May 6, 2008 through September 16, 2008, and from October 22, 2008 through December 20, 2008, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $540.72 per week for a period of 32.25 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical charges and fees incurred by Petitioner through and including March 9, 2009, 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

18IWCC0743

for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: DEC 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:102418
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACOBSEN, JOHN
Employee/Petitioner

Case# **14WC000292**

ILLINOIS DEPT OF EMPLOYMENT SECURITY-SOI
Employer/Respondent

18IWCC0743

On 1/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.59% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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CHICAGO, IL 60603

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE COPELAND
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CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
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SPRINGFIELD, IL 62794-9255

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

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

JAN 17 2017

GERALD A. HARRIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0743

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

John Jacobsen
Employee/Petitioner
v.
Illinois Dept. of Employment Security – *State of Illinois*
Employer/Respondent

Case # **14 WC 0292**

An *Application for Adjustment 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 **Aug. 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 6, 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 sustained a fracture of left femur and related pressure sore to the left hip that *were* causally related to the accident. Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**$46,862.40**; the average weekly wage was $**901.20**.

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

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

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

Respondent shall be given a credit of $**161,963.78** 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 §8(j) of the Act.

ORDER

Respondent shall pay Pettioner total temporary disability benefits from **May 6, 2008** through **September 16, 2008** and from **October 22, 2008** through **March 9, 2009, 38 & 5/7 week.**

Respondent shall pay all reasonable and necessary medical charges and fees incurred by Petitioner through and including March 9, 2009, pursuant to §8(a) of the Act, adjusted in accord with the fee schedule provided by §8.2 of the Act.

Respondent shall pay Petitioner partial permanent disability benefits due to Petitioner sustaining **10%** loss of a person-as-a-whole, **50** weeks at **$901.20**/week.

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

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

date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

January 16, 2017
Date

JAN 17 2017

John Jacobsen v. Illinois Dept. of Employment Security – State of Illinois
14 WC 0292

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD, PTD;* ***O:*** Is Petitioner entitled to vocational rehabilitation counseling services?; and, alternatively: ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

Petitioner John Jacobson is a 55-year-old quadriplegic who has been employed by Respondent Illinois Department of Employment Security (IDES) since 2000. He earned a BS degree in finance at Southern Illinois University and has a certificate in computer-aided design. Petitioner testified that he has been a wheelchair-bound quadriplegic as a result of a diving accident at age 18. He explained that he only lives 15 minutes from the commuter train station, so that he can travel in his motorized vehicle to catch the train. Once he arrived at LaSalle Street station in Chicago he would continue by wheelchair to his place of employment, a trip which took approximately 20 minutes.

Petitioner described his duties at IDES: inputting data from contribution and wage reports prepared by employers throughout the stat at state. His work was mostly clerical. He explained that he would take contribution and wage reports and do a comparison of what employer sent to the federal government.

At work Petitioner entered data by using a pencil strapped to his hand. He would punch one key at a time to enter data. He testified that on May 6, 2008 he was leaving his work cubicle which was approximately 3½ feet wide. As he was pulling out and rotating his chair his left foot, which extended out from his footplate, caught on the cubicle across from his. He noticed that his ankle was twisted and when he arrived home his left knee was swollen.

As his knee became more swollen he sought medical attention from Dr. Michael Stachowski, his general practitioner, at Little Company of Mary Hospital. Dr. Stachowski referred him to Dr. Basel Al-Aswad, an orthopedic surgeon, whom he first

saw May 14, 2008 (RX #3). Dr. Al-Aswad diagnosed fracture of the left distal femur. He fitted a 3D brace at first but then applied a long leg cast on May 22, 2008. Petitioner testified that he had difficulty with the cast because it irritated his leg.

Dr. Al-Aswad monitored Petitioner's skin condition throughout his care, noting on May 22 that the cast was padded to avoid ulcers. Dr. Al-Aswad changed the cast June 12, noting no skin problems. Dr. Al-Aswad noted a small pressure sore on the left side of the hip on July 10. Petitioner's cast was removed August 4, 2008 at which time the fracture seemed clinically stable. A hinge brace was then applied. Dr. Al-Aswad released Petitioner to return to return PRN on September 3, 2008 and released Petitioner to work full duty without restrictions regarding his leg fracture on September 16, 2008.

Petitioner testified that he developed a pressure sore on his left buttock. He returned to Dr. Stokowski who referred him to Dr. Vossoughi, a wound care specialist. He testified that the Respondent's IME doctor, Dr. Ingberman, did not identify the correct location of his pressure sore when Dr. Ingberman testified during trial. He continued that Dr. Ingberman pointed to an ulcer which occurred when he was 18 years old and was located on the left side of his hip. He explained that the ulcer on the left side of his hip had not been giving him any problems. He testified that there was no pressure on the ulcer on his left hip from his wheelchair or anything else. However, he stated that there was pressure on the sore from sitting on it with the cast.

Petitioner testified that the old sore and the new sore were about 4 inches apart. While he said the pressure sore was really on his buttocks and not his left hip, he also admitted that he did not point to his buttock when Dr. Ingberman asked to view his sore during the IME. He testified that he told Dr. Ingberman the sore was under his buttock.

Petitioner was returned to work by his orthopedic surgeon on September 16, 2008. He testified that he returned to work for one month but that he was too uncomfortable because of taking pressure off his buttocks. He was taken off work again on October 22, 2008. Petitioner stated that he was told just to stay off the affected area as much as possible. He also said that the pressure sore opened 3 times, once while working and twice when he was off work. The last time he saw the wound care specialist Dr. Vossoughi was March 9, 2009. Dr. Vossoughi cleaned the area and instructed him to stay off the area as much as possible Dr. Vossoughi recommended Petitioner seek disability as opposed to returning to work.

On November 22, 2013 Dr. Stachowski gave Petitioner specific restrictions of staying off the pressure ulcer for 2 hours every 2 hours. Petitioner described how he complied with this restriction by having his caregiver transfer him from the wheelchair onto his bed and being rolled off the area where the ulcer pressure ulcer was. In addition, his wheelchair reclines so that he can move his body to a prone position, allowing him to stay off the affected area for the 2 hour increments. Petitioner testified that he cannot be vigilant in following his restrictions without the help of his caregiver. Petitioner has not returned to employment since his failed attempt to return to work in September 2008.

Petitioner testified that all IDES information is highly confidential. Therefore he could not work at home.

Petitioner explained that he continue to receive temporary total disability payments until October 2013 when he received a letter from the state advising him that benefits were being terminated since his inability to return to work was not causally related to the accident in 2008.

Petitioner was examined August 26, 2014 pursuant to §12 of the Act by Dr. Dinora Ingberman at Respondent's request (RX #1). Dr. Ingberman reviewed Petitioners medical history, including his work accident on May 6, 2008. She took note of Petitioner's cervical fracture at age 18 which caused his quadriplegia. She also noted that he had a history of prior pressure ulcers. Petitioner had been dependent on daily caregivers for turning in bed, transfers in and out of bed, bathing and other activities of daily living.

On examination Dr. Ingberman noted a well-healed left greater trochanteric ulcer. There was no direct pressure from Petitioners wheelchair on the area of the ulcer. On further examination she found no other ulcers or skin irritations. Dr. Dr. Ingberman also noted that there was no additional risk of recurrent ulceration and that no further treatment or diagnostic evaluations were necessary for the May 6, 2008 injury.

Dr. Ingberman opined that Petitioner did not require additional restrictions or limitations due to his May 6, 2008 work injury. She further opined that he was capable of working a full day in his pre-injury job without additional restrictions related to his injury. Dr. Ingberman also opined that Petitioner had reached MMI by December 20, 2008 and that Petitioner's underlying femoral fracture and the ulcer related to pressure from the cast had completely healed. She found no ongoing problems related to Petitioner's chronic C5-7 quadriplegia. She further opined that the original date

diagnosis of decubitus ulcer from the injury was no longer present and that there was no current diagnosis related to the injury at issue.

On October 29 2014 Monika Szaflarska, FMLA Leave Coordinator of Labor Relations, office of the Illinois Department of Employee Security, wrote to Petitioner (PX #7). Ms. Szaflarska wrote in response to receiving a disability statement from Dr. Vossoughi and a follow-up telephone conversation with the doctor. Dr. Vossoughi's statement noted his opinion that Petitioner had severe limitation of functional capacity and was incapable of minimal work activity. Dr. Vossoughi had further indicated his opinion that Petitioner was permanently and totally disabled for employment. Dr. Vossoughi did not note whether the permanent total disability opinion was based on Petitioner's work injury on May 6, 2008 or his underlying condition of quadriplegia or some combination of the two factors.

Ms. Szaflarska informed Petitioner and her letter that he was terminated from his employment with Respondent due to the determination that his condition was not related to his work injury and that he was permanently totally disabled for any employment, referencing Dr. Vossoughi's attached Physician Statement.

Testimony of Michael Stachowski, M.D.

Petitioner's primary physician Dr. Stachowski testified at trial. He retired from active medical practice in June 2014. Prior to his retirement he was employed by Little Company of Mary Hospital as an internist. Dr. Stachowski testified that he is board certified in internal medicine and in infectious diseases. His practice consisted of a family practice.

Dr. Stachowski treated Petitioner for general medical care for 10 years. Petitioner is a quadriplegic since a diving accident as a teenager. Dr. Stachowski did not know what Petitioner's job duties were for the State. He testified that he did not see Petitioner while he was being treated by Dr. Al-Aswad for the fracture. Dr. Stachowski did treat Petitioner for general medical care after release by Dr. Al-Aswad. He said that Petitioner developed an ulcer from the long leg cast. The ulcer was on the posterolateral aspect of the left thigh. He did note that Petitioner had a prior small ulcer on his left hip that was dimpled.

Dr. Stachowski testified that the ulcer on the thigh resulted from pressure from the cast. It was not visible by simply removing Petitioner's pants. Petitioner's pants would have to be lifted and tilted to view the ulcer. He explained that the wound should

be kept clean. Dr. Stachowski testified that Petitioner could develop infections if the ulcer was not properly cared for. He stated a deep ulcer would have to be debrided.

By November 2013 the pressure sore had not been open for "quite some time". In fact, Dr. Stachowski testified that he did not think Petitioner hitting anyone for wound care for three or four years. He testified that he issued work restrictions for the first time in November 2013, which consisted of staying off the area of his left hip every 2 hours. He stated that the standard of care for pressure ulcers is get pressure off the area for 2 hours every 2 hours. Dr. Stachowski explained that it be necessary for petitioner lie down or recline all the way back and arch himself.

On cross-examination Dr. Stachowski acknowledged that he was not certified in wound care. He also testified that did not perform any wound care but referred to Dr. Vossoughi, a wound care specialist. It was not until June 2014, when he wrote a letter "To Whom It May Concern" letter, that he set forth his recommendation of 2 hours on and 2 hours off. On further cross-examination he testified that Petitioner had asked him what he thought was required to prevent a recurrence of the pressure sore. Dr. Stachowski testified that he last saw petitioner in May 2014. At that time required at that time the wound was closed and did not require treatment.

Testimony of Dinora Ingberman, M.D.

Dr. Ingberman, Respondent's IME physician, testified at trial. She is board certified in physical medicine and rehabilitation, specializing in pain management. Dr. Ingberman also testified that she earned a certificate in wound care in 2009, following completion of a course that lasted several days. She is currently a medical director at Creative Pain Solutions in Gurnee where she treats patients with chronic pain.

Dr. Ingberman testified that she performed a §12 examination of Petitioner on August 26, 2014. She had reviewed medical records and took a history from Petitioner. Her examination consisted of assessing his ability to move in the wheelchair. She also checked his skin. She testified she also checked the strength and range of motion in his extremities. As part of the examination Dr. Ingberman asked Petitioner to point to the pressure ulcer which was subject of his claim. He pointed to his left hip.

Dr. Ingberman did not agree with Dr. Stachowski's recommendation of offloading every 2 hours. She further testified that sitting for 2 hours without shifting weight is not recommended. She continued by stating that for range of motion maintenance more frequent shifting is advised. Her reasoning was based on medical and scientific

authorities, which recommend weight shifting every 30 minutes for 30 to 90 seconds in order to help blood flow normalize to the area so as to prevent ulceration.

Dr. Ingberman further explained that Petitioner's difficulty in leaning forward once he returned to work was due to the limitations of his movements in the brace that had been fitted. That was documented in medical records but she indicated that normally that should be treated successfully with range of motion exercises. She further testified that there was no limitation and no permanency as a result of the fracture.

Dr. Ingberman explained that all wheelchair-bound and disabled individuals are aware of their skin breakdown risks and their need to stretch and shift weight. She noted that Petitioner was experiencing abdominal pain as well as pain in his left buttock radiating down his left his leg to the ankle, which he rated 7/10. She opined that the leg fracture or limitation of motion by itself was unlikely to cause this ongoing pain and was not related to the fracture. She added that this pattern of pain existed this pattern of pain was chronic. Dr. Ingberman further opined that Petitioner was coming capable of returning to work and also opined that he had reached MMI by the end of 2008.

On cross-examination Dr. Ingberman was asked hypothetically to assume that Petitioner has a healed ulcer he was sitting on and, if so, would it be necessary to remove pressure from that ulcer. She responded that it would be treated as any other area of the body: shift weight side to side and forward and back, whatever the wheelchair would allow.

Dr. Ingberman further explained on cross-examination that Dr. Stachowski's recommendations would be detrimental, as 2 hours was too long and weight-shifting should be done more frequently. She stated that 2 hours off and 2 hours on can increase Petitioner's susceptibility for contractures due to the need to continually shift weight.

On redirect examination Dr. Ingberman testified that persons with healed pressure sores should still do weight-shifting. She continued that there are no published studies recommending weight shifting 2 hours on and 2 hours off as suggested by Dr. Stachowski.

Evidence Deposition of Edward Steffan (PX #5)

Petitioner called Mr. Steffan as a vocational rehabilitation expert. Mr. Steffan has a master's degree in rehabilitation counseling and he is a certified rehabilitation

counselor. 80% of his practice is devoted to Worker's Compensation, although he also is able occasional expert for the Social Security Administration.

Mr. Steffan interviewed Petitioner on November 14, 2014 at Petitioner's at home. He took a medical history from Petitioner and he also reviewed medical records and reports from both Dr. Stachowski and Dr. Ingberman.

Mr. Steffan noted that Petitioner was a poor historian who had difficulty recounting his employment history. Mr. Steffan admitted that he did not obtain a good understanding of what Petitioner's job function was because Petitioner was somewhat unclear. He noted that Petitioner utilized a pencil to strike keys on a keyboard. He did not testify to how the pencil was attached to Petitioner's hand. Mr. Steffan testified that Petitioner's employment was "gratuitous", in that Petitioner was not held to the standards generally associated with accomplishing assigned work tasks. Mr. Steffan acknowledged that he had not worked with other individuals with a medical background similar to Petitioner's.

Mr. Steffan testified that Petitioner did not have the skills, abilities, or a medical release from his treating physician that would allow him to perform competitive employment. He opined that Petitioner would not be able to enjoy stable employment due to his need to alternate being "prone" [*sic*] and upright every 2 hours.

On cross-examination Mr. Steffan testified that absent Dr. Stachowski's restrictions it was possible for Petitioner to return to full-time employment. He was unsure of what the Illinois Department of Rehabilitation could offer Petitioner to aid him in finding a job since that department deals with persons with conditions similar to Petitioner's.

On further cross-examination Mr. Steffan was asked about use of voice-activated computer software. Mr. Steffan acknowledged that voice-activated software has gained wide acceptance but that he was uncertain of Petitioner's capabilities to train in the use of that software. Mr. Steffan acknowledged that if voice-activated software could assist Petitioner he might change his mind as to Petitioner's employability.

Mr. Stefan also testified that Petitioner could perform his work duties within Dr. Ingberman's restrictions, if accommodated. He further noted that he had the impression that Petitioner wanted to work but that he felt "defeated".

In reviewing his billing Mr. Steffan was asked about telephone conference charges with petitioner on October 30, November 5, November 7, and November 12, 2014. He did not document the content of any of those conversations and had no independent recall of those conversations.

Affiliated Physician Group-Evergreen/Dr. Stachowski (RX #2)

Dr. Stachowski's care of Petitioner dates back to 2002. He treated Petitioner for infections and other pressure sores before the 2008 work accident. Following Petitioners work accident Dr. Stachowski charted that Petitioner's pressure sore was on his hip: February 6, 2009, March 9, 2009, November 22, 2013, and June 4, 2014. A note on August 10, 2009 makes reference to a chronic hip decubitus without reference to an open wound. A note on September 20, 2010 made reference to a sore on the left thigh.

The February 6 note stated that Petitioner was seeking a doctor's return to work note but that, also, Petitioner was seeing the wound doctor the next Monday. The March 9 note stated that Petitioner had seen Dr. Vossoughi and was going on disability because of an open wound on his left hip and buttocks.

Dr. Stokowski wrote a "To Whom It May Concern" letter June 10, 2014 (PX #4). I n that letter he stated that Petitioner developed a pressure sore on his left hip as a result of the femur fracture he sustained in May 2008.

Little Company of Mary Hospital (PX#3)

Petitioner's record records date back to 2005 when he was treated for a pressure ulcer on his right ankle. He was treated again for that pressure ulcer for another pressure ulcer in 2006. During his 2006 care Petitioner gave a history of other pressure sores on his heels, hips, shoulders, and tailbone. He also gave a history of a prior broken right leg and a broken left forearm.

Petitioner was seen at Little Company of Mary under the care of Dr. Farhad Vossoughi on October 22, 2008 for a stage 3 left lateral ischium pressure sore. He was seen in follow-up November 19 and December 17, 2008. The left lateral ischium wound was noted as heal on December 17. Petitioner was seen again on February 9, 2009 with a stage 1 sore on the left hip. Petitioner was treated extensively for other pressure ulcers on his feet before his work accident in May 2008.

CONCLUSIONS OF LAW

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

There is no genuine dispute Petitioner sustained a left femur fracture while at work May 6, 2008. His broken leg was placed in a long-leg cast which eventually caused a pressure sore on his leg. The evidence was clear that Petitioner achieved total healing of his leg fracture by September 2008. However, while there was evidence that the pressure sore had initially healed but subsequently reopened 2 or 3 times, there was no evidence that Petitioner had any further recurrence of the pressure sore since 2009.

There is a dispute regarding the location of the pressure sore which developed as a result of the cast placed on Petitioner's left leg. That dispute is germane to whether Petitioner's pressure sore injury resolved or became a continuing condition of ill-being.

Petitioner and his treating physician, Dr. Stachowski, testified that the pressure sore at issue was located on the posterior of Petitioners left thigh, an area described by Dr. Stachowski as where Petitioner sat on it. The Arbitrator finds this testimony was not credible. The medical records submitted in evidence document the location of the pressure sore as the left hip or ischium, not the posterior thigh or buttock. Further Dr. Stokowski's June 10, 2014 "To Whom It May Concern" letter specifically refers to Petitioner's left hip and not his thigh or buttock.

Petitioner testified that Respondent's IME physician was wrong when she noted the pressure sore was on his left hip. Petitioner testified that he told Dr. Ingberman twice that the sore was on his buttock. The Arbitrator finds this testimony was not credible in light of the well-documented medical records noting that the sore was on the left hip. The evidence established that Petitioner sustained a pressure ulcer on his left hip caused by pressure from his long-leg cast for treatment of the fracture to his left femur. This pressure this pressure sore recurred after removal of the cast but has not but there is no evidence that it has recurred since Spring 2009. Medical records do not support the contention that the pressure sore at issue was located on the posterior left thigh or buttock. The evidence established that Petitioner developed a pressure sore on his left hip that was related to his May 6, 2008 accident but which resolved by Spring 2009.

Since 2009, there has been no substantive change in Petitioner's condition of paraplegia. He was a quadriplegic prior to May 2008 and that condition remains the same today. At the same time, there is no dispute that he has experienced no pressure

sores since 2009 and that the leg fracture has healed. His orthopedic doctor released him to full duty in September 2008. Further, there has been no substantive change in Petitioner's underlying risk of pressure sores due to his quadriplegia.

The only issue as to Petitioner's current condition of ill-being relate to the restrictions placed on him by his general practitioner, Dr. Stachowski, at Petitioner's request some 4 years despite the lack of recurrence of any pressure sores. Again, the Arbitrator takes note of the fact that Dr. Stachowski is not trained in wound care nor did he ever treat Petitioner for pressure sores. The Arbitrator finds that Sr. Stachowski's "To Whom It May Concern" letter was written in contemplation of litigation. It was written at Petitioner's request shortly after Petitioner's TTD benefits were terminated. The Arbitrator disregarded the "To Whom It May Concern" opinions for violation of §16 of the Act.

Moreover, the Arbitrator finds that Dr. Ingberman's opinions more persuasive than Dr. Stachowski's opinions. Dr. Ingberman specializes in the field of wound care and is familiar with the research and protocols treating pressure sores given her treatment of wheelchair-bound individuals who share the same susceptibility to pressure sores as Petitioner. Even if Dr. Ingberman did not view the correct healed sore, her testimony was that it is necessary for Petitioner to shift weight every thirty minutes for 30 to 90 seconds if he were sitting on it. She opined that sitting for a 2 hour period was too long and was counter-indicated. The Arbitrator noted that Petitioner has been instructed to shift his weight since the time of his original injury as a teenager.

After reviewing the evidence, the Arbitrator finds that Petitioner failed to prove that he sustained any permanent change in his pre-existing permanent condition of paraplegia that was related to his work accident May 6, 2008. The only conditions of ill-being causally related to the work accident, the fractured femur and left hip pressure sore, had resolved by March 2009.

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

Petitioner last received active medical care for his left hip pressure sore on February 9, 2009 at Little Company of Mary Hospital. He saw Dr. Stachowski in follow-up March 9, 2009, when no clinical care for the pressure sore was documented. The next clinical note by Dr. Stachowski mentioning the pressure sore is dated November 22, 2013. Dr. Stachowski testified that the pressure sore has been healed for some

years. The Arbitrator finds that this passage of more than 4 years fails to prove a causal chain to the original injury.

The Arbitrator therefore finds that the reasonable and necessary medical care provided to Petitioner for treatment of his fractured femur and subsequent pressure sore reasonably ended on March 9, 2009. Respondent shall pay any and all outstanding medical bills for treatment through March 9, 2009 in accord with the fee schedule provided by §8.2 of the Act.

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

Petitioner was paid temporary total benefits through October 31, 2013, well beyond the time when Respondent's expert opined that he had reached MMI. Petitioner's treating orthopedic surgeon, Dr. Al-Aswad, released Petitioner to return to work full duty without restrictions on September 16, 2008. The Arbitrator finds that the issue of restrictions rests on which doctor's recommendations one follows. Dr. Stachowski admitted he has no expertise in the field of wound care and never treated Petitioner for any wounds but, in fact, deferred to Dr. Vossoughi for issues related to pressure sores. It is also significant that Dr. Vossoughi who treated Petitioner for his pressure sores never issued any restrictions.

The Arbitrator finds the opinions of Dr. Ingberman regarding restrictions more persuasive that the opinions of Dr. Stachowski. Dr. Ingberman' expertise in the field of wound care is clearly superior to that of Dr. Stachowski. Further, Dr. Stachowski credibility is questionable when he testified to the pressure sore being on the posterior thigh when his clinical notes document the hip. The Arbitrator accepts Dr. Ingberman's opinion that Petitioner could avoid pressure ulcers if he shifted in his wheelchair for 30 to 90 seconds every 30 minutes. Based on Petitioner's description of his job duties Petitioner could perform his normal job duties with that protocol. Petitioner is at no greater risk of developing pressure sores now as opposed to his pre-existing condition.

Accordingly, the Arbitrator finds Dr. Ingberman's opinion that Petitioner was at MMI by December 20, 2008 was supported by the evidence, but for Petitioner's continued reasonable and necessary medical consultation for his pressure sore through March 9, 2009. Therefore, Petitioner would have been entitled to TTD from May 6, 2008 through September 16, 2008 and from October 22, 2008 through March 9, 2009, 38 & 5/7 weeks.

K: Is Petitioner entitled to PTD?

Petitioner has been a C5-7 quadriplegic since age 18. Petitioner's condition of quadriplegia is unchanged. Petitioner's work injury did not cause any substantive change in Petitioner's quadriplegia. Petitioner position that he is unable to return to his former employment is based of Dr. Stachowski's limitations. The Arbitrator has previously found that Dr. Stachowski's work restrictions are not reasonable in comparison to more persuasive opinions by Respondent's expert, Dr. Ingberman. Petitioner failed to prove that because of his work injuries from May 6, 2008 that he is no longer able to work. His femur fracture has healed and he has had no pressure sores in several years.

Respondent's expert, Dr. Ingberman testified that Petitioner was at MMI with regard to his work-related pressure sore. She opined that petitioner could return to his pre-accident employment within the restrictions she deemed advisable for all patients with quadriplegia: shift weight every thirty minutes for 30 to 90 seconds. Dr. Ingberman persuasively opined that the restrictions recommended by Stachowski were actually detrimental to Petitioner's well-being.

After considering the testimony of both experts and all other evidence, the Arbitrator finds Dr. Ingberman's opinion more persuasive inasmuch as she specializes in the area of wound care and actually treats patients like Petitioner on a regular basis. Accordingly, the Arbitrator adopts the opinions of Respondent's expert, Dr. Dinora Ingberman.

Therefore, the Arbitrator finds that Petitioner failed to prove that he is permanently totally disabled as a result of his work injury on May 6, 2008.

O: Is Petitioner entitled to vocational rehabilitation counseling services?

Petitioner consulted a certified rehabilitation counselor Edward Steffan for an assessment as to whether or not Petitioner was employable in a stable labor market. Mr. Steffan opined that, based on restrictions set by Dr. Stachowski, Petitioner was not employable and was in need of vocational counselling. The Arbitrator finds that the opinions of Mr. Steffan are not reasonable and, therefore, not persuasive.

Mr. Steffan testified that his opinions were based on the 2 hours on and 2 hours off restrictions recommended Dr. Stachowski. The Arbitrator previously found those restrictions were not reasonable and not persuasive. In addition, Mr. Steffan

acknowledged that he did not fully understand Pettioner's work duties. Also, he testified that he had not previously counselled anyone with physical restrictions such as Petitioner's. Finally, Mr. Steffan acknowledged that Petitioner could return to his pre-accident employment with the restrictions recommended by Dr. Ingberman.

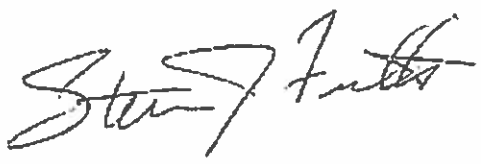
Accordingly, the Arbitrator finds that Petitioner failed to prove that he is entitled to vocational counselling services.

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

There is no dispute that Petitioner suffered a fracture to his distal femur as a result of his work accident May 6, 2008. That injury required orthopedic intervention which included reduction of the fracture and casting. However, prior to his injury Petitioner was wheelchair-bound due to quadriplegia suffered at the age of 18. His treating orthopedist released him for return to full duty work regarding the fracture on September 16, 2008. Due to his pre-existing quadriplegia Petitioner had no continuing disability relating to the femur fracture.

Petitioner developed a pressure sore from the cast fitted to treat the femur fracture. That pressure sore was successfully treated and has not recurred since 2009. Petitioner's treating physician Dr. Stachowski and Respondent's IME physician Dr. Ingberman both described the pressure sore as healed. The medical evidence established that despite some recurrences the pressure sore condition resolved by March 9, 2009, when Petitioner was at MMI. The evidence established that Petitioner could return to work within the restrictions set forth by Respondent's wound-care expert.

Based on consideration of all the evidence the Arbitrator finds that Petitioner sustained a partial permanent disability of 10% of a person-as-a-whole, 50 weeks at $901.20/week.



January 16, 2017

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald Flatt,
Petitioner,

vs.

Wingle Construction,
Respondent.

18IWCC0744

NO: 13 WC 13671

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 18, 2018, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,500.00. 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: DEC 7 - 2018
o11/1/18
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 ARBITRATOR DECISION

18IWCC0744

FLATT, GERALD
Employee/Petitioner

Case# **13WC013671**

WINGLE CONSTRUCTION
Employer/Respondent

On 2/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2126 SMITH LAW LTD
RODNEY L SMITH
622 JACKSON AVE
CHARLESTON, IL 61920

0734 HEYL ROYSTER VOELKER & ALLEN
JOE GUYETTE
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824-1190

18IWCC0744

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GERALD FLATT
Employee/Petitioner

v.

WINGLE CONSTRUCTION
Employer/Respondent

Case # **13 WC 13671**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **12/15/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/24/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**61,691.24**; the average weekly wage was $**1,186.37**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **0** children under 18.

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

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

Respondent shall be given a credit of $**49,827.33** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**49,827.33**.

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

ORDER

Petitioner has failed to establish that his current condition of ill-being is causally related to the accident of October 24, 2011.

For the injury sustained by Petitioner as a result of the accident of October 24, 2011, Respondent shall pay Petitioner permanent partial disability benefits of **$695.78/week** for **15 weeks**, because the injury sustained caused **3% loss of use of a person as a whole**, as provided in §8(d)(2) of the Act.

Respondent shall pay Petitioner compensation that has accrued between **October 24, 2011** and **April 21, 2013** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

February 4, 2018
Date

FEB 8 - 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner was initially seen at the Tuscola Pain and Wellness on December 1, 2005. (RX 6). The initial report form indicates that Petitioner was complaining of neck and mid back pain since a whiplash injury "6 years ago". (RX6). Petitioner was seen at that facility 20 times from December 2005 through December of 2006. (RX 6).

From April of 2010 through December 22, 2010, Petitioner was seen at Tuscola Pain and Wellness 11 times. (RX 6). Visits in August of 2010 specifically referenced treatment for Petitioner's neck. (RX 6)

In 2011 Petitioner was again seen at Tuscola Pain and Wellness. (RX 6). In the notation for each of those visits, there is an indication that Petitioner had neck pain. The expanded note from February 25, 2011, indicates that Petitioner was experiencing moderate pain in the cervical area (5/10). He was also experiencing moderate and constant pain across his shoulders (6/10) with activity which varied in intensity. The same pain was radiating into Petitioner's right arm, which he rated as 5/10. Petitioner also had moderate (6/10) pain in his upper mid back bilaterally. "This is with activity, constant, varying in intensity." Dr. Hemmer noted, "He has trouble with this area secondary to his work activity." (RX 6) In the "assessment" portion of the note, it is indicated that Petitioner was suffering from chronic injury:

> "This injury has resulted in muscular splinting. Muscular splinting is a term given to muscles, which have gone into spasm to act as a restrictive agent, like a natural cast. This natural cast is formed to restrict motion of the spine and to protect the spine from further injury. Chronic muscular splinting or spasming may lead to myofibrositis. Myofibrositis has occurred in the above mentioned areas for Gerald. The long–term effects of myofibrositis may include calcification of the damaged muscular tissue. This would obviously cause loss of function of the muscle and would result in pain and discomfort."
> (RX 6)

Petitioner was to be seen by the doctor once a week until stability was achieved. (RX 6)

Petitioner returned to Tuscola Pain and Wellness Center on June 13, 2011 and he was still having moderate pain in his cervical spine, radiating down his right arm. Petitioner mentioned "aggravating his neck and mid-back conditions while working over his head." (RX 6). Objective examination revealed hypomobility at C4, C5, C6 and C7. Further, deep tendon reflexes suggested nerve root entrapment at C7. Petitioner was to be seen once a week until stability was achieved. (RX 6).

Petitioner returned to Tuscola Pain and Wellness Center on August 8, 2011. (RX 6). At that time, Petitioner was continuing to complain of moderate pain in the cervical area, radiating to his right

arm. Petitioner rated the pain at 5 out of 10. Dr. Hemmer noted, "Mr. Flatt aggravated the same areas again while pushing and pulling heavy loads at work." (RX 6) Objective testing was the same as noted in the treatment note of June 13, 2011. (RX 6). In the "plan" portion of that note, Dr. Hemmer indicated "I have scheduled Gerald for one visit per week until stability is achieved." (RX 6).

Petitioner again returned to Tuscola Pain and Wellness Center on October 26, 2011. At that time, Petitioner was complaining of moderate pain in the cervical area, across the shoulders and with pain in his right arm. Petitioner rated the pain 7 out of 10. Petitioner's objective exam was the same as on 8/8/11 and 6/13/11. The diagnosis remained unchanged. Dr. Hemmer recommended 3 visits per week, for 60 days. The treatment note does not include any history of an accident at work. (RX 6)[1].

Petitioner returned to see Dr. Hemmer on October 28, 2011, and his complaints and exam findings were the same, but his pain was down to 6 out of 10 and 5/10. Throughout his post-accident treatment at the Tuscola Pain and Wellness, the exam findings remained consistent. (RX 6).

While Petitioner was continuing to treat with Tuscola Pain and Wellness, he sought treatment with Dr. Jaliparthi at the Carle Department of Family Practice. Petitioner was first evaluated at Carle on December 29, 2011. The treatment note for that date indicates Petitioner was complaining of pain in his right shoulder, arm forearm, and elbow "on and off since the end of October of 2011." Further, the note indicates that "he does not recall any particular injury or trauma to the area." (RX 3). Petitioner suggested that "most of his pain is actually in the elbow area, which is radiating up into the shoulder and lower down to his arm." Petitioner was noted to be a carpenter complaining of constant and achy pain worse with pushing or pulling. Petitioner felt most of his pain was actually in the elbow are and radiating up into his shoulder and lower down to his arm. He also mentioned occasional numbness and tingling. Petitioner felt the pain was worse on sleeping on that side and was keeping him up at night. He denied any previous shoulder injuries or surgeries. Petitioner denied any relief from chiropractic care or a massage. There is no indication that Petitioner was complaining of neck pain. Petitioner's pain complaints were attributed to inflammation and possible entrapment, and Petitioner was provided with for Prednisone, Flexor and Tramadol. Petitioner was told to return for further evaluation if his symptoms did not improve. (RX 3)

Petitioner had three visits with Dr. Hemmer between January 3, 2012 and January 20, 2012. Petitioner's pain complaints were noted to be reduced to 5/10 and 4/10. On January 23, 2012, Petitioner's pain complaints were noted to be reduced to 4/10. He was referred for an MRI to look for a herniated disc due his lack of improvement over the preceding last few months. (RX 6)

Up until February 3, 2012 Petitioner had been working full duty.

Petitioner was examined at Dr. Gurtler's office in the Carle Department of Orthopedics/Sports Medicine on February 3, 2012. The office note was prepared by P.A. Pearman. Petitioner reported working as a carpenter on October 24, 2011 when he noticed some pain in his lower neck and shoulder which significantly increased the next day. Petitioner described a shooting pain that

[1] The SOAP note has a line for "Place of Injury" and it is blank.

wrapped around the posterior of his shoulder and went down his arm. Since then he had been experiencing "repetitive bouts of lower cervical pain with shooting pains down the arm." (PX 12). Petitioner was having trouble with lifting, pushing and pulling as it caused significant increase in his neck and shoulder and distally to his digits. He also reported transient paresthesia of the digits making it difficult to squeeze his tools and certain position of the head and neck aided his symptoms. A "frank discussion" was held with Petitioner who appeared to have cervicalgia with peripheral radiculopathy and associated atrophy. It was "strongly recommended" that Petitioner be referred to the Spine Institute for further evaluation. (PX 12). Petitioner was provided with a work restrictions of no lifting, pulling or pushing over 30 pounds. He was to return as needed. (PX 12)

At the request of P.A. Pearman, Petitioner presented to Dr. Tipirneni at the Carle Spine Institute on February 10, 2012. (PX 12). P.A. Pearman had ruled out a shoulder problem but was concerned about a neck problem – hence, the referral. Petitioner complained of mid-neck pain and right arm pain radiating all the way into the second, third and fourth digits. Petitioner explained that his "symptoms started from a work–related injury that occurred in October of 2011." (PX 12). Dr. Tipirneni noted that Petitioner was a union carpenter and his job required a lot of pushing, pulling, lifting, bending or overhead activities and he was doing his regular job lifting things repetitively about 60-70 lbs. Petitioner further indicated that "he does not know of one particular incident, but indicated overall his pain got more severe at the end of his day." (PX 12). He reported being able to work but noticed more pain over the next few days. Petitioner indicated that his pain went from the mid neck to the right shoulder between the shoulder blade area and down his arm to his elbow and second and third digits. He complained of numbness, tingling and a pulling sensation, worse with lifting, pressing, and twisting actions. Petitioner was diagnosed with cervical degenerative disk disease, cervical radiculopathy and a cervical sprain/strain. Dr. Tipirneni recommended an MRI of the cervical spine to evaluate the possibility of nerve root impingement, stenosis or a herniated disc. Dr. Tipirneni also referred Petitioner for physical therapy and advised him to get into Occupational Medicine to follow up on his work restrictions. In the interim, he was placed on light duty as no one was following his work restrictions and he had been off work for the past week but felt it was increasing his pain. (PX 12)

Petitioner underwent a cervical MRI February 16, 2012. It showed right–sided C6–C7 lateral foraminal stenosis and a herniated disc along the left side at C5–C6. (PX 5)

After the cervical MRI was completed, Petitioner returned to see Dr. Tipirneni on February 20, 2012. The doctor noted the MRI showed a herniated disc along the left side at C5–C6, but Dr. Tipirneni also noted that Petitioner did not have any symptoms on his left side. Petitioner's symptoms appeared to be primarily in the right upper extremity. He had a positive Spurling's test on the right side with radiculopathy down the arm. Dr. Tipirneni again recommended physical therapy, and indicated that an epidural steroid injection would be the next step of his symptoms did not improve. Petitioner was to continue with light duty. (PX 12)

Petitioner returned to Dr. Tipirneni on April 19, 2012. (PX 12). Petitioner indicated that physical therapy had resolved his symptoms in his right arm. Petitioner continued to complain of pain in his neck and between his shoulder blades. Petitioner reported that physical therapy had helped his right arm symptoms as they had resolved. Petitioner's primary area of pain was between the

shoulder blade area. He rated his pain as 2/10 overall with a 4/10 after standing for 2 – 3 hours. He noted that the TENS unit tried by the therapist provoked his pain and a trial of cervical traction helped significantly. Spurling's test was negative. Dr. Tipirneni recommended a series of trigger point injections for the bilateral trapezius muscle, along with a course of physical therapy. Dr. Tipirneni further indicated that Petitioner was not a surgical candidate, as a result of the lack of radicular symptoms and neurological deficits. A lengthy discussion was held regarding work restrictions with the doctor again recommending Petitioner check in with Occupational Medicine to get himself established. Petitioner was advised that walking need not be restricted. He was otherwise told to engage in moderate duty and not lift more than 30 lbs. (PX 12)

Petitioner attended physical therapy as advised. (PX 12)

Petitioner returned to see Dr. Hemmer on April 25, 2012 and reported his pain complaints were now 7/10. Dr. Hemmer noted that Petitioner had "aggravated the same areas again at home." Two days later, on April 27, 2012, Petitioner's pain complaints were reduced to 4/10. (RX 6)

Petitioner returned to see Dr. Tipirneni on April 27, 2012, and underwent trigger point injections to the bilateral trapezius muscles. Petitioner reported he was going to physical therapy. He felt his radicular symptoms had improved to the point where the majority of his pain was now in the mid-neck area and bilateral posterior shoulder blade area. He did have a lot of tenderness along the trapezius muscle. She recommended some trigger point injections as the epidurals would not helped the mid-neck area as his radicular symptoms had gotten better. Petitioner underwent the trigger point injection and the doctor continued to recommend further physical therapy. Petitioner denied any new onset of weakness or recent trauma, fall, or motor vehicle accident except for the work-related one that "started his symptoms." Petitioner also reported a lot of crackling when he moves and popping sensation with his neck area which the doctor felt was more related to arthritis and the facet joint irritation. His restrictions were advanced to moderate duty but no lifting more than 30 lbs. or overhead activity. He was to avoid ladders and alternate sitting/standing every 15 minutes. The doctor's impression was myofascial pain syndrome, cervical degenerative disc disease, cervical spondylosis without myelopathy and 100% improved cervical radiculopathy due to time and therapy. Petitioner wished to do his therapy closer to home and was told to speak the Paula Wright, the work comp coordinator in the doctor's office, to see if that could be done. (PX 12).

Petitioner returned to see Dr. Tipirneni on May 11, 2012, indicating that the trigger point injections had resulted in a 40% reduction in his symptoms. Dr. Tipirneni completed a second set of trigger point injections and also increased Petitioner's lifting restriction to 50 pounds. Petitioner felt the majority of his pain was in the posterior neck area and mainly consisted of pressure, tightness, and muscle spasms. He reported that extension made things worse and that his job required him to do that. He felt he would have no problems with the 30 pound weight restriction. Petitioner denied any right upper extremity symptoms. Petitioner asked the doctor about the herniated disc on the MRI and the doctor advised him that she didn't treat the MRI; rather, she treated symptoms and it appeared that the nerve had called down even with the herniated disc. She also noted that his herniated disc was on his non-affected side. Dr. Tipirneni felt Petitioner's pain was still due to disc degeneration as well as a muscle component to his neck pain. She suggested that Petitioner undergo

the second injection and return in two weeks for a final set of trigger point injections. His lifting restriction was increased to 50 lbs. (PX 12).

When Petitioner returned to see Dr. Tipirneni on May 25, 2012, he indicated that the second set of injections further reduced his pain complaints. Petitioner rated his pain at 1/10, but complained that he was still unable to do any overhead work. Dr. Tipirneni completed the series of three trigger point injections on that date, and recommended that an epidural steroid injection might be necessary if his symptoms did not improve. She also recommended that he continue with the physical therapist and try using a cervical traction unit. Petitioner again denied any upper extremity symptoms. (PX 12).

Petitioner next saw Dr. Tipirneni on June 7, 2012. At that time, he indicated that the third set of trigger point injections did not fully resolve his symptoms. Dr. Tipirneni recommended proceeding with an epidural steroid injection at C7–T1. The epidural steroid injection was completed on that date, and Dr. Tipirneni suggested that he should continue with physical therapy. (PX 12)

Petitioner was discharged from physical therapy as of June 11, 2012 due to lack of progress. The therapist felt he might benefit from a work conditioning program. (PX 12)

Petitioner last saw Dr. Tipirneni on June 28, 2012. (PX 12[2]). Petitioner indicated that the cervical epidural steroid injection provided only minimal relief, and his primary complaint was that he would develop a headache when he looked up with cervical extension. Dr. Tipirneni noted that "I indicated headache I do not feel it is coming from the spine standpoint nor do I feel from his mechanism of injury would be issues from his work–related injury." (PX 12). Dr. Tipirneni's physical examination of Petitioner was normal. She felt the majority of his symptoms were muscular in origin as disc degeneration. He, again, had no radicular symptoms. Dr. Tipirneni also reviewed Petitioner's physical therapy notes, and indicated that he was capable of lifting up to 130 pounds, pursuant to the physical therapy note of June 11, 2012. His cervical extension was 4+/5. The rest of his PT notes showed considerable improvement in Petitioner's condition. She felt he should continue with the work conditioning for about two weeks as well as his home exercise program. Based on those physical therapy notes and her examination, Dr. Tipirneni indicated "I do feel that patient can return back to work with no work restrictions." (PX 12). She also indicated that she would refer him [to] Occupational Medicine to provide "those return back to work as there is nothing else we can provide here at Spine as there is nothing neurologically nor anatomically I am seeing on his x-rays that would inhibit him from going back to return to work with full duty." (PX 12). Dr. Tipirneni concluded that "the objective symptoms seem significantly better compared to his subjective symptoms." The doctor also noted that Petitioner reported that he had not worked since October of 2011. (PX 12)

Petitioner was examined by PA-C Michael Steveley at L.T. Occupational Health on July 16, 2012; however, the office note from the examination is not a part of the record. PA-C Steveley completed an Occupational Status Report at that time and imposed work restrictions of no lifting, pushing, or pulling over 50 lbs., no climbing or overhead work, and alternating standing and sitting. He was to return on July 31, 2012 and was to see Dr. Stroink on July 24, 2012. (PX 13)

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[2] See also RX 4

Petitioner saw Dr. Ann Stroink on July 24, 2012. (RX 11). At that time, Petitioner was complaining of neck pain with right arm pain since October 24, 2011 when he was pulling at an odd angle at work. (PX 11). Dr. Stroink recorded that her neurological exam of Petitioner was normal, and diagnosed degenerative disc disease of the cervical spine. A cervical MRI was ordered. (PX 11)

Petitioner returned to see PA-C Steveley on July 31, 2012. (RX 5; PX 13) At that time, Petitioner was complaining of neck pain. Petitioner reported being scheduled for an MRI on August 14th and having an appointment with his surgeon that same day. Petitioner admitted a mild headache and generally experiencing no pain except when lifting overhead. Examination of his neck showed no weakness or pain. He had full range of motion with subjective complaints of pain radiating into his right shoulder blade upon hyperextension. Petitioner indicated that he was infrequently taking Motrin because he did not like taking medications, and it occasionally bothered his stomach. Petitioner further stated that he generally had no pain, "except for when he is lifting over his head." (RX 5) PA-C Steveley listed a diagnosis of "neck pain, question of malingering." (RX 5) Mr. Steveley reiterated the need to consistently take Motrin to relieve inflammation, and suggested that "he may continue to work with the prior restrictions." (RX 5; PX 13).

Petitioner underwent an updated cervical MRI on August 14, 2012. The films were read as showing significant developmental acquired spinal stenosis of the cervical spine canal at multiple levels and a moderate degree of stenosis at C3-4 and C4-5. He had moderate to severe stenosis at C5-6. The left neural foramen at C5-6 was especially narrowed. (PX 4)

Petitioner returned to see Dr. Stroink on August 14, 2012, after getting an updated cervical MRI. (PX 11). At that time, Petitioner indicated that his arm pain was better but that he continued to have neck pain. (PX 11). Dr. Stroink reviewed the MRI and noted stenosis at several levels, but no cord compression. (PX 11). Dr. Stroink noted that she did "not see a large disc herniation or a neurological deficit on today's examination," and concluded that Petitioner was not a surgical candidate. (PX 11). Dr. Stroink noted that "he is happy with this conservative approach," and told Petitioner to return as needed. (PX 11).

When Petitioner returned to Mr. Steveley's office on August 17, 2012 he indicated that he had seen a surgeon who had reiterated that he was not a surgical candidate. (RX 5). Petitioner further indicated that he was only taking Motrin on an occasional basis, contradicting Mr. Steveley's recommendations. Mr. Steveley noted that "the patient today seemed somewhat reluctant at suggestions for treatment, which included ongoing physical therapy, even though he does continue to say that he wants to continue to work and that he does not want to go onto disability." (RX 5). The physical exam on that date was normal, except for pain during extreme extension of the neck. Mr. Steveley updated his diagnosis to reflect neck strain, with probably malingering and deception." (RX 5). Petitioner's restrictions remained unchanged. (PX 13)

Petitioner again returned to see Mr. Steveley on August 31, 2012. Dr. Stroink's August 14, 2012 office note had been sent to Mr. Steveley and he noted inconsistencies between what it said and what Petitioner was telling him. Dr. Stroink's notes stated that Petitioner's arm discomfort had improved; however, during the visit that day and on previous ones, Petitioner had advised Mr. Steveley that the pain continued. Petitioner indicated that Dr. Stroink suggested that he needed to find a new line of work, which did not require him to look above his head. They again discussed

the need for therapy and Mr. Steveley reiterated that Petitioner "is very reluctant as he has been in the past, about trying any kind of treatment." Petitioner also acknowledged not taking his medication on a regular basis "for at least the third time" and he was told he needed to do so whether he believed it was helping or not. (RX 5)

Petitioner returned to see PA-C Steveley with the same complaints on September 28, 2012. Petitioner indicated his neck pain continued and was about the same as he was sore all of the time and if he is up all day it would hurt "really bad." Additionally, if he just laid around the next day, it hurts eve more. He had been taking Motrin Mr. Steveley recorded that "even though the patient states several times he wants this over with, he continues to say that he wants to continue on with work. I have problems with this, if lying around hurts him even more, and nobody believes that he needs any surgery, then I do believe he is able to return to work." (RX 5) Mr. Steveley concluded that "the patient may, in my opinion, return to work, however I am unclear if this patient will do this." He also told Petitioner that he expected an IME to be scheduled. (RX 5) PA-C Steveley's Occupational Status Report is not found in PX 13.

Petitioner returned to see Mr. Steveley on October 26, 2012. Petitioner's neck and shoulder pain was described as a 3-4/10. He felt therapy was helping to loosen up his muscles but wasn't doing anything for his pain. He was taking the Motrin but not on a regular basis. Petitioner denied any numbness, tingling or burning radiation from his neck into his shoulders or upper extremities. On range of motion the results were good and Petitioner complained of pain with extension and trying to touch his right ear to his shoulder. He was to continue with physical therapy. Mr. Steveley diagnosed Petitioner with degenerative disc disease, bulging disc and "malingering, deception, exaggeration of condition." (RX 5) Petitioner's restrictions remained unchanged. (PX 13)

Petitioner returned to see PA-C Steveley on November 26, 2012 and once again reported improvement with therapy in terms of relaxing his muscles. He continued to report constant pain of a 3/10. He had stopped taking his Motrin three days earlier due to GI problems. He had no complaints in his upper extremities. His primary discomfort was when he lifted his head (hyperextension). Mr. Steveley noted that he spoke with Petitioner about the possibility of returning to work; however, Petitioner advised him that he couldn't do the job that he used to do and was unclear what he was going to do in the future. On examination Petitioner had full active and passive range of motion of his neck. On extension, there was pain reproduced but PA-C Steveley could not palpate it or reproduce it during the exam except upon hyperextension. Mr. Steveley diagnosed degenerative disc disease, bulging disc and "malingering, deception, exaggeration of condition." (RX 5) At the next visit they hoped to discuss options for returning him to work. Petitioner's restrictions remained unchanged. (PX 13)

Petitioner underwent a functional capacity evaluation on December 6, 2012. Petitioner gave maximal effort on all tests and reported discomfort in his upper back and headache. The therapist noted Petitioner's perception of abilities was less than his actual abilities. He reported discomfort in his upper back and headaches while testing. Objective signs correlated with his complaints. It was also noted that Petitioner demonstrated limitation in forward bending, half kneeling/kneeling and walking. The therapist also indicated Petitioner's ability to return to work could not be fully assessed as there was no actual job description to review. (PX 3)

Petitioner returned to see PA-C Steveley on December 21, 2012. Petitioner reviewed the results of his functional capacity evaluation with Mr. Steveley. (RX 5). Mr. Steveley noted that "I find it interesting, to say the least, that he demonstrated limitations in postures of forward bending, half kneeling, walking, when the patient's main complaint is neck discomfort." (RX 5) While Petitioner was taking his Motrin he was not doing so on a continuous basis. PA-C Steveley expressed concern if Petitioner was truly discontinuing it due to GI problems. He was given a script for Soma to see if it would help him sleep. Mr. Steveley concluded that "As I stated before, I really wonder and have concerns about this patient, and if he is malingering or if there is some deception or exaggeration of his condition. At this point, I need to hear from the insurance company, as with these concerns, I do believe the patient is at MMI." (RX 5). Mr. Steveley diagnosed degenerative disc disease, bulging disc and "malingering, deception, exaggeration of condition." (RX 5) Petitioner's restrictions remained unchanged. (PX 13)

Petitioner again saw Mr. Steveley on January 21, 2013. PA-C Steveley noted that Petitioner reported being "lazy last week and states that he believes this is causing his neck to be stiff this week." He was only taking half his medication dose and reported lightheadedness, dizziness and pain when bending his head." Petitioner was asked about contact from the insurance company and told him "they are talking about some type of rehab, however he is not really talked with them." His exam and diagnoses were unchanged from the previous visit. Petitioner was told to take his medication as instructed. PA-C Steveley also expressed the need for some intervention from the insurance company, writing "Again, when we looked at his functional capacity, the items he complained about have nothing to do with his alleged work injury." (RX 5) His restrictions remained unchanged. (PX 13)

Petitioner again saw Mr. Steveley on February 28, 2013. (RX 5). Petitioner reported neck pain rated 3/10. He reported meeting with a lady at the library for a skill assessment but hadn't heard anything since then. He admitted to a minor headache occasionally. He had some decreased range of motion of his neck with hyperextension; otherwise, his examination was normal. A prescription for Klonopin was given. (RX 5) His restrictions remained unchanged. (PX 13)

Mr. Steveley last saw Petitioner on March 19, 2013. (RX 5). Petitioner's neck pain was reported as a 3-4/10 although it had been worse over the last few days. He had to stop his Motrin for 2-3 days due to GI problems and realized it must be working as his pain got worse. He didn't get the Klonopin filled as he said the insurance company wouldn't pay for it; however, PA-C Steveley advised him it was a rather old medication and should be fairly cheap. Nevertheless, Petitioner advised Mr. Steveley that he wasn't going to get it filled if he had to pay for it. An IME had been scheduled for April 3rd. On exam Petitioner had pain over the traps especially at the edges of his neckline and in extreme flexion of his neck and with resistance. Mr. Steveley's diagnosis remained degenerative disc disease, bulging disc and "possible exaggeration of condition." (RX 5). Petitioner was to return in one month or sooner if they had the IME results. Petitioner's restrictions remained unchanged. (PX 13)

Dr. Van Fleet examined Petitioner on April 3, 2013 at the request of Respondent. (RX 1) In his report to the insurance company Dr. Van Fleet addressed several specific questions posed to him. He also related meeting and speaking with Petitioner, reviewing records, and examining Petitioner. In speaking with Petitioner, Dr. Van Fleet noted that Petitioner denied any prior history of

difficulty with his cervical spine before his injury. Petitioner described his accident as occurring on October 24, 2011 and that he was yanking on a piece of wood that was stuck, and when he did that, it resulted in pain across the back of his neck. Petitioner reported continuing to work until February when he was taken off work for which he had not returned. Petitioner was primarily reporting pain mostly across the base of his neck at the cervicothoracic junction with some occasional numbness and tingling into his right upper extremity. On exam, Petitioner had mild palpable discomfort across the cervicothoracic spine. Dr. Van Fleet also reviewed Petitioner's August 14, 2012 MRI which he felt showed evidence of degeneration at C3-4, C4-5, C5-6, and C6-7 with evidence of disc osteophyte complex. Petitioner also had an inherent amount of narrowing within the spinal canal that did compress the thecal sac and mildly displaced the cervical cord but there was no evidence of any cord signal change. He also had appreciable bilateral foraminal stenosis at the same levels. Dr. Van Fleet felt Petitioner's accident caused a cervical strain of the muscle across the base of Petitioner's neck. He felt Petitioner "certainly" had an underlying pre-existing condition and the accident created a muscle tension as well as perhaps exacerbating the underlying disc disease. He further stated that the mechanism of injury was consistent with cervicalgia but "to the extent that he described it at this point in time, in my estimation, no, it does not support his diagnosis." He did not feel the mechanism Petitioner described would create a chronic neck condition dating to this point in time. Dr. Van Fleet stated that he felt Petitioner suffered a temporary aggravation of a pre-existing condition. He currently suffered from cervical degenerative disc disease and muscle deconditioning. There were no objective findings on his physical examination that corroborated or supported the level of pain he was currently experiencing. His imaging studies were described as "entirely consistent with a pre-existing pattern." Dr. Van Fleet felt Petitioner was at maximum medical improvement. His treatment had been appropriate but he didn't need any more. He felt restrictions should be based upon the functional capacity evaluation which was a valid study and showed Petitioner could be functioning at a medium demand level, which would not be consistent with his job duties as a carpenter. Dr. Van Fleet noted that he didn't feel the restrictions were subjective. He wrote, "Based upon his performance and based upon his limitations, these are due entirely to his own complaints of pain and are not medically substantiated, and these restrictions are not required based upon his condition." He felt any limitations were due to subjective complaints of pain which the doctor felt related to his underlying pre-existing condition and not to his work injury in 2011. He did not feel Petitioner's insomnia was related to his work injury. (RX 1)

Petitioner signed his Application for Adjustment of Claim herein on April 16, 2013, alleging herniated discs in his neck after "yanking on a piece of wood." (AX 2)

Petitioner returned to see Dr. Stroink on August 15, 2013, having last been seen in August of 2012. (PX 11). Petitioner continued to complain of neck stiffness and pain since his work injury and also noted that right arm numbness had returned. According to the doctor's office note, she had seen Petitioner in August of 2012 for similar complaints, reviewed his x-rays from August 2012 and left a note in December 2012.[3] The doctor noted that Petitioner had had very little arm pain in August of 2012 as he had reported the physical therapy and neck traction had helped him. However, in the last seven months, the arm pain had returned. The doctor again reviewed Petitioner's two 2012 MRIs and noted he had evidence of stenosis at C5-6 and a herniated disc at C5-6 on the left side for which he was asymptomatic. Examination of Petitioner's upper

[3] The latter of which is not a part of the record.

extremities showed questionable weakness in the finger extensors of the right hand but all else was normal. Sensory examination suggested sensory numbness in the C7 distribution of the right arm. Dr. Stroink's impression was that of ongoing neck pain. Petitioner advised the doctor that he felt his injury was work-related as he was bent over at work pulling on a board and had been having a lot of neck pain ever since. Dr. Stroink's notes indicate she explained to him that he had developmental spinal stenosis and she was aware that he reported headaches and further neck pain when working overhead. Petitioner was wondering what he might be doing in terms of employment in the future and the doctor advised him that with spinal stenosis overhead work was probably not an ideal work situation but she was no expert. She suggested he either see someone in occupational health or a physiatrist to assist him with those questions. In light of his ongoing or new C7 radiculopathy the doctor recommended an updated MRI. (PX 11)

Petitioner has undergone no further medical treatment for his neck, shoulder or upper extremities since August 15, 2013.

Dr. Van Fleet was deposed on November 13, 2013. (RX 2) In conjunction with his examination, Dr. Van Fleet reviewed records from Dr. Tipernini, Dr. Stroink, Dr. Hemmer, and Physician's Assistant Steveley. (RX 2, p. 7). Petitioner provided Dr. Van Fleet a history involving a work accident on October 24, 2011, when "he was yanking on a piece of wood, as I described it, that was stuck and when he did this he developed pain across the base of his neck." (RX 2, p. 8). Dr. Van Fleet testified that Petitioner specifically denied any prior neck problems or injuries. (RX 2, p. 8).

Dr. Van Fleet testified that when he examined Petitioner, Petitioner was "mostly reporting pain across the base of his neck and at the cervical thoracic junction. Perhaps occasional numbness in the extremity. But again, it was the chronic axial neck pain that really was his predominant complaint." (RX 2, p. 10). On exam, Dr. Van Fleet did not find any neurological abnormalities that would be consistent with spinal cord compression. (RX 2, p. 11). Dr. Van Fleet reviewed Petitioner's cervical MRI of August 14, 2012, and noted that degenerative changes found in that study pre-dated the accident. (RX 2, p. 12). Based upon the findings of the MRI, Dr. Van Fleet would have anticipated that Petitioner had neck pain even before the date of accident. The doctor saw no signs of an acute injury on the MRI. (RX 2, p. 12).

Dr. Van Fleet diagnosed Petitioner with a cervical strain as a result of the accident of October 24, 2011, along with underlying cervical degenerative disc disease. (RX 2, p. 13). Dr. Van Fleet testified as follows:

> Basically if somebody is going to have a strain that strain is going to resolve over a period of time. The natural history of a degenerative disorder anywhere in the spine, really anywhere in the body, is that there is a state of inflammation that takes place after an injury. The body has a tendency to work on the inflammation. Eventually the acute episode transitions into a chronic disorder, where the disorder is related more towards the chronicity of the underlying degenerative condition, and not as a result of the acute or the injured mechanism. (RX 2, p. 14)

Dr. Van Fleet noted that Petitioner should have reached maximum medical improvement (MMI) for this condition 6 to 8 weeks after the accident, and up to 12 weeks, at the most. He felt that as of April 3, 2013 Petitioner was clearly at MMI for his strain. (RX 2, pp. 13-15).

Dr. Van Fleet reviewed Petitioner's functional capacity evaluation, and found it to be a valid study. (RX 2, p. 15). Dr. Van Fleet testified that the limitations identified by the functional capacity evaluation were the result of pain and related to Petitioner's pre-existing cervical degenerative condition. (RX 2, p. 16).

Dr. Van Fleet did not feel Petitioner's insomnia was related to the claimed accident. (RX 2, p. 16)

Dr. Van Fleet, on cross-examination, acknowledged being paid for both his report and testimony. He thought he performed about 3 IMEs per week. (RX 2, p. 19) He also acknowledged that he did not review the earlier April MRI but he did look at the film from the August MRI. He also acknowledged that he didn't review Dr. Hemmer's medical records pre-dating the accident. (RX 2, p. 21)

Dr. Van Fleet testified that he was under the impression at the time of the IME that Petitioner had no prior cervical problems and that he had been doing the same type of work for about eight years before the accident. When asked "absent this incident at work, would you have an opinion when he would have started feeling this pain or having problems" and the doctor replied, "It would be hard to know." (RX 2, pp. 21 – 23)

Dr. Van Fleet further testified that right arm numbness can result from multi-level foraminal stenosis. He did not recommend any surgery for Petitioner and he would impose no restrictions. (RX 2, pp. 23 -28) Dr. Van Fleet did not record Petitioner's weight or height. He also acknowledged no independent recollection of what type of shape Petitioner was in. (RX 2, p. 28) Dr. Van Fleet also testified that he associated the headaches with cervicalgia or the multi-level cervical disc disease. (RX 2, p. 29)

Petitioner's attorney and Dr. Van Fleet had the following exchange:

> Q. This accident, as described to you – and let's have you assume that he wasn't having any problems with his neck, no pain in his neck, was able to do all of his regular activities. And so let's make that assumption. He has this incident at work as described to you. Isn't it possible that this aggravation of a preexisting condition could not go back to baseline because of this incident as described to you?
>
> A. It's possible. (RX 2, p. 34)

On redirect examination Dr. Van Fleet was asked to assume that Petitioner had undergone treatment for his neck in December of 2005. He was shown a copy of the office note for that visit

and agreed that the note/record directly contradicted what Petitioner had told him in terms of prior problems. (RX 2, pp. 35-36)

At the request of Petitioner's attorney Dr. Sandercock examined Petitioner on December 21, 2015, regarding "neck problems stemming from an injury on 10/24/11." (PX 2) According to the doctor's office note:

> The patient remembers it quite well because it was his birthday. He was working for [Respondent] through the union hall as a carpenter when he yanked on a board that caused him some pain in his right shoulder and upper extremity. It was something that he thought was not a big deal. He went to a chiropractor on a regular basis that gave him minimal relief. In February of the following year, he developed numbness in his 2nd, 3rd, and 4th digits and at that point filed a workman's comp claim because he was getting worse." (PX 2)

Petitioner explained that he had been told surgery wasn't recommended and that he would probably get worse after any surgery. However, Petitioner felt he could no longer lift anything heavy and wished to get back to carpentry work. Performing anything above his head would cause a headache in the back of his head. His numbness and tingling had resolved except for the right ring finger. Petitioner also noticed greatly decreased strength in the triceps area of his right arm. According to Petitioner he had been diagnosed with herniated discs at C3-4, C4-5, and C5-6 along with foraminal stenosis. Dr. Sandercock performed a physical examination and reviewed some 8/14/12 imaging studies which he felt showed disc bulging and foraminal stenosis at multiple levels along with central canal stenosis. The doctor was also shown an FCE indicating Petitioner could lift 80 lbs. occasionally and 35 lbs. frequently. Dr. Sandercock felt Petitioner was suffering from chronic right upper extremity weakness along with neck pain and headaches after the 10/24/11 work injury. He felt Petitioner's current condition was related to the work injury as "he did not indicate to me any difficulties or restrictions existing prior to this incident." Dr. Sandercock didn't have any opinion regarding further treatment but did feel permanent work restrictions would be appropriate if no further treatment options were available. (PX 2)

Dr. Sandercock's deposition was taken on January 9, 2017. (PX 1) Dr. Sandercock, an orthopedist, testified that he examined Petitioner one time and at the request of Petitioner's attorney. Petitioner related to him that he was having neck problems from "what he believed" was an injury on October 24, 2011. The doctor testified that "I am unclear exactly what happened, but he said he yanked on a board that caused him some pain in his right shoulder and upper extremity." (PX 1, p. 6). The doctor testified that Petitioner told him he "put it off for a while" but then saw and chiropractor and, a few months later, he was having trouble with some numbness in his fingers. At the time of his examination, Dr. Sandercock recorded a normal sensory examination of Petitioner's right hand. The doctor noted extremely limited range of motion of Petitioner's neck and a positive Spurling's. (PX 1, pp. 6, 8) Dr. Sandercock diagnosed Petitioner with right upper extremity weakness, with neck pain and headache which he felt was related to the work injury of October 24, 2011. He also felt Petitioner had a bulging disc, foraminal stenosis and central canal stenosis. (PX 1, p. 9).

Regarding Petitioner's work abilities, it was Dr. Sandercock's opinion that the functional capacity evaluation was a valid test, with appropriate restrictions. (PX 1, p. 10). Further, Dr. Sandercock believed that the restrictions identified by the functional capacity evaluation should be permanent. (PX 1, p. 10). Dr. Sandercock reviewed Petitioner's cervical MRI from August of 2012, and believes that the pathology seen in that study (the bulging disc and foraminal stenosis) was aggravated by the accident of October 24, 2011. (PX 1, pg. 10).

Dr. Sandercock's opinions were based on his understanding that Petitioner had no complaints of neck pain prior to the accident of October 24, 2011 and he felt the absence of prior complaints was significant. (PX 1, pp. 10-11). Dr. Sandercock did not recommend surgery, noting that "this is not my area of practice and I don't even know if he is a candidate for surgery." (PX 1, p. 12). With regard to the need for further treatment, Dr. Sandercock noted, "I would recommend an evaluation by the people who provide those services, but, once again, I don't want to say this is what needs to be done. That's not my area of practice." (PX 1, p. 12).

On cross-examination, Dr. Sandercock acknowledged that he did not review any chiropractic records in conjunction with his examination, and did not know if Petitioner ever saw a chiropractor before the accident. (PX 1, p. 13). He also acknowledged that if Petitioner had some prior neck problems it was possible that he could have returned to baseline before he examined Petitioner. (PX 1, p. 14) Dr. Sandercock also acknowledged that he was unsure of the cause of Petitioner's ongoing headaches. He did agree that they could be due to degenerative disc disease. (PX 1, p. 15).

Dr. Sandercock felt Petitioner's bulging disc, foraminal stenosis, and central canal stenosis would explain Petitioner's complaints. (PX 1, pp. 15-16) He agreed that Petitioner's numbness and tingling in his fingers had generally resolved by the time he examined Petitioner. (PX 1, p. 17)

On redirect examination Dr. Sandercock agreed that he had no information indicating Petitioner couldn't do his carpentry job before his accident and he recalled no history of headaches prior to Petitioner's accident. (PX 1, p. 18)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on December 15, 2017. Petitioner was the sole witness testifying at the hearing. The disputed issues were causal connection, temporary total disability, and permanency. Petitioner maintains he is entitled to a wage differential award as a result of his accident.

Petitioner testified that he worked for Respondent for eight or nine years prior to the accident. Petitioner had been a union carpenter for around 11 years, and was working for Respondent through that union.

Petitioner denied any problems performing his job before October 24, 2011.

According to Petitioner, Respondent's work was primarily centered on commercial buildings, with work ranging "from framing walls to setting trusses, hanging drywall, cabinets, countertops,

acoustical ceilings." On the date of the accident, Petitioner was working in a small building in Urbana, performing some demolition work.

Describing the accident, Petitioner explained that they were doing some small demolition and there was a higher countertop and underneath there was some wood that they were trying to take off the wall and he was bent over "kind of at a weird angle" yanking on it and when he pulled, he could feel "kind of a strain" in his neck. Petitioner further explained that it felt like he had pulled a muscle or overdone something. He also testified that his neck stiffened as the day went on. Petitioner finished his work that day, and called his boss to report the accident on the day it occurred. Petitioner continued working in his regular position until February of 2012.

Petitioner testified that after the accident, he first sought treatment with Tuscola Pain and Wellness Center, on October 26th. Petitioner explained that he had previously sought chiropractic treatment with that office on an occasional basis for "maintenance."

Petitioner testified that he continued to work as he thought this issue would go away, and did not think he had suffered a major injury.

Petitioner testified that he went to Carle Clinic on December 29, 2011 to see his family doctor. He continued with chiropractic treatment in December and January and then presented to Dr. Gurtler on February 3, 2012 per his family doctor. Petitioner testified that he was then told he needed to go to the Spine Clinic (Dr. Tipirneni).

Petitioner testified that he has not worked since February 6, 2012. According to Petitioner, it was just getting where it was hurting so bad and his arm/muscles started to tingle all the way down to his fingers and he couldn't feel his fingers. Petitioner explained that overhead work was difficult, and that he was frequently having headaches. Petitioner testified that he was provided with work restrictions; however, Respondent was unable to accommodate those restrictions.

Petitioner eventually sought treatment with Dr. Tipirneni, at Carle Hospital. Petitioner testified that Dr. Tipirneni performed an epidural steroid injection, but that made his condition worse. Dr. Tipirneni also provided trigger point injections, and Petitioner explained that those helped his condition. According to Petitioner, "it relaxed the muscle and took some of it away. Dr. Tipirneni also prescribed a course of physical therapy. Petitioner testified that Dr. Tipirneni released him from treatment on June 28, 2012, but he continued his treatment with a physician's assistant in Occupational Medicine, PA-C Steveley. Petitioner didn't know who sent him to PA-C Steveley.

Petitioner also testified that he sought further treatment with Dr. Stroink in Bloomington. Dr. Stroink ordered an updated MRI. Petitioner explained that both Dr. Tipirneni and Dr. Stroink refused to perform surgery on his neck. He further testified that Dr. Stroink agreed that he shouldn't do any overhead work and told him to work with a physiatrist. Petitioner testified that he continued with PA-C Steveley who primarily oversaw his medications.

Petitioner further testified that he underwent a Functional Capacity Evaluation on December 6, 2012, per PA-C Steveley. Pursuant to the restrictions indicated by that Functional Capacity Evaluation, he was unable to pursue further job opportunities through the carpenters' union.

Petitioner testified that he met with a vocational rehabilitation person at the Tuscola Library in January of 2013. She never issued a report nor has anyone assisted him with vocational rehabilitation.

Petitioner acknowledged undergoing an Independent Medical Examination with Dr. Van Fleet in April of 2013. Petitioner testified that the exam lasted about 3 – 4 minutes and his benefits were terminated as of April 21, 2013. Since then he started looking for work. (See also PX 10)

Petitioner testified he was unemployed from April 22, 2013 through September 7, 2013. Thereafter, Petitioner began working as a guard at a power plant. He earned $10.50 per hour and worked 20 hours per week. He left that job on November 15, 2013, and was again unemployed through January 1, 2014. On January 2, 2014, Petitioner started working part-time at the Atwood Gun Shop. At the gun shop he earned $200.00/week. He held that position until April 18, 2014, when he began working for Premiere Utility Services. There he earned $14.00/hour and averaged "40+" hours per week. Petitioner switched jobs again on August 7, 2014, when he began working at Golden Rule Trucking. At the time of arbitration, Petitioner was continuing to work for Golden Rule Trucking. He earns $160.00/day or $800.00/week. (See also PX 7,8, and 9)

Petitioner identified PX 6 as Local Union #23's wage documents regarding his hourly pay rates since the accident. Petitioner testified that the wage benefit information as indicated in Petitioner's Exhibit No. 6 through Carpenter's Local Union # 243 indicated an hourly wage rate of $35.70 for a union carpenter in May of 2016. Beginning May of 2017, the hourly rate increased to $36.04 per hour.

Petitioner testified that he was initially hired to drive a truck through Golden Rule Trucking but was unable to do so because his neck hurt too much while driving. Therefore, he took a position working in the shop doing maintenance on the trucks. Petitioner testified that he is still looking for additional employment at this time and is hoping to obtain employment with the University of Illinois. He has had several interviews, but has not yet received a job offer.

Petitioner testified that he continues to have pain in his neck, along with headaches. He testified that he is unable to work as a carpenter, because it requires overhead work. Petitioner explained that he continues to regularly take ibuprofen for pain, and is unable to get a full night's sleep. Petitioner denied that he had problems with his neck before this accident. Petitioner explained that he had suffered a whip-lash injury 15 to 18 years ago, but that injury was fully resolved before this accident. Petitioner also denied having regular headaches prior to the accident.

Petitioner testified that he sleeps 4-5 hours a night and wakes up sore on a daily basis. Petitioner stated that the reason he only sleeps 4-5 hours a night is due to the stiffness and pain in his neck. Petitioner testified that he has headaches on a regular basis. Petitioner has between 2-4 headaches a week. Petitioner also testified that he has numbness in his right arm and hand and still has it at the time of the hearing. Petitioner has tingling that goes from the back side of the arm to his index, middle and ring fingers. Petitioner testified that prior to October 24, 2011, he did not have daily numbness, tingling or problems with his right arm. Petitioner is right-arm

dominant. Petitioner testified that he did not have daily neck pain and stiffness in his neck prior to October 24, 2011, and that he had headaches only once or twice a year.

On cross-examination, Petitioner acknowledged that his injury initially felt like a pulled muscle. Petitioner also testified that the pain radiating down his right arm did not begin immediately after the accident.

Petitioner confirmed that he worked his regular job without any restrictions from the date of accident through February of the following year. Petitioner acknowledged that the Functional Capacity Evaluation indicated that he had problems with posture, forward bending, half kneeling, kneeling and walking. Petitioner was unable to explain how his neck condition affected those activities.

Petitioner testified that he complained of pain in his neck when he first sought treatment at Carle Hospital. Petitioner testified that Dr. Tipirneni gave him a weight restriction of 80 pounds when he was released from her treatment.

Petitioner acknowledged that he was first seen at Tuscola Pain and Wellness Center in 2005. According to Petitioner, he told his chiropractor at Tuscola Pain and Wellness Center about his work accident, when he went there on October 26, 2011.

The Arbitrator concludes:

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

Petitioner failed to prove that his current condition of ill-being in his neck, shoulders, mid-back and/or right upper extremity is causally related to his October 24, 2011 accident. While Petitioner did sustain an accident on October 24, 2011 which Respondent stipulated to, that accident resulted in a temporary aggravation of a pre-existing condition. The Arbitrator finds Petitioner reached maximum medical improvement for said aggravation by April 21, 2013, at the latest. In so finding and concluding, the Arbitrator notes problems with Petitioner's credibility and she gives no weight to the opinions and testimony of Dr. Sandercock, Petitioner's one time examining physician.

Petitioner was not an altogether credible witness. His testimony at the hearing was not corroborated by the medical records admitted into evidence. Petitioner denied any radiating right arm pain prior to October 24, 2011; however, Tuscola Pain & Wellness records indicate to the contrary. Petitioner also denied having any problems working as a carpenter before October 24, 2011 but, again, Dr. Hemmer's notations in his chiropractic records pre-dating October 24, 2011 state to the contrary as he comments on Petitioner's problems with work on several occasions prior to October 26, 2011. As early as June 13, 2011 Petitioner was reporting aggravating neck and mid back pain while working over his head. When Petitioner saw Dr. Hemmer on October 26, 2011 his complaints were quite similar/almost identical to those of prior visits but absolutely no mention was made of any work accident on October 24, 2011. While Petitioner testified that he told Dr. Hemmer about the accident at work, the doctor's records don't corroborate that. Petitioner could have deposed Dr. Hemmer for that corroboration and for clarification of any problems (or lack of problems)

Petitioner might have had before October 24, 2011. Dr. Hemmer's records contain no reference to any work accident on October 24, 2011.

It is also unclear from Dr. Hemmer's records, just how often he may have seen Petitioner. His office notes in June and August of 2011 indicate Petitioner was to be seen one time a week until his condition stabilized. Whether additional weekly visits ensued is unknown as there is no reference to same in the doctor's notes and no bill for services was included in the record. Petitioner's testimony regarding his visits with Dr. Hemmer provided no insight as Petitioner was very vague about his treatment with the doctor.

It should also be noted that Petitioner continued working full duty as a union carpenter after the October 24, 2011 accident through early February of 2012. Petitioner's treatment notes from Tuscola Pain and Wellness reveal that Petitioner's pain complaints were less than his pre-accident levels, before the end of January 2012. Additionally, the treatment notes both before and after the stipulated work accident show similar treatment being provided. With regard to Petitioner's credibility, the Arbitrator further notes Petitioner's misrepresentation to Dr. Tipirneni on June 28, 2012 regarding his work status since his accident. Contrary to the facts, Petitioner told the doctor he had not worked since his accident.

Petitioner also gave varying accounts of his accident. While Respondent stipulated to accident, the Arbitrator notes Petitioner's failure to mention the accident whatsoever to Dr. Hemmer and the fact that upon presenting to Dr. Tipirneni in February of 2012 Petitioner related that his symptoms began in October of 2011 but he did not know of one particular incident. Rather, Petitioner reported pain that got more severe by day's end. Petitioner has pursued this claim as one stemming from a specific accident and not repetitive trauma. Even if viewed as a possible claim for repetitive trauma, Petitioner failed to provide a causation opinion in support thereof. However, his varying accounts of exactly what he attributed his symptoms to (a specific accident v. repetitive activities over time) impacts the causation determination.

Also concerning is Petitioner's motivation in this case. He claims he has been unable to return to work as a union carpenter and that no one ever returned him to regular work after the accident. Within this context, it is concerning that some of PA-C Steveley's records are missing. PA-C Steveley completed an Occupational Status Report on July 16, 2012 when he first saw Petitioner after having been referred to Occupational Medicine by Dr. Tipirneni who felt Petitioner could return to work on a full duty basis. Why PA-C Steveley imposed work restrictions on July 16th isn't known because the office note from that visit is missing. Also unusual is the fact the September 28, 2012 office note with Mr. Steveley is in the record but the Occupational Status Form for the visit is not and, therefore, what he indicated on the form is unknown. According to Steveley's office note, Petitioner could return to work. The office note, overall, does not suggest the need for any restrictions. While subsequent Occupational Status forms indicate Petitioner's restrictions remained unchanged, it's unclear what restrictions, if any, are being referred to as the September 28th form that would have outlined any restrictions (or lack of them) is missing from the record.

By December 21, 2012 PA-C Steveley felt Petitioner was at maximum medical improvement. He last saw Petitioner in March of 2013 as Petitioner didn't follow up. Dr. Steveley's records suggest,

at a minimum, possible underlying motivational issues on Petitioner's part. Dr. Van Fleet, a board certified orthopedic surgeon, examined Petitioner on April 3, 2013. He felt Petitioner had sustained a temporary aggravation of a pre-existing condition for which he was at maximum medical improvement. Respondent has stipulated to causal connection through April 21, 2013 and the Arbitrator finds that to be a reasonable cut-off date.

Petitioner has undergone no further treatment since being examined by Dr. Van Fleet in April of 2013. While he did return to see Dr. Stroink on August 5, 2013 she provided no treatment recommendations other than getting an updated cervical MRI which Petitioner apparently did not elect to pursue. None of Petitioner's treating doctors were deposed regarding the issue of causation.

Petitioner saw Dr. Sandercock in December of 2015 solely for the purpose of getting a causation opinion. The doctor had no treatment recommendations as same would have been beyond his area of expertise. His causation opinion was unpersuasive as it was based upon an inaccurate history from Petitioner as he denied any prior problems with his neck or shoulders or problems being able to work. Again, Dr. Hemmer's records (which the doctor wasn't provided) contradict this.

In describing his accident and injury, Petitioner repeatedly explained that he felt like he pulled or strained a muscle. He did not develop any symptoms in his right arm until weeks after the claimed accident and after continuing to work full duty as a union carpenter. Even after that, Petitioner's complaints were inconsistent. In the initial visit at Carle, Petitioner identified pain primarily in his elbow, without mentioning any issues with his neck or headaches. The record, from Tuscola Pain and Wellness show that Petitioner had more neck pain two and a half months before the accident, than two and a half months after the accident. Petitioner's treating physicians consistently found no evidence of a neurological problem. The lack of objective findings led Dr. Tipirneni to release Petitioner from treatment in June of 2012.

After being released by Dr. Tipirneni, Petitioner continued to seek treatment with Physician's Assistant Steveley and Dr. Stroink. Mr. Steveley consistently noted signs of malingering and symptom exaggeration. The continued lack of objective findings led Mr. Steveley to declare that Petitioner was capable of returning to work. Dr. Stroink also failed to identify any objective findings that would account for Petitioner's complaints. Dr. Stroink found that Petitioner was not a surgical candidate, and did not offer any further treatment options, just a diagnostic test (which Petitioner didn't pursue).

Petitioner underwent a Functional Capacity Evaluation, which indicated that he was incapable of returning to work as a union carpenter. None of the treating physicians opined that the study was invalid, but the limitations identified by the evaluation have nothing to do with an injury to Petitioner's neck or right arm. Instead, Petitioner had difficulty walking, kneeling and squatting. Petitioner was unable to explain how these functions had anything to do with the accident at issue in this case.

Compared to the report and testimony of Dr. Sandercock, Dr. Van Fleet's report and testimony are more consistent with the evidence in this case. While Dr. Sandercock's opinions were premised on the lack of pre-existing problems, Dr. Van Fleet's opinions were primarily based on the existence of those problems. Dr. Van Fleet's conclusion that Petitioner suffered nothing more than

a cervical strain is consistent with the improvement and symptoms seen in the medical records. That opinion is also consistent with the subsequent findings of malingering and symptom exaggeration.

The Arbitrator is aware that Dr. Van Fleet acknowledged on cross-examination that it was "possible" Petitioner might not have returned to baseline after his aggravating work injury. However, in giving that answer he was asked to assume that Petitioner had no problems with his neck before the accident, including any pain, and was able to perform all his regular activities. As has been pointed out Dr. Hemmer's records undermine that assumption.

In summary, the Arbitrator finds that Petitioner reached maximum medical improvement by April 21, 2013, at the latest and he failed to prove ongoing causation thereafter.

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

The Arbitrator finds that Petitioner reached maximum medical improvement by April 21, 2013 at the latest. The parties stipulated that Respondent paid all TTD benefits up to that date. Consistent with her causation determination, no further benefits are owed to Petitioner. Petitioner's request for additional maintenance and TTD benefits is hereby denied.

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

The Arbitrator finds that Petitioner suffered a cervical strain as a result of the accident of October 24, 2011. While Petitioner maintains he is entitled to a wage differential award as a result of his accident, the Arbitrator denies same consistent with her causation determination. Petitioner failed to prove he has been unable to return to work as union carpenter on account of his work injury.

Section 8.1(b) of the Act establishes the criteria for determining permanent partial disability in this instance. It states:

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.

Accordingly:

Neither party submitted an AMA impairment rating at the time of trial, the first factor referenced in § 8.1b(b) of the Act. Therefore, the Arbitrator assigns no weight to this factor.

The second factor considered pursuant to § 8.1b(b) is the occupation of the employee. In this case, Petitioner was working as a union carpenter at the time of his accident. For a period of over three months after the accident, Petitioner continued working in his regular position without any restrictions. The Arbitrator notes that a subsequent Functional Capacity Evaluation indicated that Petitioner was unable to return to work as a union carpenter, but those results are not causally

related to this accident. The Arbitrator finds that the accident of October 24, 2011 resulted in no change to Petitioner's occupation. Petitioner was engaged in a physically demanding job both before and after this accident. Because Petitioner was able to continue with these duties for over three months after the accident, the Arbitrator gives weight to this factor.

The third factor to be considered pursuant to §8.1b(b) of the Act is Petitioner's age. In this case, Petitioner was 37 years old at the time of his accident. The Arbitrator gives some weight to this factor.

The fourth factor to be considered pursuant to §8.1b(b) of the Act is the impact of the accident on Petitioner's future earning capacity. In this case, the Arbitrator finds that Petitioner's injury has had no impact on Petitioner's future earning capacity. Petitioner continued working in his regular position for several months after the accident, without any change in his wages. While Petitioner no longer works as a union carpenter, he failed to prove that the inability to do was causally related to his work accident. Therefore, the Arbitrator gives no weight to this factor.

The final factor to be considered pursuant to §8.1b(b) of the Act is evidence of disability as corroborated by the treating medical records. In this case, Petitioner's treating physicians were unable to note any objective findings to corroborate Petitioner's subjective complaints. Petitioner was released from treatment by Dr. Tipirneni on June 28, 2012. After that date, the treatment notes reflect inconsistent subjective complaints and findings of malingering and symptom exaggeration. By September 28, 2012 Petitioner's complaints were minimal and PA-C Steveley felt he was capable of returning to work. Petitioner did not follow up with Mr. Steveley after the IME as he had been instructed. More significantly, Petitioner did not undergo any further treatment after March 19, 2013. While Dr. Stroink re-examined Petitioner on August 15, 2013 she noted sensory numbness in the C7 distribution but she did not relate it to the work accident, noting Petitioner had developmental spinal stenosis. Petitioner did not follow-up with any of the doctor's recommendations. Consistent with her causation determination, Petitioner sustained a cervical strain for which he underwent conservative treatment such as therapy and injections. No surgery has ever been recommended. As such, the Arbitrator views this factor as weighing in favor of less permanency being awarded.

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 3% loss of use of a person as a whole, pursuant to Section 8(d)(2) of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Anthony J. Segura,

18IWCC0745

Petitioner,

vs. NOS: 15 WC 9801

Illinois Youth Center Kewanee,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 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: DEC 7 - 2018
o11/1/18
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 ARBITRATOR DECISION

18IWCC0745

SEGURA, ANTHONY J
Employee/Petitioner

Case# **15WC009801**

15WC025540

ILLINOIS YOUTH CENTER KEWANEE
Employer/Respondent

On 6/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
KARIN K CONNELLY
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CHICAGO, IL 60606

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

6066 ASSISTANT ATTORNEY GENERAL
BRETT D KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 30 2017

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

18IWCC0745

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

ANTHONY J. SEGURA,
Employee/Petitioner

v.

ILLINOIS YOUTH CENTER KEWANEE,
Employer/Respondent

Case # **15** WC **9801**

Consolidated cases: **15 WC 25540**

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 **Rock Island**, on **6/6/17**. By stipulation, the parties agree:

On the date of accident, **12/18/14 and 4/30/15**, Respondent was operating under and subject to the provisions of the Act.

On these dates, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of these accidents was given to Respondent.

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

In the year preceding the injuries, Petitioner earned **$79,432.60**, and the average weekly wage was **$1,527.55**.

At the time of injuries, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $735.37/week for a further period of **13.5** weeks, as provided in Sections **8(c)** of the Act and Sections **8(d)2** of the Act, because the injuries sustained caused **petitioner a 2.5% loss of use of his person as a whole, and 1 week of disfigurement.**

Respondent shall pay Petitioner compensation that has accrued from **12/18/14** through **6/6/17**, and **4/30/15** through **6/6/17**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

6/25/17
Date

JUN 30 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner, a 33 year old juvenile justice specialist, sustained an accidental injury to his right arm that arose out of and in the course of his employment by respondent on 12/18/14 and 4/30/15. Petitioner provides security at the respondent's facility in housing unit 6, which is a unit for inmates that are problems.

On 12/18/14 he responded to a Code 1 disturbance, which was a fellow staff member being attached. Petitioner responded to the east walk where Juvenile Justice Specialist Martinez was being attacked. As petitioner was trying to get the inmates under control, he scuffled with the inmates and went to the ground. petitioner heard a pop in his right arm and experienced immediate pain in his right arm. Once he got the inmates under control he sought treatment at the facility healthcare department. The inmates involved in the incident were between 5'11" and 6'2" tall.

After seeking treatment at the respondent's healthcare facility, petitioner presented to the emergency room at St. Luke's Hospital. He rated his right shoulder pain at a 5/10 and aching. Petitioner underwent x-rays of the right shoulder that were normal. Petitioner was assessed with a shoulder sprain and joint pain of the shoulder. He was given Norco and restricted from lifting any more than 5 pounds with the right arm for 3 days, then increase as tolerated.

On 12/23/14 petitioner presented to Dr. Ahearn, his primary care physician. He continued to complain of right shoulder pain that was now aching. He reported deep shoulder joint pain when picking up his kids or putting on his coat. An examination revealed decreased range of active flexion motion, flexion motion passive, active internal rotation, passive internal rotation, active external rotation, and passive external rotation, tenderness and pain on palpation, and reduced range of motion. He was assessed with right shoulder pain. He was given NSAIDs, and prescribed rest and ice. An MRI was ordered.

On 1/29/15 petitioner underwent an MRI of the right shoulder. The impression was subacromial/subdeltoid bursitis; that the configuration of the acromion may contribute to impingement; and acromioclavicular joint arthritis.

On 2/11/15 petitioner underwent x-rays of the right shoulder. The impression was mild degenerative changes with no acute bone abnormalities identified. No acute fractures were noted.

On 2/26/15 petitioner returned to Dr. Ahearn. He continued to complain of the right shoulder pain anteriorly especially with rotation of the arm in an extended position. He reported that physical therapy was helping a lot. He demonstrated decreased range of active internal rotation and active external rotation, and tenderness at the bicipital groove of the anterior right shoulder. He was assessed with right shoulder tendinitis. He was released to light duty work.

On 2/11/15 petitioner presented to Dr. Stewart at ORA Orthopedics with right shoulder pain since 12/18/14. He complained of pain with motion, but noted that he was getting better. He noted that working and recreational activities bother him. He reported pain and weakness. He reported a stabbing, throbbing pain at 5/10. He reported that it was an intermittent type pain that did not radiate. An examination revealed tenderness over the bicipital groove on the right shoulder. Dr. Stewart assessed a biceps tendonitis. Petitioner was instructed to undergo a course of Indocin three times a day. He was released to light duty with no prisoner contact. He was instructed to do some early strengthening exercises.

On 2/25/15 petitioner began a course of physical therapy. On 3/11/15 he complained of intermittent right anterior shoulder pain that was worse with repetitive motions. He reported that he was doing 25% better since starting physical therapy. Petitioner still reported pain and limitations with certain activities. He continued in physical therapy.

On 3/25/15 petitioner was returned to full duty work without restrictions by Dr. Stewart. Dr. Stewart assessed tendinitis of the right shoulder. Dr. Stewart noted that petitioner had no complaints of pain in his right shoulder. He also demonstrated full range of motion. After returning to work petitioner reported that his right shoulder continued to hurt and pop. For these complaints he takes ibuprofen. He stated that it relieves his pain and reduces swelling. Petitioner reported that he experiences swelling 1-2 times a week. He also experiences stiffness in his shoulder.

On 4/7/15 petitioner was discharged from physical therapy. He was discharged because he was having surgery on his eye/face.

On 4/30/15 petitioner again responded to an inmate that was being hostile to staff. He scuffled with the inmate, and as he was trying to cuff the inmate, the inmate bit him in his right forearm right under his elbow crease. Petitioner was wearing a coat at the time. The skin on his right arm was red and bleeding. Petitioner presented to Dr. Michael Ahearn. An examination revealed a human bite wound. It was cleaned and they made sure that there were no rips in his coat that saliva could get through. It was noted that there was low risk to petitioner since the skin was not broken. Petitioner was given ibuprofen.

The petitioner described a scar on his right forearm an inch below the elbow crease that was 1/2 inch by 1/8 inch and lighter in color.

Petitioner testified that he has not returned to Dr. Stewart despite the fact that he still has complaints. He complained of soreness on occasion and intermittent popping in his right shoulder. He testified that he goes to the VA one to two times a month for general meds and other unrelated issues. He also sees the VA for his right

shoulder. He testified that he is just going to live with the pain and popping. Petitioner takes some over the counter medication 1-2 times a week. Petitioner does not work out because of shoulder pain.

Petitioner testified that he no longer works for respondent because the facility is no longer for youths. He testified that he still works for the Department of Corrections and his wages have not changed.

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 juvenile justice specialist at the time of the accidents and that he was able to return to work in his prior capacity as a result of said injuries, but could not because respondent's facility was closed. He has continued working full duty for the Department of Corrections. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 32 years old at the time of the accident. Because petitioner has been released to work with no restrictions and has continued working full duty without restrictions for the Department of Corrections, 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 his future earning capacity has not been impacted by the injuries to his right shoulder on 12/18/14 and right arm on 4/30/15. Because of this, 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 when petitioner last followed-up with Dr. Stewart for his right shoulder on 3/25/15 he was assessed with tendinitis of the right shoulder. Dr. Stewart noted that petitioner had no complaints of pain in his right shoulder. He also demonstrated full range of motion. After returning to work petitioner reported that his right shoulder continued to hurt and pop. For these complaints he takes ibuprofen, and it relieves his pain and reduces swelling. Petitioner reported that he experiences swelling 1-2 times a week. He also experiences stiffness in his shoulder. With respect to the human bite to his arm on 4/30/15 presented to Dr. Michael Ahearn. An examination revealed a human bite wound. It was cleaned and they made sure that there were no rips in his coat that saliva could get through. It was noted that there was low risk to petitioner since the skin was not broken. Petitioner was given ibuprofen. Petitioner described a scar on his right forearm an inch below the elbow crease that was 1/2 inch by 1/8 inch and lighter in color. Because of this, 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 2.5% loss of use of use of the person as a whole pursuant to §8(d)2 of the Act. The Arbitrator further finds that Petitioner sustained permanent partial disability to the extent of 1 week of disfigurement pursuant to §8(c) of the Act.

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

William Mark Kerley,
Petitioner,

18IWCC0746

vs.

NO: 15 WC 20516

Continental Tire North America 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 disability, causal connection, medical, permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 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: DEC 7 - 2018
o10/11/18
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

Stephen J. Mathis
Stephen J. Mathis

David L. Gore
David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0746

KERLEY, WILLIAM MARK
Employee/Petitioner

Case# **15WC020516**

CONTINENTAL TIRE NORTH AMERICA INC
Employer/Respondent

On 6/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1724 HASSAKIS & HASSAKIS PC
JAMES M RUPPERT
206 S 9TH ST PO BOX 706
MT VERNON, IL 62864

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0746

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

WILLIAM MARK KERLEY
Employee/Petitioner

v.

CONTINENTAL TIRE NORTH AMERICA, INC.
Employer/Respondent

Case # **15** WC **20516**

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 **Mt. Vernon**, on **September 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 7, 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 **$47,732.36**; the average weekly wage was **$917.93**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$712.72** for other benefits, for a total credit of **$712.72**.

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment On April 7, 2015. 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, 2017
Date

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

18IWCC0746

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM MARK KERLEY
Employee/Petitioner

v.

Case #: 15 WC 20516

CONTINENTAL TIRE NORTH AMERICA, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On April 7, 2015, Petitioner was 50 years old, married, and had two dependent children. He had been employed by Respondent for 21 years. He testified his education consisted of two and a half years of college.

Petitioner testified that on Tuesday, April 7, 2015, he was pulling the cassette on number two windup when the cassette got hung up in the machine and he felt a pull in his stomach. He testified that the cassette weighed about 1,215 pounds. He continued working and tried to shake it off. He did not report the injury to his employer at that time and did not know he had a hernia at that time. He testified he first noticed a bump that night while taking a shower. Petitioner testified that from April 2, 2015, through April 12, 2015, he and his family were camping, and he commuted to work from his campsite. When he showered after work on April 7, 2015, he noticed he had a bump on his stomach and thought it was a mosquito bite. When he got back to the camper, his wife saw the bump as well. He worked on Wednesday, April 8 and a half day on Thursday, April 9, 2015. He took a vacation day on Friday April 10.

Petitioner testified that on Friday evening, April 10, 2015, he and his family and friends were around the campfire. His dog had killed a skunk, and the skunk had gotten on his shirt. He took his shirt off, and others around the campfire noticed the bump on his stomach.

On Monday morning, April 13, 2015, at about 7:00 a.m., Petitioner talked to his supervisor, Mike Peterson, before the safety meeting. He was instructed to go to health services, where he was seen by the nurse and then the doctor. The doctor advised he had a hernia in his stomach and that he could go back to work if he felt he could do his job. Petitioner testified he returned to work and worked until Thursday, April 16, at which point he was told he could no longer work until the hernia was repaired.

On Monday, April 20, 2015, Petitioner saw his primary physician, Dr. Salem. He testified that he told Dr. Salem that his hernia was work-related and that his employer was questioning whether it was work-related. Dr. Salem referred him to Dr. Martin, who ultimately performed surgery to correct the hernia.

Petitioner reviewed Petitioner's Exhibit J and identified it as an hourly description for his position that he was performing on April 7, 2015.

Petitioner testified he currently has pain when he bends down on his knees and tries to get up. He feels like he has a bunch of needles sticking him in the stomach, and the stomach area is hard. He has stopped playing basketball and has a hard time picking up things with his left side. He has trouble with above the head reaching and trying to get up from being on his knees. He is careful in his activities, to avoid the symptoms.

Petitioner testified he eventually returned to work in the same job with Respondent, though currently works on a different machine that has lighter stock on it. Petitioner testified that he did not recall ever speaking to Respondent's employee Clay McDaniel about the incident that occurred on April 7, 2015.

On cross-examination, Petitioner testified he had never previously been diagnosed with a hernia. He testified that on Monday, April 13, 2015, he talked to Mike Peterson before the safety meeting and told him that he thought he had a hernia. He lifted his shirt and showed him, and Mr. Peterson instructed him to go to the office. Petitioner testified that he did not believe he told Mr. Peterson when he developed the hernia or that he thought it was work-related. He testified that he did tell the nurse that he thought it was work-related. Petitioner identified Respondent's Exhibit 1, Claimant's Statements of Events, as a document that the nurse had given him and that he had completed on Monday, April 13. After he saw the nurse, he saw the company doctor, who told him he had a hernia. The doctor asked if it bothered him, and he said it did not. He asked if he could do his job, and he said he could. The doctor then gave him a slip to allow him to return to work. He returned to the floor and finished his shift that day.

Continuing on cross-examination, Petitioner testified that he knew who Clay McDaniel was, but that he had never met him and had never spoken to him about the work incident. He had no recollection of ever speaking directly to Mr. McDaniel about his hernia. Petitioner acknowledged that he was very family with the plant safety rules, including the first rule that all work-related injuries, near misses and medical problems, even if minor, were to be reported to the supervisor no later than the end of the shift that the incident occurred on. He acknowledged that he did not report the incident on April 7, 2015, or on April 8 or on April 9.

Petitioner testified that when he saw the nurse on April 13, he told her that he had been trying to get a cassette out of number two, that it was hung up and he didn't know it, and that when he jerked it he felt the strain. He testified that he told his primary doctor the exact same thing, and told his surgeon the exact same thing. He testified that he believed there was one specific event that led to the hernia, and that it occurred sometime between 10:30 and 11:30 a.m. on April 7, 2015. He was working with a trainee at the time, and believes he may have told the

trainee that he pulled something. He did not work with the trainee after that day. There were no other employees around him at the time that this occurred.

Petitioner reviewed the Injury/Illness/Incident Report, which was also a part of Respondent's Exhibit 1. He testified that the form was given to him by either the nurse or the doctor. He testified that the upper portion was completed by someone else, but that he signed the bottom of the form. He did not remember who completed the top portion, but testified that they filled it out while he was in there.

Petitioner confirmed that he was camping with his family and friends from April 2 through April 12, 2015, and that they were in a camper rather than a tent. He was shown Petitioner's Exhibit K and identified it as a picture of his smoker. He testified that it runs on both charcoal and wood. He puts the wood in the firebox, lights it, and then pours charcoal on top of the wood to get the fire started. He brought the wood with him, which he had purchased. The smoker is built on a trailer, which he connects to his truck. He testified he does not have to lift the trailer to attach it. The only time he used the smoker while camping was on April 11.

Petitioner testified that when the incident occurred on April 7, he had some pain around his belly button, that the pain went away for a period, and that when he saw his primary care doctor on April 20 he was not having any pain. In the interim, there was "a little pain", but it didn't bother him to where he was unable to do his job. Petitioner testified that he told both his primary care physician and his surgeon that he believed he injured himself at work and that others had observed the hernia when he had taken his shirt off. Petitioner testified that his dog was running around the campsite after the skunk got in its eyes, but he denied that he had to chase after the dog.

Petitoner's wife, Melisa Kerley, testified on his behalf. She testified that she first saw her husband's hernia on Tuesday night, April 7, 2015. He had come back to the camper from the shower house and showed her a bump that looked like a mosquito bite near his belly button. It was about the size of a nickel. She was not aware at the time that it was a hernia, as she did not know what one looked like. The next time she saw the bump was when Petitioner took off his shirt after the dog got sprayed from a skunk. They were around the campfire with family and friends at the time. The bump had gotten bigger and was between the size of a quarter and a half dollar. At that time, she and others in the group told Petitioner he should get it checked.

On cross-examination, Mrs. Kerley conceded that when she first saw the bump near her husband's belly button, he did not mention that he thought it could have happened at work. She further conceded that when everyone was around the fire and observed the bump, Petitioner did not suggest that he thought it could have happened at work. She testified she did not have any discussion with him that night about whether or not it could have happened at work.

Petitioner called Ms. Krista Crews as a witness. She testified that the first time she saw the hernia on Petitioner was when they were camping, around April 10, and standing around the campfire. She testified, "He had his dog out there and she got ahold of a skunk, and in the process of chasing the dog and trying to tackle her and stuff he had gotten the smell on him so he

was changing shirts." She observed the bump on Petitioner's stomach at that time, as did others. One of the others commented that it looked like a hernia and should be checked out.

On cross-examination, Ms. Crews testified that the dog "was running around the camper so we were trying to catch her". She further testified that they were all trying to get ahold of her and that there was some physical activity required to catch the dog. It was after that point that Petitioner took off his shirt and everyone saw the bulge on his stomach. Ms. Crews conceded that Petitioner did not tell her that evening that he though he hurt his stomach at work.

Respondent called Mr. Clay McDaniel as a witness. He has been employed by Respondent for nearly nine years. He has been in his current position as Plant Safety Coordinator for about five and a half years. In his position he oversees the plant safety programs, compliance with OSHA regulations, and investigates incidents. Incidents include work-related injuries, accidents, near-misses, machinery faults, and the like. He testified that the number one plant safety rule is that employees are to report all work-related injuries, no matter how minor, no later than the end of the shift they occurred.

Mr. McDaniel testified that he first learned that Petitioner was alleging a work injury on Monday or Tuesday of the week following the alleged date of accident of April 7, 2015. Standard procedure for every incident, near-miss, or accident is that health services staff will triage the injury, then an Injury/Illness/Incident Report is completed. When an incident occurs, employees are generally sent from health services to his office, which is about 15 to 20 yards from the nurse's station. Mr. McDaniel identified Respondent's Exhibit 1 as the Injury/Illness/Incident Report regarding Petitioner's alleged accident. He testified that he completed the top portion of the Report, and that Petitioner signed the bottom of the document in his presence and that he observed him sign it. Mr. McDaniel testified that he interviewed Petitioner in his office and obtained information from him in order to complete the top portion of the Report. During his testimony, Mr. McDaniel observed that the date he put on the Report (April 14, 2015), appeared to be an error. He believed the correct date was April 13, especially in light of the fact that that is the date Petitioner wrote.

Mr. McDaniel testified that Petitioner gave a very vague description of the incident and he mentioned that part of his job entailed moving cassettes. He further testified, "He stated that he thought that it may have been in relation to moving a cassette and basically something related to the fact that that's about the only thing that it could have been." Petitioner did not provide a more specific description, but rather indicated that he noticed it while he was camping and that would be the only way it could have happened. Mr. McDaniel acknowledged that cassettes can get jammed or bound, and when that happens the protocol is to hit the cycle button and call maintenance if it does not recycle. He noted there was no work order for that machine.

Mr. McDaniel testified that on April 14, 2015, he emailed a summary of his investigation to Melody Cravens in the Work Comp Department. He identified Respondent's Exhibit 3 as a copy of that email.

On cross-examination, Mr. McDaniel "absolutely" disagreed with Petitioner's testimony that he had never spoken to him about the incident. He agreed that Petitioner provided a date,

time, and place for the alleged incident. However, he testified that Petitioner's statement to him was that "it's (pulling cassettes) the only thing that could have happened". He further testified that Petitioner phrased it in such a way that it led him to believe that he was uncertain, and that that was the only thing it could have been. This raised suspicion on Mr. McDaniel's part. With regard to the date discrepancy on the Injury Report, Mr. McDaniel again testified that he believed the correct date that he completed the report was April 13, not April 14. He testified that he did not complete his portion after Petitioner signed it, as that would mean Petitioner would have signed a blank document. The Arbitrator notes that Petitioner testified that the report was already completed when he signed it.

Following the accident, Petitioner presented to his primary physician, Dr. Anad Salem, on April 20, 2015. He testified this appointment had been previously scheduled for quite some time, as it was for his annual physical examination. He denied any abdominal pain, but did report he had a new hernia in his umbilicus. Dr. Salem noted, "He is currently discussing with his employer on whether it is work related or not." The Arbitrator notes there was no history of the incident described by Petitioner in his testimony. On examination, Dr. Salem noted a small reducible umbilical hernia and a reducible right inguinal bulge. He referred Petitioner to a surgeon and cleared him for full duty work. PXB.

On April 24, 2015, Petitioner returned to Dr. Salem's office and inquired about his FMLA forms and short term disability forms. He advised the office he now preferred FMLA and asked that it be made out for the whole year, or at least until he had the surgery. It was noted his appointment with the surgeon was on May 6, 2015. Later that same day, Petitioner underwent a CT scan of the abdomen, which revealed small fat-containing umbilical and right inguinal hernias. PXB.

On May 6, 2015, Petitioner presented to Dr. Adrian Martin of SIH Medical Group. Under "History of Present Illness", it was noted, "This patient presents with a chief complaint of a right inguinal hernia and an umbilical hernia. He states that the umbilical hernia happened while at work, where he does a lot of pulling heavy material." The Arbitrator notes there was no history of the incident described by Petitioner in his testimony. Examination confirmed the presence of the hernias, and Dr. Martin recommended surgical repair of both. Petitioner underwent the surgery on June 29, 2015, by Dr. Martin at Memorial Hospital of Carbondale. He followed up with Dr. Martin on July 14, 2015, and reported he had no pain and was not taking any pain medication. Dr. Martin noted he was doing well and advised that no follow up appointment was necessary unless he was having problems. He completed a Fitness for Duty Certification for Respondent, and indicated Petitioner could return to work without restrictions on July 21, 2015. PXC.

On August 25, 2015, Petitioner returned to Dr. Martin. He reported he was doing generally well, but complained of pain in his right testicle. He reported the pain was almost daily, on and off, mild to moderate in intensity, and mostly on contact but also spontaneously. The groin and abdomen were not painful. A scrotum ultrasound was conducted on August 27, 2015, which showed some fluid around the testicle, but which was of no significance. Petitioner was sent a letter to that effect, and was advised to return in four weeks if he still had pain. PXC.

Dr. Martin testified by way of deposition on June 2, 2016. He attended medical school in his home city of Timisoara, Romania. After his surgical residency, he became a board certified surgeon in Romania. He is also board certified in Germany. His current practice is as a general surgeon. He estimated he had performed a thousand or so hernia surgeries in his career. PXA.

Dr. Martin testified that he first saw Petitioner on May 6, 2015, at which time Petitioner reported he had an umbilical hernia that happened at work, where he does a lot of pulling. He also had an inguinal hernia at that time. He surgically repaired both hernias. Dr. Martin did not recall exactly what Petitioner told him with regard to what had occurred at work. He testified that he usually looks at the treating notes from the referring doctor, but did not recall whether, in this case, he had reviewed Dr. Salem's records. He also did not recall whether he had looked at the CT scan, but testified that the umbilical hernia was visible and the inguinal hernia was palpable, such that a clinical diagnosis could be made. PXA.

Dr. Martin identified Petitioner's Deposition Exhibit 2 as a copy of a report he authored on February 4, 2016. The report was sent to Petitioner's attorney, in response to a letter from the attorney. In preparing the report he reviewed his notes, along with records, a job description, and a Claimant's Statement form provided by Petitioner's attorney. The attorney's letter contained the following question, "Did Mr. Kerley's pulling on a jammed cassette at work on April 7, 2015, cause or contribute to cause Mr. Kerley's umbilical hernia that you treated?" Based on that description, Dr. Martin opined that the event could have caused or contributed to cause the umbilical hernia. He was not able to say whether the inguinal hernia was related to work or not. Dr. Martin testified that either hernia, by itself, would have warranted surgery. PXA.

On cross-examination, Dr. Martin admitted that he did not know what a cassette was, how big it was, or how much it weighed. He did not know what an individual did with the cassettes or how much force would be required to move one. He did not know whether Petitioner had to pull the cassette, lift up the cassette, or any other details. He testified that Petitioner just told him that he was pulling heavy material at work, and that was all he knew. He did not recall anything more than what was documented in his records. He did not remember if there was an issue of repeatedly pulling the cassettes or if it was a one-time event. He did not recall Petitioner telling him anything about a camping trip or when he first noticed the bulging in his abdomen. He agreed that lifting a barbecue grill weighing 1,400 to 1,500 pounds could cause or contribute to the development of an umbilical or inguinal hernia. Dr. Martin conceded that his records did not document whether Petitioner provided a specific date of an event occurring, and that he did not know if Petitioner gave a specific date. He agreed that the details of an incident as outlined in the letter from Petitioner's attorney were not recorded anywhere in his office notes. Dr. Martin conceded that his causation opinion was based on the history provided, and that if that history was inaccurate, his opinion might change accordingly. PXA.

Dr. Martin agreed that umbilical hernias could be hereditary, or contributed to by obesity, coughing, or sneezing. He agreed that Petitioner's BMI was 38.89, which was considered obese. Dr. Martin testified that he had no reason to believe that Petitioner had any impairment as a result of the surgeries performed. PXA.

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.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 testimony to be inconsistent and further finds the record to be lacking in specificity as to the event alleged by Petitioner.

Petitioner testified as to a specific event of pulling on a cassette that was stuck and thereafter feeling a pull in his stomach. He and his wife both testified that they both saw a bump in his stomach that night. However, she testified that he did not mention to her that anything had happened at work. Three days later, when he took his shirt off by the campfire, others also saw the bump. Both Mrs. Kerley and Ms. Crews testified that Petitioner did not say anything at that time about anything happening at work.

The record is consistent that on Friday, April 10, 2015, Petitoner's dog was sprayed by a skunk and was running around their campsite. On cross-examination, Petitioner testified that did not chase the dog. However, his own witness, Ms. Crews testified on direct examination that "in the process of chasing the dog and trying to tackle her and stuff he had gotten the smell on him so he was changing shirts". On cross-examination, she testified that the dog was running around the camper, that Petitioner and the others were trying to catch the dog, and that there was some physical activity required to catch the dog.

Despite being fully aware of the requirement to report any incident or near-miss, Petitioner did not report the alleged incident that day, the following day, or the day after that. It was not until six days later that he reported anything to Respondent. Clay McDaniel testified that he personally met with Petitioner in his office on Monday April 13, and that Petitioner stated he thought the hernia may have been in relation to moving a cassette and that was "about the only thing that it could have been". Mr. McDaniel testified that Petitioner phrased it in such a way that it led him to believe that Petitioner was uncertain. Mr. McDaniel also testified that he completed the top portion of the Injury/Illness/Incident Report, based on what Petitioner told him, and that Petitioner signed it in his presence after it was completed. Petitioner acknowledged that the Report was filled out while he was in the office and that he signed the Report after it was filled out. Yet, he testified that he had never met Mr. McDaniel and had

never talked with him about this incident. The Arbitrator finds this testimony to simply not be credible.

Petitioner also testified that he told each of his medical providers the specific history that he was trying to get a cassette out, that it was hung up, and that when he jerked it harder he felt a strain. However, none of the medical records corroborate this testimony. The only history recorded by Dr. Salem was, "He is currently discussing with his employer on whether it is work related or not". The only history recorded by Dr. Martin was, "He states that the umbilical hernia happened while at work, where he does a lot of pulling heavy material." Dr. Martin testified multiple times that he had no further documentation with regard to what allegedly occurred. Although Petitioner's attorney apparently sent a letter to Dr. Martin which purported to provide a detailed account of what allegedly occurred, the medical records made contemporaneous with the treatment do not contain such an account.

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 on April 7, 2015, that 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)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK McCARRON,

Petitioner,

vs. NO: 11 WC 19462

NASH BROTHERS CONSTR. CO.,

Respondent.

18IWCC0747

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County after its review of the Commission's December 27, 2017 Order, which had awarded $4,600.00 in penalties under §19(l) of the Act, $760.61 in penalties under §19(k), and $304.24 in attorney's fees under §16. In its Opinion and Order, dated June 22, 2018, the court wrote, "The Commission failed to employ conscientious judgment when it awarded only partial penalties" and "Defendant presented no reasonable reason for non-payment." *Cir.Ct.Ord. at 10.* The court confirmed the Commission's award of penalties under §19(l) of the Act but reversed the award of partial penalties under §19(k), reversed the denial of additional attorney's fees under §16, and remanded this matter for further proceedings, because "[t]he finding of the Commission is against the manifest weight of the evidence and an abuse of discretion." *Id. at 11.*

As a brief summary, an arbitration decision was issued in this case on December 5, 2016. Petitioner was awarded unpaid medical expenses of $43,126.39, temporary total disability benefits (TTD) from June 8, 2011 through April 6, 2015, and permanent total disability (PTD) benefits beginning April 7, 2015. Respondent was given credit of $233,007.43 for TTD/PTD benefits already paid. Neither party filed a Petition for Review and, in our previous Order, we found that the arbitrator's decision became final on January 6, 2017.

As discussed in our previous Order, the parties' attorneys engaged in a series of communications and correspondence to determine the total amount due under the arbitrator's decision. One of the issues in this case was that Respondent had been paying $949.39 per week to Petitioner for many years during the pendency of this case, and continued to do so after the arbitrator's decision. This amount was based on Respondent's calculation of Petitioner's pre-injury average weekly wage (AWW). Based upon our review of the record, Petitioner never disputed this calculation of the AWW. However, at the arbitration hearing on October 6, 2016, Respondent stipulated to an AWW of $1,732.00, which increased the TTD/PTD rate to $1,154.67 per week and resulted in an underpayment of benefits for all those years.

By March 20, 2017, the problem with the weekly underpayment of PTD benefits had been corrected so Petitioner began receiving the correct weekly benefit of $1,154.67 from that point forward instead of the incorrect amount of $949.39 per week, which Petitioner had been receiving for many years. Respondent had also paid the $43,126.39 medical award by April 5, 2017, but had not yet paid the *underpayment* of TTD/PTD that had accrued through March 20, 2017, so Petitioner filed a Petition for Penalties and Attorney's Fees on April 24, 2017.

On May 15, 2017, the parties appeared before Commissioner DeVriendt who continued the matter without holding a hearing but instructed Respondent's attorney to issue a check. A check, dated that same day, was issued by Respondent's insurance carrier in the amount of $91,638.25. However, there was still an outstanding balance of $1,521.21 that remained unpaid at the time of the hearing on Petitioner's Petition on June 9, 2017.

In our December 27, 2017 Order, the Commission awarded §19(l) penalties due to Respondent's failure to pay the accrued benefits in a timely manner "without good and just cause." In our analysis of §19(k) penalties and §16 attorney's fees, we separated Respondent's conduct into two time periods. We found that Respondent's delay in paying $91,638.25 of the accrued benefits until May 15, 2017, did not rise to the level of being unreasonable and vexatious under those sections of the Act. However, we also found Respondent's failure to pay the full amount due and the fact that there remained an outstanding unpaid balance of $1,521.21 as of June 9, 2017, was unreasonable and we awarded §19(k) penalties and §16 attorney's fees on that unpaid amount.

In compliance with the circuit court's order, and substituting the court's judgment for that of our own, we make the following analysis regarding penalties under §19(k) and attorney's fees under §16:

Total TTD and PTD benefits accrued as of the arbitration hearing on October 6, 2016:		
278-2/7 weeks (6/8/11 – 10/6/16) x $1,154.67 =	$321,328.15	
Respondent's stipulated credit (amount paid) as of 10/6/16:	- $233,007.43	
TTD and PTD benefits due to Petitioner as of date of hearing:		$88,320.72
Underpayment of PTD from 10/7/16 through 3/20/17:		
23-4/7 weeks X $205.28 per week =		+ $4,838.74
Total Due from Respondent for underpayment of TTD/PTD as of May 15, 2017, when Respondent issued a check for $91,638.25:		$93,159.46

Based on the above, we award §19(k) penalties of $46,579.73 ($93,159.46 * 50%). We also award §16 attorney's fees in the amount of $9,315.95 (20% of the §19(k) penalties).

However, we respectfully disagree with the court's finding that our previous award was against the manifest weight of the evidence, an abuse of discretion, and the characterization that the Commission "failed to employ conscientious judgment when it awarded only partial

penalties." *Cir.Ct.Ord. at 10.* In our view, the question is not whether the Commission *could* have found that Section 19(k) penalties and Section 16 attorney's fees were warranted in this case. Rather, the question is whether the Commission *must* find that they are warranted in this situation such that it falls outside the discretion of the Commission.

In *Jacobo v. IWCC*, 2011 Ill. App. LEXIS 1186, the employer failed to pay the uncontested portion of benefits due to claimant for *over two years*. *Id. at 16.* The appellate court found that the Commission's denial of penalties and attorney's fees in that case was against the manifest weight of the evidence and an abuse of discretion. The court wrote:

> while a penalty under section 19(*l*) is in the nature of a late penalty, section 19(k) penalties and section 16 attorney fees address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose. *Zitzka*, 328 Ill. App. 3d at 849, 767 N.E.2d at 408. Section 19(k) penalties and section 16 attorney fees, therefore, require a higher standard than section 19(*l*) penalties. In addition, even when the facts support an award of penalties and attorney fees under sections 19(k) and 16, the decision to award penalties and fees is left to the discretion of the Commission. An abuse of discretion occurs when the Commission's ruling is "arbitrary, fanciful, unreasonable, or where no reasonable person would take the view adopted by the [Commission]." (Internal quotation marks omitted.) See *Blum v. Koster*, 235 Ill. 2d 21, 36, 919 N.E.2d 333, 342, 335 Ill. Dec. 614 (2009).
>
> In the present case, the Commission's determination that the facts do not support penalties and fees under sections 19(k) and 16 is against the manifest weight of the evidence. In addition, we find that the denial of section 19(k) penalties and section 16 attorney fees under the facts of this case constitutes an abuse of discretion. *Id. at 22-23.*

In *McMahan v. IC*, 183 Ill. 2d 499 (1998), the Supreme Court affirmed the appellate court's finding that the Commission abused its discretion by awarding only Section 19(l) penalties but denying Section 19(k) penalties and Section 16 attorney's fees. *Id. at 516.* In *McMahan*, the claimant sustained a low back injury at work on May 20, 1992, timely notified his supervisor, Jenny Colburn, and underwent medical treatment. *Id. at 502-03.* Ms. Colburn testified it was the employer's policy to "take care of small workers' compensation claims internally and not to submit accident reports on such claims to the insurance company." *Id. at 504.* However, "[b]y November 1992, Colburn realized claimant's condition was more serious than first believed and therefore completed an accident report that was forwarded to the insurance carrier. The carrier informed her there was a problem with coverage on the accident because the employer had not complied with its policy provisions. As a result, the carrier refused to pay any of claimant's medical bills. Colburn was also told not to pay any more of claimant's bills internally. Claimant was left to deal with those bills on his own." *Id.* In addition to not paying claimant's medical bills, the employer also failed to pay temporary total disability benefits when claimant underwent surgery. *Id.* The Supreme Court found:

> While the Commission is right that a higher standard is required for section 19(k) penalties and section 16 attorney fees than for additional compensation under section 19(l), we agree with the appellate court's conclusion that such penalties and fees should have been awarded here. The employer's conduct was not the result of simple inadvertence or neglect. More was involved than a lack of good and just cause. The

> employer made an intentional decision not to honor its statutory obligations to the employee, and it did so simply because it had not complied with the requirements of its insurance policy and was unwilling to absorb the cost itself. Compounding the situation is that the employer's violation of its insurance policy was not accidental or inadvertent. It was the product of an established company policy, a policy which, as the dissenting commissioner observed, also contravened the provisions of section 6 of the Workers' Compensation Act (820 ILCS 305/6 (West 1992)). Under these circumstances, the Commission's determination that the facts do not support section 19(k) penalties and section 16 attorney fees is contrary to the manifest weight of the evidence. We further hold that it would be an abuse of discretion to refuse to award such penalties and fees under the facts present here. The appellate court was therefore correct in ordering that the arbitrator's award of section 19(k) penalties and section 16 attorney fees be reinstated. *Id. at 515-16.*

In the case at bar, due to Respondent's failure to timely pay the arbitrator's award, we awarded penalties under §19(l). However, the appellate court has stated, "Sections 19(k) and 16 do not mandate that penalties be imposed after a certain period of delay." *Armour Swift-Eckrich v. IC*, 355 Ill. App. 3d 708, 711. Based on our review of the facts in this case, and in light of the cases noted above, we did not find that Respondent's delay rose to the level of being "deliberate or the result of bad faith or improper purpose" until it had failed to fully pay the accrued TTD/PTD benefits by the time of the June 9, 2017 hearing on Petitioner's Petition for Penalties and Attorney's Fees. We issue this Order, as instructed, but respectfully maintain that our previous Order was not against the manifest weight of the evidence nor an abuse of discretion.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $46,579.73 as provided in §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the attorney for the Petitioner legal fees in the amount of $9,315.95 as provided in §16 of the Act; the balance of attorneys' fees to be paid by Petitioner to his attorney.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $56,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 7 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 9/12/18
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

CHRISTOPHER BIEDRON,
Petitioner,

v.

NO: 12 WC 31193
13 WC 17744

TRAFIC SERVICES,
Respondent.

18IWCC0748

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. The case originally proceeded to hearing before Arbitrator Thompson-Smith on July 29, 2014; in dispute were alleged lumbar spine injuries on August 22, 2012 and May 21, 2013. In her October 22, 2014 decision, the Arbitrator found Petitioner proved he sustained injuries on August 22, 2012 and May 21, 2013 due to his "heavy work duties," further found a causal relationship between the injuries and Petitioner's current condition of ill-being and awarded benefits accordingly.

Respondent filed a timely Petition for Review. On December 18, 2015, the Commission reversed the decision of the Arbitrator and found Petitioner failed to prove he sustained accidental injuries on either August 22, 2012 or May 21, 2013. The Commission also found Petitioner failed to prove he sustained accidental injuries based upon a repetitive theory of recovery.

Petitioner filed a timely review to the Circuit Court of Cook County. On August 15, 2016, the Circuit Court issued its decision setting aside the decision of the Commission and remanding the matter with instructions that the Commission "address the facts presented to it under the repetitive trauma factors." *August 15, 2016 Order*, p. 4.

Respondent filed a timely appeal to the Appellate Court, First District Workers' Compensation Commission Division. On August 17, 2017, the Court issued an order pursuant to Rule 23 dismissing the appeal for want of appellate jurisdiction. In the Order, the Court noted

certain undisputed facts found in the record specifically, 1) "[the arbitrator] made detailed findings of fact regarding the claimant's numerous and repetitive job responsibilities as a traffic control technician for the employer, working on various highway construction projects since 2004," and 2) "the Commission did not directly address the law and facts related to repetitive trauma injuries..." *Biedron v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 162462WC-U, ¶¶ 4, 5.

The matter is now before this panel to analyze the facts based upon a theory of repetitive trauma. The Commission, having considered the issues and being advised of the facts and law, finds Petitioner proved he sustained accidental injuries which arose out of and in the course of his employment. The Commission vacates the decision of December 18, 2015 and reinstates and modifies the October 22, 2014 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

Based upon the Order of the Appellate Court as well as the Commission's *de novo* review of the evidence, the Commission affirms and adopts the statement of facts as set forth by the arbitrator in her decision of October 22, 2014 and incorporates such facts herein.

Conclusions of Law

As the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." "There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties.'").

In the case at hand, Petitioner testified without rebuttal to a plethora of heavy, repeated lifting activities. Petitioner's duties required him to lift barrels and tires weighing between ten and thirty pounds from 100 to 300 times per day. T. 14-15, 17. Petitioner also lifted verticades weighing 20 to 25 pounds approximately 100 times per day. T. 22. Additionally, Petitioner testified he lifted both tape and paint weighing 50 to 200 pounds multiple times per day. T. 22. The Commission finds the manner and method of Petitioner's job duties were sufficiently repetitive to sustain a finding of accident based upon a theory of repetitive trauma.

Due to these lifting activities, Petitioner sought treatment on June 13, 2012 from his primary care physician, Dr. Kalenowski. Certainly, the history contained in Dr. Kalenowski's June 13, 2012 medical record does not memorialize Petitioner's specific job duties, instead it merely notes Petitioner's occupation as construction. PX1. Dr. Kalenowski refers Petitioner for an MRI, as well as evaluation by a pain specialist and an orthopedic physician. PX1. During Petitioner's treatment with Dr. Kalenowski in 2012, Petitioner continued to work his full duty job except for a short period (July 6, 2012 through July 11, 2012) where he worked a lighter job due to restrictions imposed by Dr. Kalenowski. T. 30-32; PX1.

At Dr. Kalenowski's direction, on July 2, 2012, Petitioner was evaluated by Dr. Yaacoub, a pain specialist. No history of Petitioner's specific job activities is memorialized in the medical records, instead Petitioner indicates he is a laborer and his pain began and increased due to overwork. The Commission observes Petitioner, in completing the initial intake form, placed a "?" next to the following question: "Is this a work related injury?" PX3. Dr. Yaacoub performed several injections, and Petitioner continued to work full duty. T. 32, PX3.

On August 22, 2012, Petitioner was using a 50-pound hammer and experienced an increase in his back pain. T. 33. Petitioner testified he informed Mr. Jim Sinirch, the site manager, that he was unable to perform his work. *Id.* On August 29, 2012, Petitioner sought treatment from Dr. Murtaza, a pain specialist. Petitioner provided the following history: "The patient tells me that the pain has gotten worse since almost 1-1/2 to 2 weeks ago in August. The patient states that he does very rigorous lifting and heavy labor, and that is how the pain started." PX5. Dr. Murtaza provided several injections, eventually referred Petitioner for a surgical consult, and authorized Petitioner off work as of August 29, 2012. PX5.

On December 19, 2012, Petitioner sought treatment from Dr. Herman, a neurosurgeon, and the following history was memorialized: "35 yo WM, single with job at TSI (traffic services) and lifts barrels on highways. I JUne [*sic*], 2012, he was lifting barrels and experienced severe low back pain…He tried to work after the June injury, but the pain worsened and he finally reported it to his supervisor in sept 22, 2012 [*sic*]." PX10. On October 17, 2013, Dr. Herman provided testimony via evidence deposition. Dr. Herman testified, "That the disc herniation was caused by the work activities that he described, which occurred in June of 2012, which was basically lifting heavy barrels while working on the highways." PX17, p. 12. Dr. Herman was questioned at length during cross-examination regarding the varying histories Petitioner provided to his numerous providers, and ultimately testified, "Well, he does – he describes doing a lot of heavy lifting at work and the pain is aggravated with overworking, physical activities." PX17, p. 38.

On June 18, 2013, Dr. Salehi evaluated Petitioner on Respondent's behalf pursuant to Section 12 of the Act. During the evaluation, Dr. Salehi noted the following history from Petitioner: "he started getting hip and low back pain in June 2012 and was having so much pain he could hardly drive so he saw a physician. He does not recall any one specific injury but states he did a lot of lifting repetitively and with the accumulation of activities he developed the pain." RX3, DX3. Dr. Salehi authored a report stating, "The records which specifically indicate there was no prior trauma or injury are the ones from 6/14/12 as well as 6/28/12 [Dr. Kalenowski]. Had it

not been because of these two notes, then the stated history by the patient would have been the cause of his current condition." *Id.*

On October 1, 2013, Dr. Salehi provided testimony via evidence deposition. Dr. Salehi testified consistent with his June 2013 report stating, "Given the discrepancy in the records, I felt that there was no work-related trauma…Specifically, I mean he has stated that his pain has started in June, and yet the most relevant notes which are the closest note in time are the June 14th and June 28th do not mention any trauma or injury to the lower back." RX3, p. 15. On cross-examination, Dr. Salehi acknowledged Petitioner's job required heavy lifting, and such occupation as a laborer would be a risk factor contributing to Petitioner's lumbar spine condition. RX3, p. 27-28.

"In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Williams*, 244 Ill. App. 3d 204, 209 citing *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 510 N.E.2d 502 (1987). The Commission finds the medical testimony establishes Petitioner's lumbar spine condition was caused, wholly or in part, by his work duties of repeated heavy lifting. Dr. Herman testified such activities were the cause of Petitioner's condition and specially referenced lifting of barrels. Dr. Salehi, Respondent's expert, also testified that heavy lifting activities would be a cause of Petitioner's lumbar condition. Dr. Salehi testified he was unable to causally relate Petitioner's lumbar condition to a single traumatic incident given the lack of contemporaneous medical records, but such testimony is irrelevant in the context of a repetitive trauma claim. Dr. Salehi indicated in his June 18, 2013 report, "had it not been because of these two notes, then the stated history by the patient would have been the cause of his current condition" -the stated history being "he does not recall any one specific injury but states he did a lot of lifting repetitively and with the accumulation of activities he developed the pain." RX3, DX3.

Regarding the manifestation date, the Commission finds such date to be August 22, 2012 with an aggravation on May 21, 2013. "The date of injury in repetitive trauma cases is the date on which the injury manifests itself, meaning the date on which the fact of injury and the causal relation to work would have become plainly apparent to a reasonable person. [citation omitted]." *Edward Hines Precision Components*, 356 Ill. App. 3d at 194. Petitioner experienced pain initially in June of 2012 requiring him to seek medical treatment. During Petitioner's initial treatment in 2012, he continued to work full duty. While seeking treatment in July of 2012, Petitioner began to wonder if his condition was caused by his work duties as evidenced by the intake sheet completed on July 2, 2012 by Petitioner. PX3. On August 22, 2012, Petitioner's pain increased to such an extent while he was using a 50-pound hammer that he advised his site manager he was unable to continue to work. Petitioner was authorized off work shortly thereafter on August 29, 2012. The Commission finds it was plainly apparent as of August 22, 2012 that Petitioner's lumbar condition was caused by his repetitive lifting activities.

IT IS THEREFORE ORDERED BY THE COMMISSION that its decision of December 18, 2015 is vacated.

18IWCC0748

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2014, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $734.84 per week for a period of 84 1/7 weeks, representing August 29, 2012 through March 14, 2013, and May 21, 2013 through June 15, 2014, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $123,327.56 for the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's lumbar spine pursuant to Sections 8(a) and 8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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: DEC 7 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/se
O: 6/5/18
49

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

BIEDRON, CHRISTOPHER
Employee/Petitioner

Case# **12WC031193**

13WC017744

TRAFIC SERVICES
Employer/Respondent

18IWCC0748

On 10/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4239 LAW OFFICE OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

18TWCC0748

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
CORRECTED ARBITRATION DECISION
19(b)

Christopher Biedron
Employee/Petitioner

Case # **12 WC 31193**

v.

Consolidated cases: 13 WC 17744

Trafic 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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on July 29, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the dates of accident, 8/22/12/ & 5/21/13, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On 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 $57,317.53 and the average weekly wage was $1,102.26.

On the date of accident, Petitioner was **36** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner $734.84 per week in temporary total disability benefits from August 29, 2012 to March 14, 2013, and from May 21, 2013 to June 15, 2014, a period of 82 6/7 weeks, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner$123,327.56 in medical services as delineated in this Decision, pursuant to 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.

Findings of Fact

The disputed issues in these matters are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability benefits; and 6) whether the Statute of Limitations applies. *See*, Ax1.

As of August 22, 2012, Christopher Biedron ("Petitioner") was 35 years old, employed full time as a traffic control technician with Trafic Services, Inc. ("Respondent"). He has been employed with Respondent in this position since May of 2004.

As a traffic control technician, Petitioner's job duties involved setting up lane closures and reconfigurations, for construction projects on highways. His typical day started at the garage, where he loaded his truck with the equipment necessary for that day's job. Petitioner would then drive the truck out to the job site, unload the equipment, and set up the lane closures. On occasion, he would also break down a lane closure, load the equipment back into the truck, and return it to the garage. Petitioner testified that he did not get any assistance loading or unloading his truck.

The equipment used for a typical project included barrels, tires, cones and verticades. Petitioner described the barrels as about two feet tall, round, and weighing about ten (10) pounds each. The tires, which weighed between twenty-five (25) and thirty (30) pounds, would go around the barrel. Depending on the weather, each barrel would hold up to three (3) tires. Petitioner testified that he would use between one hundred (100) and three hundred (300) barrels per project.

Petitioner described a verticade as being approximately two (2) feet long by one (1) foot wide, with a base at the bottom that would snap on. Petitioner testified that each of these weighed between twenty (20) to twenty-five (25) pounds; and he would use approximately one hundred (100) of these for a typical project.

Petitioner testified that he also used sandbags, barrels and signs. The sandbags were used to hold up signs and barricades and he would typically use between sixty (60) and one hundred (100) sandbags per project.

Petitioner testified that he would set up foldout signs and the sandbags were used to hold them down. Additionally, Petitioner put up "green posts", which range in length from seven (7) to twelve (12) feet; and there were times when twenty (20) to thirty (30) feet was used to construct a Telespar, which could weigh up to four hundred (400) pounds. Putting up this type of sign was a two or three man job and often, the posts were driven into the ground using a compression hammer.

When a job involved painting, he would load tape and painting machines, along with boxes of tape and buckets of paint. He would sometimes have assistance loading his truck, depending on the size of the job. He testified that the paint machine weighs approximately two hundred (200) pounds and the

tape machine about fifty (50) pounds. If he was taping, he would bring out twenty (20) or more boxes of tape, and if they were painting, he would bring ten (10) or more buckets of paint.

Petitioner testified that he had a prior injury to his lower back in 2009, while performing work duties for Respondent. He went to Mercy Hospital's immediate care, where he received x-rays, was given pain medication and discharged. Petitioner received no further treatment for his lower back until the time of the injury, which is the subject of these claims. He missed no time from work, and continued working in a full duty capacity.

Petitioner testified that he began experiencing lower back and left hip pain in June of 2012. He testified that the pain came on gradually and as a result, on June 13, 2012, Petitioner went to Alexian Brothers to see his primary care provider, Dr. Kalenowski. He told Dr. Kalenowski that his work duties were causing him pain in his lower back and hip. The records do not contain a history of Petitioner's condition. The records indicate that Petitioner is a construction work, and that he did have a previous injury or trauma. Dr. Kalenowski diagnosed Petitioner with a backache, gave him a prescription for Meloxicam, and recommended an MRI of his lumbar spine. PX1.

Petitioner had the lumbar MRI at St. Alexius Medical Center on June 22, 2012, which showed a prominent disc protrusion at L4-5 effacing the L5 nerve root, a "tiny" L5-S1 disc herniation; and mild degenerative disc disease at L4-5. PX2.

Petitioner returned to Dr. Kalenowski on June 28, 2012. Again, the records do not contain a specific history of Petitioner's complaints. Petitioner reported "myalgia" and a limited range of motion. Dr. Kalenowski diagnosed Petitioner with anxiety and displacement of thoracic or lumbar intervertebral disc, without myelopathy. He prescribed Fluoxetine and Alprazolam for anxiety and Norco for the low back pain. According to the records, Dr. Kalenowski also recommended that Petitioner see an orthopedic specialist for his lower back and radiating complaints but Petitioner testified and the record reflects that instead, Dr. Kalenowski referred him to a pain management specialist. Petitioner continued to work full duty. PX1.

On or about July 2, 2012, Petitioner was examined by Dr. Chadi Yaacoub, a pain management specialist at Illinois Pain Institute. Petitioner told Dr. Yaacoub that he had been having low back pain for about four years, he denied any trauma, but did indicate that he did a lot of heavy lifting at work and that the pain was aggravated by overworking. After performing an MRI of the lumbar spine, Dr. Yaacoub's assessment was lumbar degenerative disc disease, lumbar facet joint disease, low back pain syndrome and myofascial pain syndrome. He recommended lumbar epidural and lumbar facet joint injections. Petitioner continued working full duty. PX1 & 3.

On July 11, 2012, Petitioner returned to Dr. Kalenowski, who places him on light duty work restrictions. Petitioner testified that Respondent cut his work hours immediately, so he returned to Dr. Kalenowski on July 1, 2012, and asked the doctor to lift his restrictions. Dr. Kalenowski returned Petitioner to work without restrictions, and Petitioner continued to work in a full duty capacity.

On July 18, 2012, Petitioner had epidural steroid injection at L4 on the left and L5 on the right. On August 20, 2012, Petitioner had bilateral facet injections at three (3) levels and fluoroscopy in multiple planes. Dr. Yaacoub performed these procedures at Barsurg Procedure Center. PX3 & 4.

Petitioner testified that on August 22, 2012, he was asked to pound a post into the ground at work, using a compression hammer. He testified that he had to hold the post and the hammer with one hand, while he flipped the switch with his other hand. He testified that the hammer weighed about fifty (50) pounds. Petitioner testified that as he attempted to flip the switch with his arms stretched out, he immediately had pain in his lower back and had trouble walking. He stopped what he was doing, and reported to his supervisor Jim Sinirch that he could not complete the task. The incident happened toward the end of the day and Petitioner finished out his shift. Tr. Pgs. 32-36.

Petitioner testified that when he returned to work the next day, he was not doing well. He had pain in his lower back radiating to his left hip, which he described as constant and intense, to the point that he could not function.

On August 29, 2012, Petitioner went to see another pain specialist, Dr. Murtazza, at Illinois Orthopedic Network. Dr. Murtazza took Petitioner off work completely. PX5.

Petitioner filled out an injury report. In the report, he indicated an accident date of August 22, 2012. He further described how the injury occurred as "while using compressor to pound post twisted back while trying to turn on compressor and hold post". Petitioner testified that he filled the report out on his own, and gave it to his supervisor Dave Wittmus. PX15.

On September 7, 2012, Petitioner had an EMG performed by Dr. Syed Naveed at Neurological Consultants Group. Petitioner indicated he was injured in June 2012, when he was doing roadside work and lifting something heavy. He began experiencing pain in his lower back. The EMG revealed mild left L5-S1 radiculopathy. PX9.

Dr. Murtaza diagnosed the petitioner as having lower back pain, lumbar radiculopathy, possible adhesions; and degenerative disk disease of the lumbar spine. On October 16, 2012, Dr. Murtazza performed a caudal epidural steroid injection for lysis of adhesions in Petitioner's lumbar spine. Petitioner testified that he did not get much improvement with the injection. He reported this to Dr. Murtazza on October 24, 2012. He also reported continued low back pain, radiating primarily into the

left hip, and that his job involved heavy labor. Dr. Murtazza discontinued further injections, and referred Petitioner to an orthopedic specialist for a surgical evaluation. PX5.

Per Dr. Murtazza's recommendation, Petitioner started a course of physical therapy at Vander Weit Chiropractic. He attended therapy approximately three times a week for a month, ending November 12, 2012. Petitioner reported no improvement. PX6.

According to Dr. Murtazza's records, Petitioner returned to him on November 28, 2012, not having seen an orthopedic specialist, and reported improvement of his lower back symptoms after the lysis injection, but that his left hip symptoms persisted. Dr. Murtazza recommended a hip injection, for diagnostic and therapeutic purposes. He also released Petitioner to return to work in a light duty capacity. Dr. Murtazza performed the hip injection on December 6, 2012. Petitioner reported no improvement. PX5.

On December 19, 2012, Petitioner presented to Dr. Martin Herman, a neurosurgeon at The Center for Brain and Spine Surgery. Dr. Herman also testified by way of evidence deposition. At the initial visit, the record indicates Petitioner reported that he lifts barrels on highways, and that in June 2012, he was lifting barrels and experienced severe low back pain. Petitioner also reported that he tried to work after the June injury, but the pain worsened, and he developed hip pain as well. And that he reported his condition as work-related on September 22, 2012. Dr. Herman took an x-ray of Petitioner's left hip, reviewed his history and diagnostic studies; and diagnosed Petitioner with lumbar disc displacement and left-sided L5 radiculopathy. Dr. Herman recommended physical therapy, but opined that eventually Petitioner would need a microdiscectomy. He also returned Petitioner to work in a light duty capacity. PX10 & 17.

Petitioner testified that he returned to work for Petitioner for about a month, and then was laid off. Petitioner returned to work again for Respondent on March 15, 2013. Petitioner also returned to Dr. Herman on April 10, 2012 and told Dr. Herman that he was back to working full duty, and doing alot of twisting. He was still having alot of lower back pain, radiating into his left buttock, hamstring and lower extremity. Petitioner also reported taking Norco every day. Dr. Herman continued to recommend surgery and light duty restrictions.

Petitioner continued to work full duty until he had a subsequent accident on May 21, 2013. Petitioner testified that he was on the back of a truck, reaching into a bin to grab Telespar. When he got toward the bottom of the bin, he felt an immediate, sharp pain in his lower back. Petitioner filled out another report of injury, on May 29, 2013, for this incident. Petitioner filed a second Application for Adjustment of Claim, alleging this date of accident. PX16.

Petitioner returned to Dr. Herman on June 5, 2013. Petitioner reported that although Dr. Herman was recommending light duty restrictions, Respondent continued to require him to work beyond his

restrictions. Dr. Herman opined that Petitioner's condition was work-related, and that he required surgery. He also did not think it was safe for Petitioner to return to work, and so took him off completely, pending surgery.

On June 18, 2013, Dr. Sean Salehi examined Petitioner, by request of Respondent. Dr. Salehi testified by way of evidence deposition on October 1, 2013. Dr. Salehi testified that the surgery recommended by Dr. Herman was appropriate. However, Dr. Salehi also testified that because there was no mention of work activities or a work-related incident in the June 14th and June 28th records from Alexian Brothers, and Petitioner did not mention the compression hammer incident of August, 2012 to him, that Petitioner did not suffer a work-related trauma. Dr. Salehi did not review Petitioner incident report for the August 22, 2012 injury. RX3, pgs. 15-30.

Upon cross-examination, Dr. Salehi admitted that Petitioner told him he thought his low back condition was related to heavy labor at work. He further testified as to not finding any section in the Alexian Brothers records, indicating a history of Petitioner's condition. He admitted not reviewing the medical record from Petitioner's first visit with Dr. Herman or any of the medical records before his examination of Petitioner.

Dr. Salehi further testified that he could not rule out Petitioner's job duties causing or contributing to his disc herniation. Lastly, Dr. Salehi testified assuming the compression hammer incident occurred on August 22, 2012, and that he reported it to his employer on August, 31, 2012, the compression hammer incident of August 22, 2012, could have aggravated his low back injury.

On March 17, 2014, Petitioner called Dr. Herman, because the medication was no longer controlling his pain. Dr. Herman sent Petitioner for another lumbar MRI at Lutheran General Hospital, which was performed on March 17, 2014. It revealed a L4-5 disc herniation, possibly effacing the left L5 nerve root; and an L3-4 disc protrusion displacing the right L3 nerve. PX10.

Petitioner was admitted to Lutheran General, and Dr. Herman performed a L4-5 microdiscectomy on March 19, 2014. Petitioner continued to follow up with Dr. Herman, who sent Petitioner for a course of post–surgical rehabilitation at AthletiCo. Petitioner underwent therapy from April 17 through May 23, 2014 and on June 10, 2014, Dr. Herman released Petitioner, declared him to be at maximum medical improvement, with permanent medium-duty restrictions. Petitioner returned to work for Respondent in a medium-duty capacity on June 16, 2014. PX11.

The petitioner states that a deposition of Dr. Martin D. Herman was taken on October 17, 2013, wherein he testified that Petitioner's need for surgery was related to the work duties that he described of lifting heavy barrels. The Arbitrator notes that only the exhibits to this deposition were entered into evidence therefore, the doctor's testimony is not of record. The Arbitrator further notes that there are certain medical records in the exhibits.

James Giammarino testified on behalf of Respondent. He is employed with Respondent as the shop manager and has been employed in this capacity since July of 2010. He testified that when an accident occurs, Respondent's procedure is for the worker to report the accident to his supervisor or to him.

Mr. Giammarino further testified that he was not Petitioner's direct supervisor and that Petitioner did not report the August 22, 2012 accident to him but to someone else; and that he did not know who that person was. He further testified that Petitioner reported the second accident of May 21, 2013 to him and that the petitioner stated that he had hurt his back at work. *See*, Tr. pgs. 75-79.

Conclusions of Law

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956). It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The record is clear that Petitioner had a lumbar spine condition that pre-dated both dates of accident. The record is also clear that, despite this condition, Petitioner continued to work full duty without restrictions for Respondent until August 29, 2012, the first day that Petitioner was placed on any restrictions for his lower back, and seven (7) days after the first alleged date of accident. It is further uncontested that Petitioner has a job in the heavy physical demand category, and that the current condition of his lumbar spine, requires surgery.

It is Respondent's position that Petitioner has failed to carry his burden of proving that his current condition is related to his work duties, because Petitioner has given differing accounts, in the record, regarding the origin of his complaints.

The Arbitrator finds that the only explanation for Petitioner's current complaints are his heavy work duties, and that Petitioner suffered subsequent aggravations, first while twisting his back using his compression hammer and then later when he was bending at the waist and reaching into a storage box on his truck for Telespar. There is no history of any other event to account for his complaints and no evidence of activity outside of work that would cause his current condition of ill-being.

Respondent's Section 12 examiner, Dr. Salehi, conceded that he could not rule out that Petitioner's heavy labor job duties contributed to his current lumbar spine condition; and further conceded that, if the incident regarding the compression hammer did occur, it could also have aggravated Petitioner's condition.

For these reasons, the Arbitrator finds that Petitioner had proven, by a preponderance of the evidence, that he sustained accidental injuries that arose out of and in the course of his employment.

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

Petitioner testified in a credible and unrebutted manner, that he gave notice of the first accident of August 22, 2012, to his immediate supervisor, Dave Wittmus. In support, he introduced into evidence an injury report dated August 31, 2012. Petitioner also testified that he reported the second accident of May 21, 2013, again to Dave Wittmus. Petitioner also entered into evidence a report of injury for this date of accident, which he filled out and dated May 29, 2013.

Mr. Gammarino testified that according to Respondent's procedures, employees were supposed to report work-related injuries to him or to their immediate supervisor. He further testified that he was not Petitioner's immediate supervisor at the time of either accident; that he was made personally aware of Petitioner's May 21, 2013, but Petitioner did not report the August 22, 2012 accident to him. However, he admitted that Petitioner could have reported it to Dave Wittmus instead of to him.

There was no evidence presented to contradict Petitioner's testimony that proper notice of his work accidents was given to Respondent. For the foregoing reasons, the Arbitrator finds that Petitioner provided proper notice to Respondent of both dates of accident, within the meaning of the Workers Compensation Act.

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

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident

and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

The Arbitrator relies of the unrebutted testimony of the petitioner and Mr. Gammarino and the medical records in evidence, to determine that the petitioner has proven, by a preponderance of the evidence, that his current condition of ill-being is related to his work accidents.

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

For the reasons stated above, the Arbitrator also finds the medical treatment reasonable and related to the work accident, and further finds that the amount of these bills should be paid to Petitioner by Respondent, according to the fee schedule, itemized as follows:

Provider	Date(s)	Balance
1. St. Alexius Medical Center	6/14/12–6/22/12	$4,546.00
2. Illinois Pain Institute	7/2/12–8/20/12	$923.35
3. Barsurg Procedure Center	8/20/13	$11,434
4. Illinois Orthopedic Network	8/2912–2/28/14	$6,253.83
5. Vander Weit Chiropractic	10/11/12–11/12/12	$1,859.00
6. Goldcoast Surgical Associates	10/16/12–12/6/12	$6,651.04
7. JMS Supplies	10/16/12	$3,750.71
8. Center of Brain and Spine Surgery	12/19/12–6/10/14	$36,009.86
9. Total Rehab	5/23/13–7/5/13	$4,778.00
10. AthletiCo	4/7/14–5/23/14	$2,585.87
11. IWP	6/28/13	$1,477.87
12. Advocate Lutheran General	12/19/12–3/20/14	$38,965.03
13. Neurological Consultants Group	9/7/12	$4,093.00
Total		$123,327.56

K. What temporary benefits are in dispute?

Based upon the foregoing discussions, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from Respondent for the time periods he was off work for his injury, from August 29, 2012 to March 14, 2013, then from May 21, 2013 to June 15, 2014, a period of 82 6/7 weeks.

O. Should the Statute of Limitations be applied in this case?

It is Respondent's contention the Statute of Limitations has run on any and all of Petitioner's dates of accident. The Arbitrator disagrees and finds that the Statute does not apply in this matter.

18IWCC0748

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12 WC 31193; 13 WC 17744
SIGNATURE PAGE

Signature of Arbitrator

October 22, 2014
Date of Decision

OCT 24 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Sumner,
Petitioner,

vs. NO 15 WC 25707

Cassens Transport,
Respondent.

18IWCC0749

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective 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 hereby remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 18, 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.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $61,700.00. 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: DEC 7 - 2018

Joshua D. Luskin

Charles J. DeVriendt

o-11/27/18
jdl/wj
68

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Jeffrey Sumner
Employee/Petitioner
v.
Cassens Transport Company
Employer/Respondent

Case # 15 WC 25707

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **August 5, 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. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident **July 1, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$82,213.04**; the average weekly wage was **$1,612.02.**

On the date of accident, Petitioner was **48** 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 $ for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**

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

ORDER

Medical benefits

Respondent shall pay Respondent shall pay the bills totaling **$3,171.00**, subject to the fee schedule and pursuant to §8 and §8.2.

Respondent shall authorize and pay for the cervical surgery proposed by Dr. Braaksma, and the attendant care, in accordance with the provisions of §8 and §8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits at the rate of **$1,074.67** per week for **57-2/7 weeks**, commencing **July 2, 2015 through August 5, 2016.**

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

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

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

Christine Roy

Signature of Arbitrator

05/18/2017
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Sumner	)
Petitioner,	)
vs.	) **No. 15 WC 25707**
Cassens Transport Company	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on August 5, 2016. The parties agree that on July 1, 2015 Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. The petitioner's average weekly wage.
4. Whether respondent is liable for the unpaid medical bills.
5. Whether petitioner is entitled to payment for prospective medical treatment.
6. Whether petitioner is due TTD.
7. Whether penalties and fees should be imposed upon respondent.

STATEMENT OF FACTS

Petitioner, Jeffrey Sumner, Testimony

Petitioner testified he had been employed by respondent for 17 years as a car hauler. The job required him to deliver new cars to dealerships.

On July 1, 2015, petitioner was backing a compact Subaru Impreza Wagon onto his truck. Petitioner had his chest and head out the driver's side window looking back at the rear tire of the vehicle and backed up over the four "flippers", one for each wheel. Petitioner estimated the flippers were two to three feet long and 14 to 15 inches wide. He estimated he was driving two to three miles an hour; having to get momentum up to get over the flippers. Petitioner hit all four flippers at once, similar to hitting a speed bump, causing a jarring. He heard a snap in his neck and felt pain that went down the middle of his back.

Petitioner continued to work, thinking if he was able to get loaded, all he would have to do is drive to Cleveland. The more he loaded, the worse the pain became. As he drove out of the rail head, which is where the vehicles are picked up which had been delivered by rail, he was having a hard time looking left and right or shifting. By the time he got out of the rail head, he pulled over as he couldn't continue to drive.

He called Tom Zitt, the terminal manager. He advised Zitt he was injured and how it happened. Zitt asked him to try and drive to the terminal in Aurora and Zitt would have petitioner fill out an accident report and send him to a doctor. When he arrived at the terminal he was advised by Tom Zitt that Bill Molter, who is in charge of claims and accidents for respondent, told him that petitioner could not have hurt himself loading the truck that way. Zitt refused to let petitioner fill out an accident report. This was the first time in his four to five times of being hurt that petitioner was not allowed to complete an accident report. Petitioner was told by Zitt to see his own doctor. Petitioner picked up his personal belongings and went home.

Petitioner called respondent's insurance company, which was then Broadspire and now Crawford and Company. The person at Broadspire asked petitioner if he would agree to see a doctor she chose. She referred him to the OSF Clinic in Belvidere. Petitioner went directly to the clinic before he went to his home. X-rays were taken.

The following Monday, which was July 6, 2015, petitioner followed up with Dr. Diamond, his family doctor. He was given a six-day steroid pack. He again saw Dr. Diamond on July 13, 2015 and was given another six-day steroid pack, a script for a cervical MRI and a referral to an orthopedic specialist. He was kept off work until he saw the orthopedic specialist. Petitioner obtained the MRI on July 21, 2015 at Four City Diagnostics.

Two to three weeks after reporting the accident, petitioner received a call from Juanita Brown, who identified herself as a Broadspire representative. Brown took a recorded statement from him as to the facts of the accident.

Petitioner first saw orthopedic surgeon, Dr. Braaksma, of Rockford Orthopedics, now known as Illinois Orthopedic, on September 9, 2015. Petitioner brought his cervical MRI with him to his first appointment with Dr. Braaksma. Dr. Braaksma recommended surgery and ordered petitioner off work until after surgery. Petitioner had used his personal health insurance until August, 2015, when he lost those benefits. He was unable to pay for COBRA as he was not receiving any benefits.

Petitioner tried to see Dr. Sweet, who had done petitioner's earlier cervical surgery in 2007, but was unable to as Dr. Sweet would not seem petitioner without insurance. Dr. Braaksma was willing to see petitioner and wait for payment. Petitioner also saw his family doctor, Dr. Diamond, every two to three months for pain medication.

Petitioner confirmed he had a previous neck injury in August, 2006, which resulted in a cervical fusion in January, 2007. Petitioner returned to work in July, 2007 after the surgery. He was cleared to return to work by a company doctor in 2007. He worked full time from his release in 2007 until February, 2011, when he had another cervical injury. Petitioner received only injections and physical therapy for this injury. He was released to return to work full duty in May or June, 2011. Later in 2011, petitioner injured his lower back. He did not receive any treatment to his cervical spine at that time, or any time since June, 2011 until July 1, 2015.

Petitioner continues to have pain in his neck that radiates down his shoulders and arms. He has this pain every day. He also finds he is getting weaker.

On cross examination petitioner agreed he had pain down his arm and felt a snap in his neck after 2006. Petitioner admitted he had an appointment already with Dr. Diamond on July 1, 2015 for his medication as he was on hydrocodone.

Petitioner admitted he had applied for social security disability in April, 2013 and received benefits for fourteen or fifteen months dating back from 2011 to 2012 until he returned to work in October, 2013.

Petitioner admitted he had bilateral pain from his neck as of February 23, 2015.

Thomas Zitt Testimony

Thomas Zitt testified in behalf of respondent. Zitt had been terminal manager in Aurora for approximately 28 years. Zitt testified that petitioner had called him on July 1, 2015. According to Zitt, petitioner advised him in the phone call that he turned his head and felt some pain and was going to continue loading vehicles. According to Zitt, petitioner did not tell Zitt that he was backing up a vehicle and hit flippers when he felt the pain.

Although Zitt has employees fill out accident reports when injuries are claimed, Zitt contacted Bill Molter, the safety director, who advised him not to have the petitioner complete the accident report as Molter did not consider petitioner to have had a work accident. Zitt testified he did not know until 60 days later when he received the report from Broadspire that petitioner claimed he hurt his neck while backing up cars onto the trailer.

Zitt confirmed on cross examination that he was told by Molter not to give an accident report to petitioner to complete. Zitt believe Molter may have told Zitt once or twice in the past not to give accident reports to those who claimed to have been injured.

Zitt did not recall receiving emails from Annette Tate with Crawford.

OSF Saint Anthony Hospital Records and Bill (PX.1)

These records reflect petitioner was seen at OSF Health on July 1, 2015 providing the precipitating factors of: "turned sharply, hit a bump while loading a car on a toe (sic) truck at work." He provided a prior history of low back problems. Diagnosis was cervical strain. He was to avoid lifting, pushing and pulling; was to follow up with primary care physician in three to five days.

The total bill claimed for this date of service is $806.00

Diamond Family Medical Center (PX.2)

The records reflect petitioner was seen on July 6, 2015 by Dr. Diamond for cervical radiculopathy. The history recorded was that on July 1, 2015 [petitioner] felt a pop in his neck when looking over left shoulder backing a car off the car van felt a bounce and a pop in his neck. He as okay for a few days but then noted pain down both arms, right greater than left arm with sense of weakness. An off work note was written.

Petitioner followed up on July 13, 2015. He continued to have pain in weakness in both arms. Medrol did not help much. Dr. Diamond continued petitioner off work.

He was seen again on October 26, 2015 with ongoing pain and both arms with weakness. Dr. Diamond noted petitioner remained off work pending surgery.

The medical bills claimed totaled $525.00

Forest City Diagnostic Imaging (PX.3)

The July 15, 2015 MRI showed C5-C6 osteophytes accompanying a broad based right paracentral disc protrusion.

The bill for services rendered was $1,663.00.

Rockford Orthopedic Records and Bills (PX.4)

Petitioner was first seen by PA Michael McCormick on September 4, 2015. The history recorded that was that the neck pain came on July 1, 2015 due to over twisting when loading vehicles onto a truck at work. The pain and paresthesia in the C6 nerve root was reportedly concordant with the MRI findings.

Petitioner saw Dr. Braaksma on May 6, 2016, who recommended surgery.
Medical bills claimed are $332.00 from September 4, 2015 and $370.00 from May 6, 2016.

Broadspire/Crawford & Company Claim File (PX.5).

These records contain a transcript of a recorded statement petitioner provided to Juanita Brown. (The date of the statement is not clear, however, petitioner indicated he was scheduled to see his family doctor, Dr. Diamond on July 13, [2015]) (76).

In the statement, petitioner related the same history as to how the accident occurred as he provided in his testimony. The transcript specifically stated: "...We unload and load our own vehicles onto tractor trailers. One of the units I was loading, which is our No. 4 unit, back on the top of the trailer and when I was in the unit, it's a small tubular car, we actually have to put our head and chest out the window as we drive. My left foot is on the brake and my right foot is in the gas. My right hand is on the steering wheel. And then I use my left hand on the seat so I could kind of stick my body out the window, and then you have to twist your body and look down at the rear tire of the vehicle as you back up theses ramps. It keeps our unit straight and keeps you from hitting the wheels and falling in between the ramps..."

The transcript further stated: "...Backing it on and when we get to this No. 4 ramp, it's on the top and it's the back towards the tractor. And we have theses flippers that are on this deck. There are 4 flippers on this particular deck. The rear flippers are thrown in to make the deck shorter and the front flippers are actually still staying out and when we did is when we back onto this ramp we basically have to get on top of theses flippers and that's where we park the vehicles. And when I got back to this ramp umm since this is such a small car, all 4 tires had hit these four flippers at the same time. And when I hit these flippers and got up on top of them, it jarred me so bad that umm I heard a snap, like the snap of a finger and I had pain between my kind of like your shoulder blades, down and about the middle of my back."

This exhibit includes emails as earlier as July 7, 2015 between claims adjuster Annette Tate and Thomas Zitt regarding petitioner's claimed injury of July 1, 2015 (86).

These records include treatment relative for his lower back after an injury occurring on November 9, 2011 According to these records, petitioner had last seen Dr. Enke on February 12, 2013 at which time he was not on any pain medication and was discharged at MMI. (121-231; 242-261)

This exhibit includes Dr. Diamond's records of petitioner's December 1, 2015 visit not included in the Diamond Family Clinic's records (PX.13). Petitioner's condition has not been helped with steroids; he remained on pain medications and was awaiting authorization for cervical surgery. (261-262)

These records contain a June, 2015 note from Diamond Family Medical Clinic indicating petitioner was overdue for an appointment for follow-up visits, lab work and medications (312).

Dr. Brian Braaksma July 11, 2016 Deposition (PX.6)

Dr. Braaksma, board certified orthopedic surgeon testified in behalf of petitioner. The September 4, 2015 exam was performed by Dr. Braaksma's PA Michael McCormick (12). Petitioner's history provided on September 4, 2015, according to the records, was a twisting injury when loading vehicles onto a truck at work; he heard a snap in his neck and felt pain into the shoulders and back (14). The positive exam findings were pain with range of motion of the neck, objective muscle weakness, which was 4 of 5 muscle strength in the right biceps and wrist extensors, subjective paresthesia in the C6 dermatome bilaterally (16).

Dr. Braaksma testified the July 21, 2015 MRI showed the prior fusion instrumentation at C6-7 as well as a C5-6 bilobed disc bulge with bilateral uncovertebral hypertrophy resulting in moderate right greater than left neuroforaminal stenosis which is significant for adjacent segment degeneration at C5-6 level with right-sided nerve impingement (16-17).

Dr. Braaksma was of the opinion that the degenerative disc caused a higher risk for an acute injury (18). By the time Dr. Braaksma saw petitioner on September 4, 2015, he had undergone enough conservative care without significant relief to justify surgical intervention (19). Dr. Braaksma did not know if petitioner was given work restrictions at that visit but confirmed he would generally provide a light-duty restriction in patients with similar findings (20).

Petitioner returned to Dr. Braaksma on May 6, 2016, at which time Dr. Braaksma himself performed the exam (22). At that time petitioner had similar complaints; however, was doing better than before (23). Dr. Braaksma did not recommend petitioner continue with the narcotic pain medication that he was being prescribed by another physician (24).

Dr. Braaksma recalled petitioner describing the injury occurring as he was driving a piece of heavy machine looking over his shoulder and there was an abrupt stop causing jarring of his neck (24). Dr. Braaksma believed the mechanics of the occurrence could cause the petitioner's neck condition (25).

Dr. Braaksma's diagnosis was adjacent segment degeneration with disc herniation, resulting in upper extremity radiculopathy which is the result of nerve root impingement and compression (27). Dr. Braaksma's restrictions remained the same, which was light-duty (28-29). Dr. Braaksma did not have any records from petitioner's injury in 2011 (31). The fact that petitioner had an injury to his cervical spine in 2011 and was able to return to work without restrictions after conservative treatment confirmed Dr. Braaksma's opinion on causation (31).

OSF St. Anthony Medical Center Records and Bills (PX.7)

Petitioner was seen in the emergency room on June 2, 2014 with history of chronic neck and back pain after multiple neck surgeries and presented to the emergency room with intermittent loss of vision in right eye. Further history was that he popped his neck about four hours prior to admission and he developed a migraine which was normal. However, he then lost vision in right eye. CT Scan was normal.

Rockford Orthopedic/ Dr. Norm Hagman Records (PX.8)

This is Dr. Hagman's October 10, 2006 report of his exam performed at respondent's request relative to petitioner's cervical and lumbar injury sustained on August 7, 2006. Dr. Hagman diagnosed C6-C7 and C5-C6 protruded discs. Surgical stabilization, including discectomy and fusion, at both levels was recommended.

Rockford Spine Center Ltd. Records and Bills (PX.9)

Petitioner saw Dr. Fred Sweet on December 6, 2006 for his August 7, 2006 cervical and lumbar injuries. Dr. Sweet noted a fairly large C6-C7 disc herniation on the right. Dr. Sweet recommended a cervical fusion.

These records reflect the next visit with Dr. Sweet was on March 16, 2011. Petitioner's history was that on he was three years' status post C6-7 anterior cervical discectomy and fusion. On February 3, 2011 he was at work, was looking behind as he was backing up a vehicle when he had an acute onset of pain in his right neck and shoulder. He was diagnosed with an acute disc

herniation on the right at C5-6 just above his previous C6-7 fusion. Epidural injections were discussed.

Rockford Memorial Hospital Records (PX.10)

These records contain the operative report of the surgery performed by Dr. Sweet on January 16, 2007, consisting of a C6-7 anterior cervical discectomy, fusion, anterior plat allograft procedure for a C6-7 herniated disc.

(The records also contain the duplicate records from the December 6, 2006 visit with Dr. Sweet.)

Also included was the physical therapy records for therapy from August and September, 2006 and from March through June, 2007 and August, 2007.

OSF Center for Health Records (PX.11)

These records include a September 15, 2010 cervical MRI. This MRI was compared with the pre-operative MRI of September 22, 2006 and reportedly showed only postsurgical changes at C6-7, no spinal stenosis or nerve root impingement and degenerative spurring and disc disease at C5-6, which was similar to the previous MRI.

Diamond Family Medical Clinic Records and Bills (PX.13)

Petitioner was first seen by Dr. Diamond on June 16, 2014. Petitioner's history includes migraine due to visual scotoma and subsequent pounding retro-orbital headache with loss of vison in right eye that lasted several hours, as well as chronic neck and back pain after undergoing three surgeries, and GERD.

Petitioner returned to Dr. Diamond on July 14, 2014 with upper right quadrant pain, mid back pain, GERD, and migraines.

The records include the lumbar MRI from March 13, 2013.

The next visit with Dr. Diamond was on September 15, 2014 for mid back/mid abdomen pain with the etiology unclear. Petitioner also underwent a chest X-ray on that day. He also underwent a chest CT scan on September 19, 2014.

Petitioner was seen on October 13, 2014 with degenerative joint disease in his hands and feet, nocturia which was apparently from use of Norco and chronic back pain.

Petitioner returned to Dr. Diamond on February 23, 2015. His complaints were of chest pain, GERD and low back pain with bilateral sciatica dating back to an injury of 2012. He also had bilateral neck pain with radiation to arms, with no weakness, which was present since his prior neck injury years ago (2008).

Rockford Spine Center Select Records (RX.1)

This is a questionnaire that was completed by petitioner on December 5, 2006. Petitioner related his neck and back pain and numbness to a work accident of August 6, 2007 while loading truck.

Rebound Therapy Center Select Records (PX.11)

Petitioner completed a new patient questionnaire on March 5, 2007. His complaints included back pain and numbness in left and right fingers.

OSF Health Care Select Medical Records (RX.3) [Duplicate of Petitioner's Exhibit 11.]

Dr. Fred Sweet Select Records (RX.4)

These records include the February 28, 2011 cervical MRI which reportedly showed post-surgical changes with a fusion at C6-7 and right paracentral disc herniation at C5-6. It was described by Dr. Sweet that: "Cephalad to that at C5-6 is a broad-based disc protrusion that narrows the neuroforaminal on the right side and just contacts and minimally displaces the spinal cord." (The remaining records includes Dr. Sweet's March 16, 2011 which were included in Petitioner's Exhibit 9.)

Rockford Pain Center Select Records (RX.5)

Petitioner received epidural steroid injections by Dr. Thomas Dahlberg on May 13, 2011 and May 26, 2011.

Forest City Diagnostic Imaging Select Records (RX.6)

Petitioner was screened for an MRI on October 29, 2012.

Saint Anthony Medical Center Select Records (RX.7)

These records are duplicate of Petitioner's Exhibit 7.

Dr. Steven Diamond Select Medical Records (RX.8)

These records were included in Petitioner's Exhibit 13.

OSF Center for Health Belvidere Select Medical Records (RX.9)

This includes the report of petitioner's July 1, 2015 cervical X-ray. The history listed as backache, unspecified. The findings were of anterior cervical fusion plate with intervertebral graft at C6-7 with no evidence of hardware failure. The disc heights were maintained. There is spurring at C5-6 level with no abnormal soft tissue swelling.

Teamsters Local 710 Health & Welfare Fund Records (RX.10)

These records show bills submitted and paid or not paid by the union.

Dr. Avi Bernstein July 26, 2016 Evidence Deposition (RX.11)

Dr. Avi Bernstein, board certified orthopedic spine surgeon, testified in behalf of respondent via deposition. Dr. Bernstein performed a records review only; he did not see the petitioner (8; 30).

Dr. Bernstein reviewed the actual MRI film study of July 21, 2015 which showed C5-6 osteophytes, bone spurs and broad right posterolateral disc herniation (14). Dr. Bernstein reviewed a report by Dr. Sweet of February 28, 2011 wherein Dr. Sweet described the February, 2011 cervical MRI that showed a right paracentral disc herniation at C5-6 with impinging nerve root (15). Based upon the review of the 2011 cervical MRI report, petitioner's complaint of neck pain radiating down to the arms petitioner had in February, 2015 and Dr. Bernstein's review of the July, 2015 cervical MRI, Dr. Bernstein concluded petitioner's cervical herniated disc at C5-6 was symptomatic before the July 1, 2015 claimed accident (17).

Dr. Bernstein did not believe the C5-6 herniated disc at the C5-6 level was related to the claimed work accident of July 1, 2015 (20-21). Dr. Bernstein did not believe any treatment rendered since July 1, 2015 was related to the claimed accident (21-22). Dr. Bernstein agreed

petitioner's treatment and proposed cervical surgery was reasonable, but was not related to the claimed work injury of July 1, 2015 (22).

Dr. Bernstein agreed that if he had the opportunity to exam petitioner and obtain a detailed history it may possibly alter his opinion as to whether the claimed work accident aggravated the degenerative condition (36). Dr. Bernstein agreed it would be important for him to review the actual 2011 MRI cervical studies for him to form his own opinion concerning the pathology (39). Dr. Bernstein agreed the report from Dr. Sweet regarding the 2011 MRI indicating the contacts minimally displaced the cord; he can't say it was compressing the cord (41).

Illinois Form 45: Employers First Report of Injury (RX.12)

The report was purportedly completed by petitioner. According to the report, petitioner stated he was loading the third unite and felt pain in shoulders, neck and arms, down to middle of back while backing up the trailer to load the vehicle.

Respondent's July 26, 2016 Response to Petitioner's 19b Petition (RX.13)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator, having the opportunity to view petitioner and his mannerisms during his testimony, found petitioner to be credible.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Based upon petitioner's testimony, the history contained in the medical records of OSF Saint Anthony Hospital from July 1, 2015 and the history contained in the records of Dr. Diamond from July 6, 2015, as well as the recorded statement given by petitioner to Juanita Brown with Crawford sometime before July 13, 2015, the Arbitrator finds petitioner sustained a work accident that arose out of and in the course of his employment with respondent on July 1, 2015. Although not word for word, all four statements are consistent with petitioner's claim that his head was turned to the left while backing a vehicle onto the trailer, hit a bumped and felt a pop or snap in his neck. This activity exposed petitioner to a risk greater than the general public.

The Arbitrator makes this finding despite the testimony of Thomas Zitt who testified petitioner had told him only that he turned his neck and felt pain. Based upon Zitt's word alone to Bill Molter, respondent's safety manager, a determination was made not to allow petitioner to complete an accident report. The Arbitrator is left, therefore, to consider Zitt's testimony of what petitioner purportedly told him, rather than seeing what would have been written by petitioner in his report of injury. Zitt's testimony as to what petitioner told him regarding the occurrence is contradicted by the history contained in the medical records.

The Arbitrator questions Zitt's credibility as he claimed he did not know until 60 days after the claimed accident that petitioner claimed he injure his neck when backing cars onto the trailer and did not recall receiving any email correspondence from Annette Tate with Crawford despite the fact petitioner introduced petitioner's Crawford and Company claim file showing there was email communication between Zitt and Tate as early as July 7, 2015.

For the foregoing reasons, the Arbitrator finds petitioner proved by a preponderance of the evidence he sustained cervical injuries from an accident that arose out of and in the course of his employment with respondent.

F. With respect to the issue of whether petitioner's condition of ill-being is causally related to the claimed accidental injuries, the Arbitrator finds the following facts:

Petitioner previously sustained a cervical injury in work accident in August, 2006, that resulted a cervical fusion at C6-7 in January, 2007. The evidence indicates petitioner returned to work in July 2007.

The next evidence of treatment of petitioner's neck was on September 15, 2010 when had a cervical MRI due to neck pain. The cervical MRI was reported as showing postsurgical changes at C6-C7 and degenerative disc disease at C5-C6 which was similar in appearance compared with the earlier MRI [of September 2006].

The record show petitioner next received treatment to his cervical spine after a February, 2011 accident. Petitioner underwent a cervical MRI on February 28, 2011 which showed, as reported by Dr. Sweet on March 16, 2011, as an acute disc herniation at C5-6. The only treatment discussed was cervical injections. Petitioner received these injections by Dr. Dahlberg on May 13, 2011 and May 26, 2011. There was no evidence petitioner received any treatment to his cervical spine after May 26, 2011, until July 1, 2015.

Between November, 2011 and 2013, petitioner received treatment for a lumbar injury, which included a discectomy in 2012 and a lumbar fusion on April 9, 2013.

The next mention of any neck problems in the record is found in the medical records from Saint Anthony Medical Center's emergency room on June 2, 2014 due to loss of vision. Petitioner provided a history that he moved his neck and heard a pop; was getting a migraine; complains of loss of vision in right eye. The diagnosis was loss of vision and migraine. The head CT scan was negative. There was no diagnostic testing to the cervical area.

The next mention of petitioner's cervical area was in the records of Dr. Diamond on June 16, 2014. On that date, petitioner had complaints of migraine due to visual scotoma and subsequent pounding retro-orbital headache with loss of vision in right eye for several hours, chronic neck and back pain after undergoing three surgeries, and GERD.

Petitioner followed up with Dr. Diamond on July 14, 2014, September 15, 2014, and October 13, 2014. Although petitioner's chronic neck and back pain was mentioned, there was no evidence of any cervical treatment during this period of time.

The last mention of petitioner's pre-existing cervical condition before the claimed July 1, 2015 accident was on February 23, 2015 when he was seen by Dr. Diamond. At that time, the petitioner's complaints included chest pain, GERD and low back pain with bilateral sciatica dating back to the injury of 2012. Although petitioner had complaints of bilateral neck pain with radiation to arms, with no weakness, which had been present since his neck injury of 2008, petitioner did not receive treatment to his cervical spine. There was also no evidence petitioner was kept off work at that time.

The next time petitioner was seen with neck complaints was on July 1, 2015 at OSF St. Anthony Medical Center when he presented with the work history. The diagnosis was cervical strain. Petitioner was then seen by Dr. Diamond on July 6, 2015 with the history of the work accident. He said he was okay for a few days, but then noted pain down both arms, right greater than left arm with a sense of weakness. On July 13, 2015 and October 26, 2015 with ongoing pain in both arms and weakness.

Petitioner obtained a cervical MRI on July 21, 2015 which showed osteophytes, bone spurs and broad right posterolateral disc herniation at the C5-C6 level.

Dr. Braaksma, who had provided treatment to petitioner on September 4, 2015 and May 6, 2016 believed petitioner's condition diagnosed as adjacent segment degeneration with disc herniation, resulting in upper extremity radiculopathy from a nerve root impingement and compression, was caused by the mechanics of petitioner's work accident of July 1, 2015. Dr. Braaksma did not review any records concerning the 2011 cervical injury. However, Dr. Braaksma concluded that because petitioner was capable of work after receiving conservative treatment for the 2011 cervical injury, petitioner's present cervical condition was caused by the work accident of July 1, 2015.

Dr. Bernstein, who did not exam petitioner; only performing a records review at the request of respondent, did not believe petitioner's cervical condition was caused by the claimed work accident of July 1, 2015. Dr. Bernstein concluded that petitioner's condition pre-existed his claimed July 1, 2015 accident. Dr. Bernstein based his opinion on the review of the actual MRI of July 21, 2015 as compared with the report of the February 28, 2011 cervical MRI. Dr. Bernstein, however, conceded the February 28, 2011 cervical MRI showed evidence of only minimally displaced cord at C5-C6; whereas the July 21, 2015 showed significant pathology of a herniated disc; sufficient enough for Dr. Bernstein to agree petitioner required surgery.

The records of Dr. Diamond from February 23, 2015 indicate petitioner had pain radiating into both arms, but had no weakness. After the July 1, 2015 incident, petitioner reportedly had weakness in both arms.

Based upon the foregoing evidence, the Arbitrator finds petitioner proved the work accident caused petitioner's condition of ill-being involving his cervical spine at C5-C6 necessitating the treatment received to date and the proposed surgery by Dr. Braaksma.

G. In support of the Arbitrator's decision with regard to petitioner's earnings, the Arbitrator finds the following:

On the Request for Hearing (Arb. Ex. 1) petitioner's earnings were disputed. In an off-the-record discussion, the parties agreed that they may be able to resolve this issue. The Arbitrator stated this understanding on the record. There was no evidence introduced by the either party that supported their respective positions. However, in their respective proposed decisions, both parties agreed that petitioner earned $82,213.04 and that his average weekly wage was $1,612.00. Therefore, the Arbitrator assumes the parties agree petitioner's average weekly wage was $1,612.00.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, having found petitioner's cervical injury was caused by an accident that arose out of and in the course of his employment with respondent on July 1, 2015, awards the following bills to be paid pursuant to §8 and §8.2, with credit for any payments made:

$806.00 to OSF Saint Anthony Hospital
$1,663.00 to Forest City Diagnostic Imaging
$702.00 to Rockford Orthopedics.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

Although Dr. Bernstein disagreed that the need for surgery was the result of the work accident, he agreed petitioner requires the cervical fusion proposed by Dr. Braaksma. The Arbitrator, having found petitioner's cervical condition, which requires surgery, was caused by the work accident of July 1, 2015, awards the costs for the surgery proposed by Dr. Braaksma, as well as the attendant care in accordance with the provisions of §8 and §8.2 of the Act.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

The evidence supports a finding petitioner was not able to return to work as a car hauler from the date of the accident to the date of hearing. This includes OSF Saint Anthony Hospital July 1, 2015 records which indicated petitioner could not lift, push or pull and to follow up with his primary care physician in three to five days.

Petitioner saw his primary care physician, Dr. Diamond on July 6, 2015 and July 13, 2015 who wrote an off work slip. Dr. Diamond reported petitioner was off work at the time of his October 26, 2015 visit.

Dr. Braaksma testified that given petitioner's physical condition from the work accident of July 1, 2015, petitioner would not be able to perform the work as a car hauler.

For these reasons, the Arbitrator finds petitioner was temporarily totally disabled from the date of the accident to the date of hearing and awards temporary total disability from July 2, 2015 through August 5, 2016, which is 57-2/7 weeks at the rate of $1,074.68 per week.

M. In support of the Arbitrator's decision with regard to penalties and fees, the Arbitrator finds the following:

Although the evidence is sufficient to support petitioner's claim for medical expense and treatment, as well as temporary total disability, the evidence of petitioner's pre-existing condition was sufficient to justify respondent's dispute of the claim. Furthermore, there is no evidence petitioner provided proof of ongoing disability. Therefore, the Arbitrator denies petitioner's claim for penalties and attorneys' fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathryn Diercouff,
Petitioner,
vs.

NO: 16 WC 30232

Village of Richton Park,
Respondent.

18IWCC0750

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, 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 9, 2018 is hereby affirmed and adopted.

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

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

DATED: DEC 10 2018
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DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DIERCOUFF, KATHRYN
Employee/Petitioner

Case# **16WC030232**
15WC002437

VILLAGE OF RICHTON PARK
Employer/Respondent

18IWCC0750

On 3/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
TIM ALBERTS
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

Kathryn L. Diercouff
Employee/Petitioner

v.

Village of Richton Park
Employer/Respondent

Case # 16 WC 30232

Consolidated cases: 15 WC 02437

18IWCC0750

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Chicago**, on **December 5, 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 ____

18IWCC0750

FINDINGS

On 6/9/2015, 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 **$52,690.81** ; the average weekly wage was **$1,013.28**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

Respondent ***has 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 **$35,915.28** under Section 8(j) of the Act.

ORDER

- The Arbitrator finds that Petitioner did not establish that she sustained a new repetitive trauma accident on June 9, 2015 or that the current condition of ill-being as it related to Petitioner's bilateral hands was causally related to the accident of June 9, 2015. The Arbitrator finds that Petitioner sustained a repetitive trauma accident arising out of and in the course of her employment with Respondent on December 1, 2014 and that the current condition of ill-being was casually connected to the work-related accident of December 1, 2014. Accordingly, the Arbitrator denies benefits in connection with the instant case and awards all benefits in connection with case number 15 WC 02437, date of accident December 1, 2014.

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

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

Signature of Arbitrator

March 9, 2018
Date

Arbitrator Decision Paragraphs

MAR 9 - 2018

Kathryn L. Diercouff v. Village of Richton Park
Case Number: 16 WC 30232
D/A: 6/9/2015

RIDER TO ARBITRATION DECISION

I. Introduction

Evidence in the above-captioned claim was presented to Arbitrator Glaub on December 5, 2017. On that date, the Arbitrator heard the testimony of Petitioner and Respondent's witness. The Arbitrator also received into evidence various exhibits, which included: 1) Applications for Adjustment of Claims; 2) medical records from multiple providers; 3) diagnostic study reports; 4) operative reports; 5) transcript of the evidence depositions of Dr. Mark Gonzalez and Dr. Bryan Neal; 6) medical bills; 7) job description; 8) payroll report; 9) FMLA documentation; and 10) correspondence from Blue Cross Blue Shield. The Arbitrator is considering the disputed issues of accident, medical causation, payment of medical bills, temporary total disability benefits and nature and extent of the injury.

A second case was filed for the date of accident of December 1, 2014. That case is pending under claim number 15 WC 02437. The exhibits and testimony was jointly presented in connection with both claims; however, the Arbitrator will make separate finding of law as it relates to both cases.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. Findings of Fact

A. Work History

Petitioner was 53 as of December 1, 2014. Petitioner testified that she is right handed. Petitioner was employed by Respondent on December 1, 2014. She began working for Respondent in 1993. Petitioner was employed by Respondent as an accounting clerk for the first eight (8) years of her employment. Petitioner then worked for three (3) years as an accountant. For the ten (10) years preceding December 1, 2014, Petitioner was employed by Respondent as the assistant finance director.

Petitioner testified regarding her job duties as an accounting clerk for Respondent. Petitioner performed payroll, took care of the accounts payable and performed IRMA liability claim processing.

Petitioner prepared bank deposits, balanced the cash drawer and sold commuter parking permits. Petitioner used a computer, keyboard and a ten (10) key adding machine. Petitioner operated the adding machine with her right hand. She keyboarded with both hands. Petitioner worked five (5) days per week, seven (7) hours per day. During a work day, Petitioner operated the keyboard or adding machine for approximately five (5) to six (6) hours. In every hour that she worked, Petitioner keyboarded or used the adding machine for approximately thirty (30) to forty (40) minutes. Petitioner did not have any ergonomic improvements to the keyboard.

As an accountant for Respondent, Petitioner prepared and entered journal entries into the computer system, completed payroll, balanced the cash drawer and reconciled the insurance. Petitioner used the keyboard and adding machine. Petitioner worked about the same hours as she did when she was employed as an accounting clerk. She operated the keyboard and adding machine for the same amount of time as she previously did working as an accounting clerk.

Petitioner became the assistant finance director for Respondent in 2004. A job description for assistant finance director was admitted into evidence. (RX 4). Petitioner reviewed the job description and agreed that it was accurate. The job description set forth the position was full time. (RX 4). The assistant finance director assisted in planning, directing, managing and overseeing the activities of the Finance Department personnel and assisted the director with budgeting, receiving accounting for Village assets, preparation of financial reports and performed payroll duties. (RX 4). The Essential Job Functions listed job duties including preparation of financial reports and account analysis, manage payroll operations, prepare payroll reports and tax forms, review the work of other Finance Department employee and assist with the annual audit. (RX 4). The list included in the Essential Job Functions was not exhaustive. (RX 4). The physical demands of the job were listed as work in an office setting with hand eye coordination, operation of computers, ability to focus and hear, use hands and fingers to handle, feel or operate objects, tools or control and reach with hands and lift up to twenty (20) pounds. (RX 4).

While Petitioner was employed as the assistant finance director, she used an ergonomic, or split, keyboard. The keyboard was split so that there was less pressure on the wrists. Petitioner used a standard

office chair and wrist guards on the keyboard. Petitioner used the adding machine to balance lengthy journal entries, such as payroll, audit adjustment and bank reconciliation. Petitioner used a cash register. Petitioner worked approximately forty (40) to 45 hours per week, five (5) to six (6) days per week. In July 2011, Petitioner's hours increased. Petitioner was assigned the task of outsourcing payroll and performing all of the payroll duties. Petitioner used the adding machine and keyboard. In general, Petitioner worked six (6) hours per day on the keyboard and an hour on the adding machine. Petitioner would be imputing information with the keyboard for approximately (40) minutes per every hour worked. Petitioner operated the adding machine with her right hand, over a forty (40) minute period per every hour worked. Petitioner operated the mouse with her right hand.

Petitioner supervised six (6) employees. Petitioner reviewed paperwork from other employees, bank statements and invoices. Petitioner took bathroom and lunch breaks. Petitioner was also involved in meetings. Petitioner did not participate in six (6) uninterrupted hours of keyboarding. Petitioner would send and respond to emails during the day. Petitioner testified that she was at her desk for seven (7) hours per day and typing for six (6) of those hours.

Petitioner testified that prior to 2011 she sewed. Petitioner used a sewing machine and cut fabric. Prior to 2011, she sewed approximately three (3) to four (4) hours per week. After 2011, Petitioner sewed three (3) to four (4) hours per month until December 1, 2014. Petitioner's sewing did involve the use of her hands.

B. Prior Medical Treatment

Petitioner testified that she was diagnosed with diabetes in 1997. She is insulin dependent and has had an insulin pump since 2014. She was diagnosed with Crohn's Disease in 1996. Petitioner is currently receiving medical treatment for both conditions. Petitioner was diagnosed with glaucoma in 1996 and 1997. Petitioner also has high cholesterol and fatigue. She was diagnosed with high cholesterol approximately fifteen (15) years ago. Petitioner received treatment for depression starting in 1996. Petitioner is on medication for depression. None of her conditions affected her ability to perform her job duties for Respondent. Petitioner was diagnosed with high blood pressure; however, she no longer has

that diagnosis and is not on medication for high blood pressure. Petitioner smoked a pack a day from 1981 to August 2017.

Petitioner was seen at Advocate South Suburban Hospital on October 12, 2012. (RX 8). Petitioner complained of numbness and tingling in her hands and feet which was present for a couple of years. (RX 8). An EMG was performed on October 12, 2012. (PX 1); (RX 8). The EMG study was normal. (PX 1); (RX 6). Following the EMG study, no medical treatment was recommended following the EMG.

Petitioner received medical treatment at Premier Orthopedic & Hand Center for a left shoulder condition. (RX 7). Dr. Labana performed surgery on the left shoulder on June 21, 2013. (RX 7). Petitioner was also evaluated in 2013 for right shoulder pain. (RX 7). Petitioner's last office visit in connection with her bilateral shoulder condition was October 15, 2013. (RX 7).

Petitioner testified that prior to December 1, 2014, she had not been diagnosed with carpal tunnel syndrome. No surgery had been recommended following the EMG of October 12, 2012. Further, no splints were recommended and no additional medical treatment was recommended.

C. Work-Related Repetitive Trauma Accident of December 1, 2014

Petitioner testified that in the thirty (30) days prior to December 1, 2014, she experienced tingling and numbness in her right and left hands and wrists. Petitioner testified that it was difficult to perform her job duties for Respondent; however, Petitioner continued to perform her job duties. While she was working, she experienced pain in her hands and wrists. When Petitioner operated a keyboard, she experienced pain and numbness in her wrists and fingers. The symptoms were worse when she was keyboarding.

Petitioner scheduled an office visit with her primary care physician, Dr. Debre, on December 1, 2014. (PX 2). Petitioner scheduled the appointment because of the increased pain, numbness and tingling in her hands and wrists. The symptoms had increased to the point where Petitioner needed relief. Petitioner's symptoms had been increasing over several months prior to December 1, 2014.

Petitioner applied for leave under the FMLA. (PX 10). The FMLA paperwork confirmed that Petitioner was unable to work from July 25, 2015 until released by her physician. (PX 10). It stated that the condition was due to work. (PX 10). The paperwork was completed by Dr. Gonzalez. (PX 10). The

Application of Adjustment of Claim and Amended Application for Adjustment of Claim for case number 15 WC 02437 for the accident date of December 1, 2014 was admitted into evidence. (RX 1).

D. Work-Related Repetitive Trauma Accident of June 9, 2015

On June 9, 2015, Dr. Gonzalez, Petitioner's treating physician, diagnosed her with De Quervain's Disease. This was the first time that Petitioner was diagnosed with De Quervain's Disease by Dr. Gonzalez. The Application for Adjustment of Claim for case number 16 WC 30232 for the accident date of June 9, 2015 was admitted into evidence. (RX 2).

E. Testimony of Respondent's Witness, David Savier

Respondent presented the testimony of David Savier. Mr. Savier was the finance director for Respondent for the last eight (8) months that Petitioner worked for Respondent. Mr. Savier began working for Respondent on May 3, 2015. He was Petitioner's supervisor.

Mr. Savier testified regarding Petitioner's job duties while she was working for him. Petitioner's job duties included payroll, accounts receivable, accountable payable, reconciling the budget and audits, answering emails and using an adding machine. He also attended meetings with Petitioner. Mr. Savier testified that the job description was accurate. (RX 4).

Mr. Savier testified Petitioner's job duties were not 75% typing. Petitioner also supervised the staff. Following her return to work, Petitioner did not make any complaints of pain in her wrists. Petitioner took off one day because her hands were swollen. Mr. Savier testified that he spent some time in Petitioner's office addressing specific problems that arose at work. He was not in her office on a daily basis. Mr. Savier testified that he monitored his staff, but could not confirm how long he spent observing Petitioner work. Mr. Savier did not have personal knowledge as to how long Petitioner spent typing per day. Mr. Savier testified that he believed that the job required between 25% and 50% of the day typing. This amounted to two (2) to four (4) hours of the day typing. Mr. Savier did not have any personal knowledge as to how Petitioner performed her job duties prior to May 2015.

F. Medical Treatment

Petitioner sought medical treatment for her hands following December 1, 2014. Petitioner was examined by Dr. Debre, her primary care physician, on December 1, 2014. (PX 2). Dr. Debre documented complaints of numbness and tingling in both hands which were worsening. (PX 2). He recommended an EMG study and referred Petitioner to an orthopedic surgeon. (PX 2).

Petitioner underwent the recommended EMG study on December 12, 2014 at Advocate South Suburban Hospital. (PX 3). The EMG report noted that Petitioner had intermittent numbness and tingling in her fingers which worsened over the last several months. (PX 3). THE EMG study revealed left and right carpal tunnel syndrome without evidence of cervical radiculopathy, brachial plexopathy or ulnar mononeuropathy. (PX 3).

Petitioner was examined by Dr. Gonzalez on January 13, 2015. (PX 4). Dr. Gonzalez noted a history that Petitioner was an accountant with bilateral hand numbness in the median nerve distribution for two (2) to three (3) months. (PX 4). He set forth an assessment of bilateral carpal tunnel syndrome. (PX 4). Dr. Gonzalez stated that being an accountant with a lot of typing aggravated her condition with repetitive activity. (PX 4). He recommended surgery. (PX 4).

Petitioner continued to have follow up examinations with Dr. Gonzalez while she waited to undergo surgery. (PX 4). On June 9, 2015, Dr. Gonzalez set forth a diagnosis of bilateral carpal tunnel syndrome and De Quervain's. (PX 4). He set froth that both conditions were aggravated as a result of repetitive work and compensable under workers' compensation since the condition was aggravated in the work environment. (PX 4). Dr. Gonzalez recommended physical therapy for the De Quervain's. (PX 4).

Petitioner was evaluated by Dr. Labana on June 16, 2015. (PX 7). Dr. Labana set forth an assessment of carpal tunnel syndrome and De Quervain's. (PX 7). He stated that Petitioner was working six (6) days per week for three (3) years and does a lot of typing and other paper handling which requires repetitive wrist and hand position changes. (PX 7). Therefore, he stated that the case should be handled under workers' compensation. (PX 7). Dr. Labana recommended physical therapy. (PX 7). Petitioner participated in physical therapy at Premier Orthopedic and Hand Center from June 19, 2015 through July 8, 2015. (PX 7).

Petitioner underwent the recommended right hand surgery on July 23, 2015 at University of Illinois Hospital. (PX 5). Dr. Gonzalez performed a right endoscopic carpal tunnel release and De Quervain release. (PX 5). The post-operative diagnosis was right carpal tunnel syndrome and De Quervain tenosynovitis. (PX 5). Petitioner continued under the post-operative care of Dr. Gonzalez. (PX 4).

Petitioner underwent left hand surgery on August 13, 2015 at University of Illinois Hospital. (PX 6). Dr. Gonzalez performed a left carpal tunnel and De Quervain's release. (PX 6). The post-operative diagnosis was left carpal tunnel syndrome and de Quervain tenosynovitis. (PX 6).

Petitioner remained under the post-operative care of Dr. Gonzalez. (PX 4). Post-operative care included follow up appointments, physical therapy and activity modification. (PX 4). Petitioner participated in physical therapy from September 9, 2015 through October 16, 2015 at Premier Orthopedics. (PX 7).

Petitioner was last examined by Dr. Gonzalez on October 20, 2015. (PX 4). Dr. Gonzalez noted increase pain at the incision area for the carpal tunnel syndrome. (PX 4). Petitioner's numbness and tingling were improved. (PX 4). Dr. Gonzalez released Petitioner to return to work. (PX 4).

G. Medical Opinions of Dr. Mark Gonzalez

The evidence deposition of Dr. Gonzalez was completed on September 27, 2016. (PX 8). Dr. Gonzalez is a board certified orthopedic surgeon with an added qualification in hand surgery. (PX 8 at 6). Dr. Gonzalez is a professor at University of Illinois at Chicago in orthopedic surgery and mechanical engineering. (PX 8 at 8). Dr. Gonzalez has authored many papers in connection with medical treatment for the hand and carpal tunnel syndrome. (PX 8 at 10). Dr. Gonzalez has performed more than 1000 carpal tunnel surgeries. (PX 8 at 14).

Dr. Gonzalez documented a history that Petitioner had bilateral hand numbness for two (2) to three (3) months with relief from splints. (PX 8 at 19). Petitioner was right hand dominant and worked as an accountant. (PX 8 at 20). On physical examination, Petitioner had positive Phalen's test, positive Tinel's and positive Durkan's, which all suggested a diagnosis of bilateral carpal tunnel syndrome. (PX 8 at 20). Petitioner did not have compression of the ulnar nerve or at the neck. (PX 8 at 20-21). Dr. Gonzalez

testified that the physical examination was consistent with the EMG. (PX 8 at 22). Dr. Gonzalez stated that the EMG revealed left and right sided mononeuropathy as seen in carpal tunnel syndrome. (PX 8 at 23).

Dr. Gonzalez's diagnosis was bilateral carpal tunnel syndrome. (PX 8 at 23). He recommended that Petitioner undergo surgery. (PX 8 at 23). Dr. Gonzalez set forth a further diagnosis of De Quervain's tenosynovitis on June 9, 2015. (PX 8 at 24). He recommended that Petitioner undergo surgery for the carpal tunnel syndrome and De Quervain's. (PX 8 at 26).

Dr. Gonzalez explained that carpal tunnel syndrome is an increase in pressure which decreases blood supply to the median nerve. (PX 8 at 29). He noted that repetitive activity causes the pressure to rise. (PX 8 at 29). The pressure causes the symptoms in the median nerve. (PX 8 at 30). Dr. Gonzalez testified that following the surgery of July 23, 2015, Petitioner would not have been able to use her right hand. (PX 8 at 33). Following the second surgery of August 13, 2015, Petitioner would not have been able to work for six (6) to eight (8) weeks. (PX 8 at 34). Petitioner would have been able to perform limited work and no typing from July 23, 2015 through October 20, 2015. (PX 8 at 37).

Dr. Gonzalez testified that repetitive activities, such as typing, can aggravate carpal tunnel syndrome and De Quervain's tenosynovitis. (PX 8 at 41). He clarified that when people have to perform activities it can cause a rise in pressure of the carpal tunnel. (PX 8 at 42). Dr. Gonzalez testified that there is no medical literature that studies an aggravation of the carpal tunnel syndrome. (PX 8 at 43). The aggravation causes the patient to come in for medical treatment. (PX 8 at 45).

Dr. Gonzalez reviewed the 2012 EMG. (PX 8 at 44). He noted that Petitioner had a normal EMG. (PX 8 at 45). The EMG changed while Petitioner was working. (PX 8 at 45). He testified that the positive EMG indicated an aggravation of symptoms which caused Petitioner to seek medical treatment. (PX 8 at 45).

Dr. Gonzalez testified that the fact that Petitioner had diabetes did not affect his opinion that the carpal tunnel syndrome was aggravated by the work activities. (PX 8 at 46). He also reviewed the report of Dr. Neal. (PX 8 at 46). He stated that he did not understand Dr. Neal use of "temporary aggravation"

since the condition was aggravated to the extent that Petitioner sought medical treatment. (PX 8 at 47). Dr. Gonzalez testified that Petitioner's symptoms were consistent throughout his evaluation. (PX 8 at 48). He stated that the medical treatment provided to Petitioner was reasonable and necessary. (PX 8 at 48). Dr. Gonzalez testified that the bilateral hand and wrist condition was permanent. (PX 8 at 48).

Dr. Gonzalez testified that females in their 50s could have a higher prevalence of carpal tunnel syndrome. (PX 8 at 52). Diabetes can also be a risk factor in developing carpal tunnel syndrome. (PX 8 at 52). With regard to causation, Dr. Gonzalez relied on the activity that causes the pain and what makes it better. (PX 8 at 57). Dr. Gonzalez found it significant that a person can stop performing a hobby, but could not stop working, if the symptoms persist. (PX 8 at 59). Dr. Gonzalez reviewed the studies related to carpal tunnel syndrome and found that they did not adequately study an aggravation of the symptoms. (PX 8 at 63).

Dr. Gonzalez testified that Dr. Neal stated that Petitioner had ongoing complaints in her hands. (PX 8 at 68). He testified that the symptoms documented in Dr. Neal's report were consistent with the diagnosis of carpal tunnel syndrome and De Quervain's. (PX 8 at 68). Dr. Gonzales testified that carpal tunnel syndrome and De Quervain's were aggravated by work activities such that they became symptomatic and Petitioner sought medical treatment. (PX 8 at 72).

H. Medical Opinions of Dr. Neal, Respondent's Section 12 Physician

The evidence deposition of Dr. Neal was completed on January 10, 2017. (RX 3). Dr. Neal completed two Section 12 examinations and an AMA impairment rating in connection with Petitioner's bilateral hand condition. (RX 3 at 9). The reports were dated May 1, 2015 and June 3, 2016. (RX 3 at 9).

Dr. Neal first examined Petitioner on April 29, 2015. (RX 3 at 10). Dr. Neal reviewed the EMG study from October 13, 2012. (RX 3 at 12). He stated that the EMG was normal and that Petitioner had diabetes and both upper and lower extremity paraesthesias. (RX 3 at 12). He noted that Petitioner had long standing complaints of neuropathic symptoms. (RX 3 at 12). Dr. Neal found it significant that

Petitioner had diabetes. (RX 3 at 14). Dr. Neal explained that diabetes is associated with neuropathies and that carpal tunnel syndrome is a common neuropathy. (RX 3 at 14-15). He testified that the EMG of December 12, 2014 revealed that Petitioner had carpal tunnel syndrome. (RX 3 at 17).

Dr. Neal documented that Petitioner's job duties included preparing journal entries, work on a computer, payroll work and data entry. (RX 3 at 20). Petitioner worked on a computer six (6) hours per day or 75% of the time. (RX 3 at 22). Dr. Neal testified that Petitioner's subjective complaints correlated with a diagnosis of carpal tunnel syndrome. (RX 3 at 27). Dr. Neal confirmed that Petitioner's diagnosis on the right hand was carpal tunnel syndrome, CMC joint osteoarthritis and De Quervain's disease. (RX 3 at 34). With regard to the left hand, Petitioner had left carpal tunnel syndrome, De Quervain's disease and CMC joint arthritis. (RX 3 at 35). Dr. Neal set forth that the diagnosis on the right and left side were not causally connected to the work activities. (RX 3 at 35-36). The basis of his opinion was that Petitioner had multiple risk factors including that the condition was common, advancing age, female, obesity and diabetes. (RX 3 at 36-37). Dr. Neal also testified that the literature does not support a finding that keyboarding activities cause carpal tunnel syndrome. (RX 3 at 38). Dr. Neal relied on the literature in support of his findings. (RX 3 at 39). The literature states that a causal relationship between repetitive work, such as keyboarding, and carpal tunnel syndrome has not been proven. (RX 3 at 40). Dr. Neal stated that Petitioner work was not vibratory or forceful. (RX 3 at 45).

Dr. Neal further found that the De Quervain's disease was not casually related to the work activities. (RX 3 at 45). He noted that De Quervain's appears sporadically for a short period of time. (RX 3 at 46). He stated that diabetes predisposes a person to De Quervain's. (RX 3 at 46). Dr. Neal stated that the literature does not support a finding of causation. (RX 3 at 46). He also noted that Petitioner worked a long time without developing De Quervain's and developed it bilaterally, which suggested a systematic underlying cause. (RX 3 at 46). He testified that the CMC arthritis appeared on x-rays and is common in females between the ages of 50 and 70. (RX 3 at 48).

Dr. Neal testified that the cause of the carpal tunnel syndrome was idiopathic in combination with the risk factors of diabetes and obesity. (RX 3 at 49). He also stated that since Petitioner had neuropathic

symptoms in her lower extremity, this would support a finding that Petitioner had an underlying systemic cause of the symptoms combined with poorly treated diabetes. (RX 3 at 49). Dr. Neal testified that the work did not aggravate or accelerate the condition. (RX 3 at 50).

As of April 29, 2015, Dr. Neal testified that Petitioner had not reached maximum medical improvement. (RX 3 at 52). He testified that further medical treatment, including splinting, steroids and surgery, would be reasonable. (RX 3 at 53). He confirmed that Petitioner did not require work restrictions. (RX 3 at 54).

Dr. Neal conducted a second examination on June 1, 2016. (RX 3 at 56). Dr. Neal documented that Petitioner had right sided tingling and intermittent day time symptoms and pain and on the right side, she had the same symptoms on the left side. (RX 3 at 60). Dr. Neal set forth the diagnosis of right and left sided pain and paraesthesias status post carpal tunnel release and De Quervain's release and CMC arthritis. (RX 3 at 62). Dr. Neal confirmed that the subjective complaints were consistent with the objective findings. (RX 3 at 65). He stated that Petitioner had reached maximum medical improvement. (RX 3 at 65). He testified that Petitioner could return to work without restrictions. (RX 3 at 66).

Dr. Neal set forth an impairment rating. (RX 3 at 67). He set forth a rating of 1% upper extremity impairment on the right and 4% on the left from the carpal tunnel syndrome. (RX 3 at 67). Dr. Neal set forth an impairment rating of 1% on the right and 1% on the left for the De Quervain's. (RX 3 at 68). The combined impairment rating was 2% upper extremity impairment on the right and 5% on the left. (RX 3 at 68). The combination of both hands was 7% impairment of the upper extremity convertible to a 4% of the person as a whole. (RX 3 at 69).

Dr. Neal testified that the impairment rating was based on the diagnosis and not the treatment. (RX 3 at 77). The definition of disability is different than impairment. (RX 3 at 78). He acknowledged that the impairment rating was not intended to intercede in the judicial process. (RX at 78).

Dr. Neal admitted that the document he reviewed was a position description and not a physical job description. (RX 3 at 93). He admitted that the description was not complete and Petitioner performed more job duties than were listed in the report. (RX 3 at 95). Dr. Neal confirmed that prior to December

1, 2014, there was a suspicion of carpal tunnel syndrome, but no diagnosis. (RX 3 at 102). He acknowledged that there was no diagnosis of carpal tunnel syndrome in 2012. (RX 3 at 103).

Dr. Neal testified that not everyone with numbness and tingling in their hands has carpal tunnel syndrome. (RX 3 at 111). He agreed that the treatment provided to Petitioner was reasonable and necessary. (RX 3 at 112). He also acknowledged that every person with diabetes does not have carpal tunnel syndrome. (RX 3 at 115). Dr. Neal testified that the first diagnosis of carpal tunnel syndrome was December 12, 2014. (RX 3 at 116). He noted that Petitioner had symptoms consistent with carpal tunnel syndrome in 2012 and on December 1, 2014. (RX 3 at 116).

Dr. Neal stated that he did not know how Dr. Gonzalez used the word aggravated. (RX 3 at 118). Dr. Neal testified that some literature set forth that there were occupational causes of carpal tunnel syndrome. (RX 3 at 119). He stated that there is little controversy over the fact that forceful gripping and "funny" wrist positions or extreme wrist positions can cause carpal tunnel syndrome; however, he stated that there is little support for keyboarding causing carpal tunnel syndrome. (RX 3 at 121). Dr. Neal testified that keyboarding is not cumulative and repetitive. (RX 3 at 122). Dr. Neal acknowledged that some studies state that keyboarding can cause carpal tunnel syndrome. (RX 3 at 123). Dr. Neal admitted that forceful and highly repetitive physical demands increase the risk of a person developing carpal tunnel syndrome. (RX 3 at 125). He stated that typing presents a minimal risk. (RX 3 at 125). Dr. Neal acknowledged that it is difficult to formulate a perfect study to determine whether carpal tunnel syndrome is caused by keyboarding. (RX 3 at 128). Dr. Neal testified that not all people with diabetes have De Quervain's disease. (RX 3 at 128). Dr. Neal testified that Petitioner's work could temporarily exacerbate her carpal tunnel syndrome. (RX 3 at 133).

f. Medical Bills

Several medical bills were admitted into evidence. (PX 9). The medical bills from ILBJ ($7,796); Premier Orthopaedic ($7,322.30); University of Illinois ($27,919.51); UIC Physicians Groups ($7,849); South Suburban Hospital ($794); and Neurology Consultants ($1,010) were admitted into evidence. (PX

9). The total charges for the medical bills were $52,690.81. (PX 9). Petitioner paid $200.02 out of pocket. (PX 9). The group insurance carried paid $35,915.28. (RX 9); (RX 10).

J. Current Subjective Complaints

Petitioner worked for Respondent until July 23, 2015. Petitioner did not perform any work activities between July 23, 2015 and October 20, 2015. Petitioner used her sick time for the period that she was not able to work for Respondent. A payroll report was admitted into evidence. (PX 5). The payroll report was for the period of August 23,2015 through September 5, 2015. (PX 5).

Petitioner returned to work for Respondent on October 21, 2015. She performed work duties for Respondent from October 21, 2015 through February 2016. Petitioner retired in February 2016. Petitioner testified that he job duties were a little less than prior to December 1, 2014 because she was transitioning her job duties to another clerk. Petitioner was keyboarding and using the adding machine. She was using the keyboard a little less that prior to December 1, 2014. Petitioner experienced some soreness in her hands. Petitioner has not sustained any new accidents or injuries involving her hands.

III. Conclusions of Law

In support of the Arbitrator's decision relating to "C," did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner established that she sustained a repetitive trauma accident with a manifestation date of December 1, 2014. The Arbitrator set forth his findings relative to the date of accident of December 1, 2014, pending under case number 15 WC 012437, in a separate opinion. Based on his finding regarding accident in case number 15 WC 012437, the Arbitrator finds that Petitioner did not establish a repetitive trauma accident with a manifesting date of June 9, 2015.

Petitioner alleges the manifestation date of June 9, 2015, which was the first date that she was diagnosed with De Quervain's. Although Petitioner was first diagnosed with Dr Quervain's on June 9, 2015, the totality of the evidence established that Petitioner's condition in her hands manifested on December 1, 2014. Petitioner's condition had deteriorated such that she sought medical treatment and was aware that the condition was related to work on December 1, 2014. The fact that she was diagnosed

with a further condition in connection with her bilateral wrists at a later date is not relevant. The manifestation date was December 1, 2014 which was the date when Petitioner's condition in her bilateral hands deteriorated to the point that she sought medical treatment. Accordingly, the Arbitrator finds that Petitioner did not sustain a repetitive trauma accident with a manifesting date of June 9, 2015.

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner did not establish that her current condition of ill-being as it relates to her bilateral hands was causally related to the repetitive trauma accident with a manifestation date of June 9, 2016. Since the Arbitrator found that the correct manifestation date was December 1, 2014, the Arbitrator finds that Petitioner's current condition of ill-being as it relates to her bilateral hands was casually related to the repetitive trauma accident with a manifestation date of December 1, 2014. The Arbitrator's findings relative to causation of the December 1, 2014 accident were set forth in a separate decision. Having found that the correct manifestation date was December 1, 2014, the Arbitrator finds that the current condition of ill-being of Petitioner's bilateral hands is not causally connected ot the manifestation date of June 9, 2015.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner is not entitled to payment of medical bills as it relates to case number 16 WC 30232 since Petitioner failed to establish a repetitive trauma accident with a manifestation date of June 9, 2016 and that the current condition of ill-being of her bilateral hands was related to the accident of June 9, 2016. The Arbitrator awards payment of the medical bills in connection with the date of accident of December 1, 2014. The award is addressed in a separate decision.

In support of the Arbitrator's decision relating to "L," temporary total disability benefits, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner is not entitled to payment of temporary total disability benefits as it relates to case number 16 WC 30232 since Petitioner failed to establish a repetitive trauma accident with a manifestation date of June 9, 2016 and that the current condition of ill-being of her bilateral hands was related to the accident of June 9, 2016. The Arbitrator awards payment of temporary total disability benefits in connection with the date of accident of December 1, 2014. The award is addressed in a separate decision.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner did not sustain permanent partial disability as it relates to case number 16 WC 30232 since Petitioner failed to establish a repetitive trauma accident with a manifestation date of June 9, 2016 and that the current condition of ill-being of her bilateral hands was related to the accident of June 9, 2016. The Arbitrator awarded permanent partial disability benefits in connection with the date of accident of December 1, 2014. The award is addressed in a separate decision.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Enedina Islas,

Petitioner,

vs. NO: 12 WC 20669

Mid-American Growers,

Respondent.

18IWCC0752

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and temporary total disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was employed by Respondent, an agricultural company.

2. On September 23, 2011 she was bending over to put plant rings on flowers. While bending over she experienced low back pain. She eventually sought medical treatment and was prescribed therapy, medication and injections.

3. After an initial §19(b) hearing on November 24, 2014 the Arbitrator found accident and causal connection and awarded temporary total disability (TTD) benefits through November 24, 2014, as well as medical expenses and prospective medical care (facet joint block injections at L3-4, L4-5 and L5-S1 to see if the pain generator is the joints) prescribed by Dr. Orteza, including all medical charges and TTD related to said prospective care. The Commission affirmed this ruling.

4. Respondent filed a §19(b) Petition, which was heard on February 23, 2018, alleging that Petitioner's condition should now be deemed to have reached maximum medical improvement (MMI) on July 9, 2015. The Arbitrator denied Respondent's Petition and upheld the award from the initial §19(b) hearing.

5. Respondent then filed this Review on April 9, 2018.

6. Petitioner noticed leg pain a few months after the accident date. She worked for a while after the accident but has not worked since November 2011. Her treatment since that time has consisted of therapy, injections and medications. She underwent 3 injections prior to the initial Arbitration hearing, which did not help.

7. Petitioner's first visit with Dr. Orteza after the initial Arbitration was April 7, 2015. Her pain was a 10/10 at the time. She stated that physical therapy did not help, but aquatic therapy did.

8. Petitioner underwent a facet joint block on July 9, 2015. She stated that it decreased her pain 80 percent, but only for about thirty minutes. On August 11, 2015 Dr. Orteza wrote a note opining that Petitioner would be able to return to work in November of 2015, however Petitioner had no discussions with him around that time about being able to return to work.

9. On September 1, 2015 Petitioner underwent a second facet joint block, which also provided relief for only thirty minutes.

10. Petitioner stated that now, her pain is 8/10 on a daily basis with no movement, and 11/10 with movement. She cannot perform activities of daily living, can only walk one minute before having to sit, can only sit for thirty minutes before needing to stand, cannot sit up straight, walks with a cane, cannot drive, can only grocery shop with an electrical cart, but cannot carry grocery bags. She attempts to cook on occasion, but mostly just rests in her bed or on the couch.

11. Dr. Orteza testified that Petitioner was in need of a denervation procedure. He testified that since the initial facet block did not give ideal results, the amount of relief from a second injection was important to determine the need for a denervation or not. He stated that if there is no relief at all from an initial injection, there would be no need for a second one. If there is any relief, he would use the results to determine if a second injection is necessary.

12. Dr. Orteza acknowledged that he only observed Petitioner for 10 minutes after the second injection before discharging her. He also stated that, absent a denervation procedure, Petitioner has reached MMI, and that she might be able to return to sedentary or light duty work if she were to undergo the procedure.

13. Dr. Lewis is a board certified orthopedic surgeon and served as Respondent's Independent Medical Exam (IME) physician. He testified that Petitioner's condition was not causally related to her work activities. He noted that, in June of 2012, Petitioner's immediate complaint was low back pain with radicular leg pain beginning 1-2 months after the accident. He believed this sequence to be atypical. His exam revealed inconsistent signs of pain, and he found no definite orthopedic or acute pathology. In his opinion, Petitioner's complaints of pain should have rendered her bed-ridden.

14. Dr. Lewis testified that lumbar MRI's from November 8, 2011 and April 5, 2012 revealed a slight disc bulge at L4-5 with an associated annular tear. He stated that a slight disc bulge is normal and not indicative of an acute injury.

15. Dr. Lewis also disagrees with the previous 19(b) Arbitration Decision and opined that an annular tear is not indicative of an acute injury.

The Commission affirms in part and modifies in part the Arbitrator's rulings on all issues.

Although the Commission affirms the finding of causal connection, it also views the evidence slightly different than the Arbitrator and terminates causal connection on September 18, 2015. The Commission finds that there was no evidence submitted alleging any new injury to the lumbar spine which would sever the causal connection chain. Additionally, the opinion of Dr. Lewis that annular tears are not caused traumatically is not persuasive. Nevertheless, the Commission holds that the testimony of Petitioner's own treating physician, Dr. Orteza, can be relied upon to deny further treatment for Petitioner and terminate causal connection on September 18, 2015. Dr. Orteza testified that if two facet joint blocks only provided 30 minutes of relief each, he would not recommend a denervation procedure. Combine this with Petitioner's own trial testimony that she only received 30 minutes of relief after each injection, and it is difficult to find adequate medical reasoning to award the denervation procedure. Dr. Orteza also testified that, absent a denervation procedure, Petitioner has reached MMI.

18IWCC0752

A review of the facts indicates that the *Law of the Case* doctrine does not apply in this case, as the ruling in the initial 19(b) hearing has been satisfied. Petitioner was able to undergo both facet joint blocks, but neither provided the necessary results with which to continue treatment.

Based on the testimony of her own treating physician, Petitioner is not entitled to undergo the denervation procedure, and has reached MMI as of September 18, 2015, which is the date she followed up with Dr. Orteza and discussed her amount of relief. Although the longevity of the relief is not noted in that day's medical record, it can be presumed that Dr. Orteza was made aware, or *should have* been aware, of the 30-minute time frame of relief. At that time Dr. Orteza would have known that the denervation procedure was not necessary. Accordingly, the Commission finds that causal connection should be terminated as of September 18, 2015.

The Commission affirms in part and modifies the medical expenses award. The Commission affirms the exclusion of bills for treatment that was not certified by the Utilization Review, as well as the exclusion of bills from 2012 that were not awarded at the time of the first arbitration hearing. However, the Commission modifies the award based on Dr. Orteza's testimony. The Commission finds that the results of the first facet block injection were encouraging enough to warrant a second injection, which was performed September 1, 2015. As stated above, it is reasonable to believe that Dr. Orteza was fully aware of the second block results by September 18, 2015. At that time the need for further medical care should terminate. Accordingly, the Commission modifies the medical expenses award, terminating benefits as of September 18, 2015.

In keeping with the causal connection ruling, the Commission modifies the TTD award and terminates benefits as of the MMI date of September 18, 2015. Moreover, although TTD is terminated on September 18, 2015, and Petitioner was still off work at the time, she is still not entitled to Maintenance benefits subsequent to the MMI date. Petitioner did not return to work, but also did not engage in a vocational rehabilitation program, nor did she perform a job search. Thus, there is no basis to award Maintenance.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner suffered back injury that was causally connected to her work duties, but that said causal connection terminated on September 18, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $286.00 per week for a period of 42-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

18IWCC0752

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner all unpaid reasonable and necessary medical expenses under §8(a) of the Act through September 18, 2015, excluding bills for treatment not certified by the Utilization Review, and also excluding bills from 2012 that were not awarded at the initial arbitration hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is not entitled to Maintenance benefits.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,200.00. 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.

DEC 10 2018

DATED:
O: 10/10/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

ISLAS, ENEDINA
Employee/Petitioner

Case# **12WC020669**

MID-AMERICAN GROWERS
Employer/Respondent

18IWCC0752

On 3/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0400 LOUIS E OLIVERO & ASSOCIATES
DAVID W OLIVERO
1615 FOURTH ST
PERU, IL 61354

5265 WOLF LAW LTD
LEE A LAUDICINA
25 E WASHINGTON ST SUITE 801
CHICAGO, IL 60602

MID-AMERICAN GROWERS)
)SS.
COUNTY OF LaSALLE)

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

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

Enedina Islas
Employee/Petitioner

v.

Mid-American Growers
Employer/Respondent

Case # 12 WC 20669

Consolidated cases: N/A

18IWCC0752

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Ottawa** on **February 23, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, September 23, 2011, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $13,510.606; the average weekly wage was $337.77.

On the date of accident, Petitioner was 36 years of age, *married* with 1 dependent child.

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

Respondent shall be given a credit[1] of $26,884.00 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $26,884.00.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a continued causal connection between her condition of ill-being in the lumbar spine and her accident at work.

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 169 & 4/7th weeks, commencing November 25, 2014 through February 23, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from November 25, 2014 through February 23, 2018, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit[2] of $26,884.00 for TTD benefits that have been paid.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid for medical treatment pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment not certified by utilization review or for treatment in 2012 that was not awarded at the time of the first arbitration hearing is denied.

---

[1] The temporary total disability credit is not intended to be duplicative of amounts previously pain. As indicated by the parties, the $26,884.00 amount is inclusive of temporary total disability benefits paid as ordered in the prior 19(b)/8(a) decision as well as additional temporary total disability paid thereafter, for which Respondent disputes liability at this hearing. *See* February 23, 2018 Arbitration Hearing Transcript.

[2] *See* FN1.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator finds that the recommended prospective medical treatment is necessary and reasonable to alleviate Petitioner of the effects of her injury at work. Thus, the Arbitrator awards the prospective medical care in the form of a denervation as prescribed by Dr. Orteza pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

March 13, 2018
Date

MAR 16 2018

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

Enedina Islas
Employee/Petitioner

v.

Mid-American Growers
Employer/Respondent

Case # **12** WC **20669**

Consolidated cases: **N/A**

FINDINGS OF FACT

Procedural History

On November 24, 2014, an arbitration hearing was held pursuant to Petitioner's Sections 19(b) and 8(a) petition. Petitioner's Exhibit[3] ("PX") 6. On January 5, 2015, the arbitration decision was issued. PX6. Findings included that the Petitioner's lumbar spine condition was causally related to the accident at work occurring on February 23, 2011. *Id.* Petitioner was awarded prospective medical treatment in the form of continued medications and injections. *Id.* The decision became final and Petitioner's case was eventually remanded to arbitration.

"The rule of the law of the case is a rule of practice, based on sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." *Irizarry v. Industrial Comm'n*, 337 Ill. App. 3d 598, 606 (2nd Dist. 2003) (*citing McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill. App. 3d 1083, 1086-87 (1st Dist. 1984) (quotations omitted)). The law of the case doctrine is applicable to issues litigated before the Illinois Workers' Compensation Commission. *Ming AutoBody/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 252, 899 N.E.2d 365, 326 Ill. Dec. 148 (2008)). Thus, the findings of fact and conclusions of law from the first arbitration hearing in this case are binding, and herein adopted and incorporated by reference.

Issues in Dispute

The issues in dispute at this hearing include continued causal connection, Respondent's liability for certain unpaid medical bills, Petitioner entitlement to temporary total disability benefits commencing on November 25, 2014 through February 23, 2018, and Petitioner's entitlement to prospective medical care in the form of a denervation as prescribed by Dr. Orteza. Arbitrator's Exhibit[4] ("AX") 1. The parties have stipulated to all other issues. *Id.*

[3] The Arbitrator similarly references the parties' and Arbitrator's exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.
[4] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Medical Treatment

Enedina Islas (Petitioner) testified through an interpreter at the hearing on February 23, 2018. Tr. at 11. She testified that at the time of the first arbitration hearing, she was under Dr. Orteza's care for her low back. *Id.* She continues under his care for her low back. *Id.*, at 11-12.

Petitioner testified that she was bending over when she originally injured her back on September 23, 2011. Tr. at 13. A couple of months later she started getting pain in your leg as well. *Id.* Petitioner continued to work for a little while after the day of the accident, but has not worked since November of 2011. *Id.* Petitioner acknowledged that her treatment since that time has included therapy, injections and some medications but no surgery. *Id.* Petitioner acknowledged that she underwent three injections before the first hearing, but they did not help. Tr. at 14.

The medical records reflect that Petitioner saw Deofil Orteza, M.D. (Dr. Orteza) on May 4, 2015. PX1. He noted the following in pertinent part:

> [Petitioner] is here today for a follow-up after having been seen almost 1 year ago for her intractable low back pain with radiation to both anterior thighs and legs. The patient indicates that most of her pain at this time is in the low back area. Activities that require walking, standing, bending, and right and left lateral rotational movements will significantly elicit the pain with a VAPS of 10/10. The patient was started on Gabap[e]ntin, Cymbalta, and Flexeril 1 year ago and they have only helped to a limited degree and she continued to have intractable low back pain. As a result, she is unable to do activities of daily living or physical therapy because of the pain. The patient's symptoms seem to be related to facet joint generated pain. Therefore, I recommend that a bilateral diagnostic lumbar facet joint block be done at the L3/4, L4/5, and L5/s1 facet joint levels to see if the pain generator is in the facet joints. If the initial injections indicates highly that her pain generator is in the facet joints, a second confirmatory injection will be done. If the second block also indicates that the pain generator is in the facet joints, this patient would then be a good candidate for a denervation procedure.

Id. Dr. Orteza diagnosed Petitioner with severe low back pain secondary to lumbar spondylosis and ordered the injections. *Id.* Petitioner followed up with Dr. Orteza on June 2, 2015 and August 7, 2015, making the same treatment recommendations. *Id.*

Petitioner testified that she reported very severe pain at a level of 10 out of 10 on April 7, 2015. Tr. at 14. She was taking pain medications and had therapy, but those modalities did not help her pain. *Id.* Petitioner testified that the aquatic therapy did help her pain. *Id.*, at 15. She explained that she asked for more aquatic therapy, but she did not recall if he recommended it. *Id.* Petitioner testified that she finally underwent wo facet joint blocks in 2015 performed by Dr. Orteza. Tr. at 16, 18. She explained that the treatment relieved about 80% of her pain for approximately half an hour. *Id.*

Dr. Orteza authored a note faxed on August 11, 2015, which indicates that Petitioner was unable to return to work for the next three months, and that Petitioner would then be reevaluated to see if her pain had resolved. PX1. Dr. Orteza also noted that Petitioner would be undergoing additional injections possibly followed by a denervation procedure. *Id.* He noted that Petitioner would then, tentatively, be able to return to work on November 16, 2015. *Id.* Petitioner testified that she was not aware that Dr. Orteza wrote a note in which he said he thought she would be able to return to work in November of 2015. Tr. at 17. She testified that she did not talk to Dr. Orteza about whether she could return to work and she never asked him if he would let her return to work or do work conditioning-type therapy to get her back to work. Tr. at 17-18.

On September 7, 2015, Petitioner returned to Dr. Orteza. PX1. He diagnosed her with severe low back pain secondary to lumbar spondylosis most notably at L2-3, L3-4, L4-5 and L5-S1. *Id.* Dr. Orteza ordered the previously noted two-session denervation procedure. *Id.* On December 21, 2015, Dr. Orteza reiterated his care plan for the denervation procedure. *Id.* Petitioner returned on April 11, 2016, at which time Dr. Orteza advised that he was still waiting on workers' compensation insurance approval for the denervation procedure. *Id.* He also adjusted Petitioner's medications. *Id.*

On May 24, 2016, Petitioner returned to Dr. Orteza reporting continued severe low back pain and symptomatology. PX1. Dr. Orteza also noted that the recommended denervation procedure had been denied by the insurance carrier. *Id.*

On October 10, 2016, February 14, 2017, and June 13, 2017, Dr. Orteza renewed or adjusted Petitioner's prescriptions given her severe low back pain noting that the recommended denervation procedure had been denied by the insurance carrier. PX1.

Petitioner testified that she last saw Dr. Orteza on June 13, 2017, almost a year ago. Tr. at 18. She testified that she was not aware that, at that time, Dr. Orteza told her to return in three months. *Id.*, at 19.

Section 12 Examination & AMA Guides Impairment Rating – Dr. Lewis

On June 22, 2016, Petitioner saw Michael Lewis, M.D. (Dr. Lewis) for the third time at Respondent's request. RX2. Dr. Lewis's report reflects that he took a history from Petitioner, examined her, reviewed various treating medical records, and rendered opinions regarding her lumbar condition and its relatedness, if any, to her injury at work. *Id.* Dr. Lewis noted that Petitioner had "multiple causative non-behavioral findings, which complicates making an appropriate diagnosis." *Id.* He found no objective evidence of orthopedic pathology and stated that he was "still of the opinion that activities at work on or about September 23, 2011, did not cause or aggravate her current conditions for reasons discussed above and for reasons discussed in [his] previous independent medical evaluation dated June 15, 2012, in [his] independent medical evaluation on September 8, 2014." *Id.* Dr. Lewis further noted that an annular tear is well known not to imply that a traumatic event occurred and that the site of Petitioner's tear does not correlate with her back pain. *Id.* Dr. Lewis further noted that EMG testing is unable to specifically test the medial branch of the dorsal ramus and the medial branch is the specific nerve branch that innervates the facet joints. *Id.*

Dr. Lewis opined that Petitioner was not in need of any additional medical treatment, and specifically that the denervation procedure was not recommended because Petitioner's first injection did not show sufficient improvement. RX2. He opined that, based solely on Petitioner's subjective complaints, she was able to work sedentary duty. *Id.* Dr. Lewis also maintained that Petitioner had reached maximum medical improvement three-to-four months after her injury at work. *Id.*

Deposition Testimony – Dr. Lewis

On December 12, 2016, Respondent called Dr. Lewis as a witness and he gave testimony at an evidence deposition regarding Petitioner's spine condition and its relatedness, if any, to Petitioner's injury at work. RX1. Dr. Lewis is a board-certified orthopedic surgeon. RX1 at 4-7; RX1 (Dep. Ex. 1). Dr. Lewis testified consistent with his first, second, and third Section 12 examination reports that Petitioner's condition was not causally related to her work activities. *See generally* RX1.

Dr. Lewis explained that at the time of his first examination on June 15, 2012, Petitioner's complaint of immediate low back pain with radicular pain in her legs beginning one or two months later was "not at all typical[.]" RX1 at 10-11. His physical exam revealed many inconsistent and nonorganic signs, and he testified he found no definite orthopedic pathology or evidence of acute pathology. *Id.*, at 11, 15. He explained Petitioner's pain disability questionnaire score indicating severe subjective pain that would render her virtually bed-ridden. *Id.*, at 21.

Dr. Lewis reviewed two lumbar MRI films, from November 8, 2011 and April 5, 2012, respectively. RX1 at 13-15. He testified the first film showed a slight disc bulge at L4-5, with an associated annular tear. *Id.* The second film was "essentially very similar[.]" *Id.* Dr. Lewis explained that a slight disc bulge is an extremely common finding and was not evidence of an acute injury. *Id.* Rather, he opined the findings on Petitioner's MRIs were age and size appropriate. *Id.*

Dr. Lewis testified that his second examination of Petitioner on September 8, 2014, strengthened his prior conclusions. RX1 at 22. He opined Petitioner reached maximum medical improvement four months after the incident on September 23, 2011. *Id.* at 23.

In conjunction with his third examination, Dr. Lewis reviewed the prior 19(b) arbitration decision, in which Petitioner's condition of ill-being was found causally related to the work accident at issue. RX1 at 30. Dr. Lewis respectfully disagreed with the decision because the annular tear was not suggestive of a traumatic injury. *Id.*, at 31-32. He further explained that the EMG and NCV studies were nonspecific and insufficient to conclude that treatment should be directed at the facet joints. *Id.*, at 20, 31-32.

Dr. Lewis also testified he disagreed with Dr. Orteza's recommendation for a medial branch denervation. RX1 at 33. He explained that Dr. Orteza's notes were inconsistent regarding the amount of relief the facet injections provided, and that "the conventional wisdom is that [relief from] an injection that lasted only for 30 minutes would not be an indication to consider a denervation procedure[.]" *Id.*

Dr. Lewis testified that at the time of his third exam of Petitioner on June 22, 2016, he again found no evidence of orthopedic pathology. RX1 at 26. He explained that the injections which Petitioner had after the first trial were designed to identify the pain generator in her back. *Id.*, at 27-29. Dr. Lewis testified that since Petitioner only had 30 minutes of relief from the first injection, no further treatment was warranted. *Id.*, at 29. He also testified it was not common to do injections at the same time at four levels because it is difficult to differentiate the effect of each. *Id.*, at 27-28.

Dr. Lewis ultimately opined that Petitioner's condition at the time of his deposition on December 12, 2016, was not casually related to the work injury in 2011. RX1 at 34. He also stated it was not typical for a lumbar strain to produce work restrictions for five years. *Id.*, at 34-35. Nor was it typical for a patient to experience such severe continuing pain complaints with no objective findings. *Id.* He was still of the opinion that Petitioner reached maximum medical improvement three to four months after the injury in 2011. *Id.*, at 35.

Deposition Testimony – Dr. Orteza

On May 4, 2017, Petitioner called Dr. Orteza as a witness and he gave testimony at an evidence deposition regarding Petitioner's spine condition and its relatedness, if any, to Petitioner's injury at work. PX2. Dr. Orteza testified that he is an anesthesiologist with a subspecialty in pain management. PX2 at 3-4.

Dr. Orteza testified that a denervation procedure uses radio frequency needles to burn the nerve that innervates the joint resolving or alleviating the patient's pain. PX2 at 6. Dr. Orteza addressed Petitioner's medical treatment with him and his September of 2015 recommendation for denervation. *Id.*, at 6-15. Thereafter, Dr. Orteza continued to recommend the denervation procedure to alleviate Petitioner's pain. *Id.*, at 16-17. He opined that the denervation procedure was reasonable and necessary to address Petitioner's pain. *Id.*, at 17.

On cross-examination, Dr. Orteza explained that Petitioner's diagnoses of facet joint impingement, myofascial pain and fibromyalgia were chronic in nature. *Id.*, at 31, 47. He also stated her right side bothered her more than her left side the entire time he treated her. *Id.*, at 31-32. Additionally, Dr. Orteza testified that he did not do any tests to confirm Petitioner's subjective complaints other than physical examination testing (i.e., range of motion, bending, flexion, etc.). *Id.* at 35-36.

Dr. Orteza testified that, since the first facet block did not give ideal results, the amount of relief from the second block was important to determine if the denervation procedure was indicated. *Id.*, at 54-56. Dr. Orteza acknowledged that he observed Petitioner for only ten minutes before she was discharged. *Id.*, at 57.

Dr. Orteza testified that Petitioner has reached maximum medical improvement if she does not undergo the denervation procedure. PX2 at 60-61. Dr. Orteza testified that Petitioner might be able to return to some light duty work after undergoing the recommended denervation procedure. *Id.*, at 67.

Utilization Review

In a letter dated March 6, 2017, Coventry Workers' Comp Services noted the non-certification of Dr. Orteza's order for Cymbalta, Gabapentin, and Norco. RX5. In so concluding, the evaluating physician, Stanley Yuan, M.D. (Dr. Yuan), an anesthesiologist and pain management doctor, found that the recommended treatment was not consistent with their clinical review criteria. *Id.*

Additional Information

Petitioner testified that she has not seen any doctor for her back pain since that time for anything other than prescriptions. *Id.*, at 19-20. Regarding her current condition of ill-being, Petitioner explained that her pain level remains normally about 8 out of 10, but is about 10 or 11 out of 10 with movement. Tr. at 21-22. She testified that her pain is increasing, and is the same on both sides. *Id.*, at 22. Petitioner explained that she cannot perform activities of daily living, sit up straight, sit for more than 30 minutes in a comfortable chair, or walk for over a minute without pain. *Id.*, at 22. She testified that she can go up and down steps a little bit, and slowly. *Id.*, at 23. Petitioner also uses a cane and cannot drive. *Id.* Petitioner testified that her husband assists her with groceries, and she has not gone to the hospital or emergency room since the last hearing. *Id.*, at 24-25.

Petitioner testified that Dr. Orteza has kept her off work during the entire time that he has been her physician. Tr. at 12. She testified that she continues to have pain in her low back. *Id.* She also testified that she wishes to undergo the recommended further treatment to help with her low back pain. Tr. at 12.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

In consideration of the totality of the record, which necessarily requires reliance on the law of this case, the Arbitrator finds that Petitioner's claimed current condition of ill-being in the lumbar spine remains causally related to the injury sustained at work on September 23, 2011 based on the treating medical records and opinions of Petitioner's treating physician, Dr. Orteza.

No evidence was submitted that Petitioner sustained any new injury to the spine or developed a structural change in the spine severing causal connection. Respondent's Section 12 examiner, Dr. Lewis, performed a third examination of Petitioner at Respondent's request. His report and the sum of his deposition testimony result in his conclusions that Petitioner's September 23, 2011 work activities did not cause or aggravate any of her conditions, an annular tear cannot occur traumatically, the site of Petitioner's annular tear did not correlate with her subjective pain complaints, an EMG cannot specifically test the medial branch of the dorsal ramus such that it can suggest facet impingement, and denervation in the lower paraspinal muscles is not a valid indicator of Petitioner's pathology—which he was unable to diagnose as Petitioner had multiple causative non-behavioral findings complicating his ability to make an appropriate diagnosis. Dr. Lewis's medical opinions and, more importantly, the rationale for his medical opinions have not changed over the course of his three examinations of Petitioner. Concordantly, the opinions of Dr. Lewis, which have not changed in substance or the analyses resulting in his conclusions, are not persuasive. As such, the findings of fact and conclusions of law, which are the law of this case, relating to the causal connection between Petitioner's accident at work and lumbar spine condition remain intact.

Based on the foregoing, the Arbitrator finds that Petitioner has established a continued causal connection between her current lumbar spine condition of ill-being and 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, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine continues to be causally related to her injury at work. However, Respondent submitted a utilization

review report regarding the reasonableness and necessity of certain prescription medications. Dr. Orteza did not appeal the non-certification by utilization review. The bills that were not certified by utilization review are not reasonable or necessary, and Petitioner's claim for payment of those bills related to Cymbalta, Gabapentin, and Norco as reflected in Petitioner's Exhibit 4 is denied.

Petitioner also submitted medical bills related to hip x-rays taken in 2012 before the first arbitration hearing in this case. To the extent that these bills were claimed during the medical treatment was found causally related as a result of the first arbitration hearing, and they have not yet been paid, they should be paid in accordance with the first arbitration hearing decision pursuant to Sections 8(a) and 8.2. To the extent that these bills were not claimed at the time of the first arbitration hearing, they precede the period of treatment at issue in this arbitration hearing beginning November 25, 2014 and the bills reflected in Petitioner's Exhibit 5 are denied.

The remainder of the medical bills submitted into evidence relate to Petitioner's lumbar spine for reasonable and necessary medical care to alleviate her of the effects of her injury at work after the first arbitration hearing. Thus, the medical bills reflected in Petitioner's Exhibit 3 are awarded pursuant to Sections 8(a) and 8.2.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work as claimed in reliance on Petitioner's credible testimony as well as the opinion of her treating physician, Dr. Orteza. Petitioner's condition has not improved after her accident at work and, as Dr. Orteza has opined, surgical intervention is required. Thus, the Arbitrator awards the recommended prospective medical care in the form of a denervation as prescribed by Dr. Orteza pursuant to Section 8(a) of the Act as this treatment is reasonable and necessary to alleviate Petitioner from the effects of her injury at work.

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

Considering the causal connection analysis explained above, the Arbitrator turns to Petitioner's claim that she is entitled to temporary total disability benefits from November 25, 2014 through February 23, 2018.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that she was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The record reflects that during the claimed temporary total disability period Petitioner was placed off work as imposed by Dr. Orteza. Thus, the Arbitrator finds that Petitioner has established that she was temporarily totally disabled during the claimed temporary total disability period from November 25, 2014 through February 23, 2018. Respondent shall receive a credit for temporary total disability benefit payments that have been made as agreed by the parties. *See* AX1.

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

Fallon Cole,

Petitioner,

vs.

NO: 14WC 17386

Walgreen's,

18IWCC0753

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 24, 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.

DEC 10 2018

DATED:
TJT:yl
o 11/20/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

COLE, FALLON
Employee/Petitioner

Case# **14WC017386**

WALGREEN'S
Employer/Respondent

18IWCC0753

On 10/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0180 EVANS & DIXON, LLC
MICHAEL A KARR
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102-2727

18IWCC0753

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

FALLON COLE
Employee/Petitioner

v.

WALGREEN'S
Employer/Respondent

Case # **14** WC **17386**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of 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 _____

18IWCC0753

FINDINGS

On the date of accident, **April 13, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,019.25**; the average weekly wage was **$680.39**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$4,535.90** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,535.90**.

Respondent is entitled to a credit of $**20,611.44** for the payment of medical expenses under Sections 8(a) and 8.2 of the Act.

ORDER

The Petitioner has sustained her burden of proof via the preponderance of the evidence that she sustained a chronic strain injury to the right shoulder, but has failed to prove she sustained a cervical spine injury, as a result of the accident of April 13, 2014.

Respondent shall pay Petitioner temporary total disability benefits of **$453.59 per week** for **10 weeks**, commencing **August 4, 2015 through October 12, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$4,535.90** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $20,611.44 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner has failed to prove that proposed right shoulder surgery (Dr. Mall) and proposed cervical spine surgery (Dr. Gornet) are reasonable and necessary pursuant to Section 8(a) of the Act, and these surgeries are denied.

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

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

18IWCC0753

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 28, 2017
Date

OCT 24 2017

STATEMENT OF FACTS

The Petitioner testified that she worked for the Respondent from May 2011 through April 2014. She initially worked as a full case picker, then got pregnant and bid into a split-case picker position, and eventually into a utility position. The Petitioner testified she is right hand dominant. Full-case picking involves constantly putting full cases of various products on a conveyor line. Split-case picking involves taking individual products from full cases and putting them into totes to fulfill an order, and then putting the tote on the conveyor line. Petitioner testified the utility job basically involved working in the receiving area, and once that job was completed, a utility worker would essentially act as a "floater", filling in wherever needed. She testified: "Utility was when we first got there, we had to receive things, and that's what it mainly was. But once you was done receiving, so the other shifts could come on and have something to do, we would get put to wherever we was needed, whether it was full case pick, shipping, split case pick, order picker, you know."

For full-case picking, Petitioner testified that products were located in either the "A" or the "B" areas, which were either at or above head level, or at a lower level. She testified: "Sometimes its up here. Most of the time its down here." The conveyor line itself was at about waist level, so she would have to bend to the lower level or reach up to the higher level. She testified she would have to twist and turn to perform this as well. She testified that the weights of the products in full-case, according to Respondent, was up to 50 pounds, but that she believed things like charcoal and water were even heavier than that. Additionally, these jobs involved a rate quota of products, so a certain hourly rate of production had to be maintained. She could not say exactly what this quota was, but estimated it was hundreds of cases over an 8 hour shift. As a split-case picker, Petitioner estimated the totes could weigh up to 25 or 30 pounds once filled. Most of her time with Respondent was as a full-case picker. To perform these jobs, the Petitioner testified she had to use her hands, arms and upper body, and would mainly use her right arm, being right-handed.

Petitioner testified she began to notice her hands getting numb, and her shoulder "kept having pain through it", indicating she thought it was her elbow that was the problem. She continued to work, however, and it continued to worsen.

Petitioner was terminated by Respondent on 4/13/14 based on a point system: "I was late for work, and I told them honestly about me being late for work." It was after the termination that she first reported the noted upper extremity problems. She testified she went to Respondent's facility to complete a report, but was "kicked off the grounds" because she was no longer an employee. She subsequently returned to complete an incident report on 5/16/14 after retaining an attorney, indicating problems with the bilateral hands and elbows, and the right shoulder. Petitioner agreed that she did not report any injuries to Respondent or request any medical treatment, including with the in-house medical

facility, prior to her termination. In rebuttal, the Petitioner testified that she did not report anything prior to her termination because she didn't want to lose her job.

Petitioner saw her primary provider, Dr. Reyes, on 5/19/14 with complaints of numbness and tingling in the bilateral hands and wrists. She reported that she performed repetitive motion and that the visit should be covered under workers' compensation, and she requested a referral. Dr. Reyes' diagnosis was idiopathic peripheral autonomic neuropathy and he prescribed EMG/NCV testing to evaluate for carpal tunnel (CTS). A form contained in Dr. Reyes' records confirms Petitioner's story that the Respondent would not allow her onto the premises to complete an accident report because she had been terminate. The form also states that while working as an order picker Petitioner noticed pain in her hands, elbows and right shoulder, with paresthesias and pain through the elbows. (Px3).

The Respondent sent Petitioner to see Dr. Brown on 10/28/14. Dr. Brown's report notes the Petitioner was referred for examination of her bilateral upper extremities. She reported working 8+ hours per day, 40+ hours per week. Petitioner reported her full and split-case picking duties. She could not say what the exact production quota was, but estimated 60 to 70 cases per hour for full cases, and 100 items per hour for split cases. She reported that full cases weighed between 2 and 50 pounds, and split-case totes weighed 2 to 60 pounds. She reported that of the three years she worked for Respondent, the first 1.5 were as a full-case picker, after which she worked as a split-case picker until working the last four months of the job as "weekend utility", which she indicated generally involved filling in as a full or split-case picker. (Px4).

Petitioner reported that she first noticed symptoms in her hands in 2013, including cramping, numbness and tingling and some medial elbow pain, right greater than left. She also noted right shoulder pain. She indicated her symptoms increased in April 2014, and she saw her primary provider Dr. Reyes on 5/16/14 with bilateral hand and wrist pain that she alleged was due to repetitive motion. At Dr. Brown's exam, Petitioner reported that she had numbness primarily in the middle three fingers bilaterally, right greater than left. She was noted to be 5'8" and 220 pounds. X-rays of the bilateral wrists and elbows were within normal limits. Dr. Brown concluded that the Petitioner's symptoms and findings suggested CTS, and he recommended EMG/NCV testing. Pending same, he recommended splinting, NSAIDs and stretching. For the right shoulder, he recommended that she see a specialist. (Px4).

Dr. Brown indicated Petitioner had two CTS risk factors – being female and being overweight – but also that her job involved fairly repetitive hand-intensive activity involving picking of products between 60/70 and 100 times per hour. Given the three year duration of exposure, Dr. Brown opined that the job duties were a causative factor in Petitioner's development of CTS. (Px4).

Petitioner underwent EMG/NCV testing with Dr. Phillips on 11/19/14. She reported a 7 month history of gradually progressive sharp, throbbing, aching bilateral hand and elbow pain with intermittent global hand numbness mainly involving her first three fingers. Cervical radicular pain was not reported. The testing showed relatively moderate but predominantly demyelinative sensorimotor right CTS, and milder sensory left CTS. (Px5).

Following the EMG/NCV, Dr. Brown issued an 11/24/14 addendum noting the findings and indicated that if recommended conservative measures did not resolve the symptoms, bilateral release surgeries would be indicated. (Px4). On 5/4/15, Petitioner reported continued bilateral hand numbness and tingling that was now constant in the right 3rd and 4th fingers, and splinting, NSAIDs and home therapy were recommended. Full duty was continued pending 6 week follow up. (Px4).

Petitioner then sought treatment with Dr. Mall on 7/31/15, indicating she was there for a second opinion regarding CTS surgery, and that she wanted to treat with one doctor and Dr. Brown did not treat shoulders. She reported bilateral wrist and right shoulder pain, as well as "pain along the neck and trapezial region, deep right shoulder pain, pain over the superior aspect of the shoulder and bilateral wrist complaints of numbness and tingling into the median distribution." Petitioner demonstrated how she would throw cases for three years while employed with Respondent: ". . . she basically was bending over at the waist level and had to throw cases across her body." Petitioner reported she had a failed attempt working for Continental Tire from 2/27/15 to 4/13/15 as a tire trimmer due to shoulder and wrist complaints. At that time she worked for a home healthcare agency, indicating she was able because she was not required to lift over 15 pounds or lift overhead. Following examination, Dr. Mall diagnosed bilateral CTS, and right shoulder AC joint arthrosis and subacromial impingement with a possible SLAP tear. Given the failure of conservative treatment, Dr. Mall recommended bilateral CTS releases, noting the condition had already been determined to be work related. He agreed there was causation given that Petitioner performed a lot of gripping and grabbing and pushing and pulling, "hand-intensive activities [that] often times lead to the development of CTS." He also stated: "Based on the way she demonstrated her shoulder movements, this appeared to be at chest height despite the fact that she was bent over on this." Dr. Mall also opined that the right shoulder condition was causally related to Petitioner's work duties with Respondent. The right shoulder subacromial space was injected and physical therapy was recommended. She had relief with the injection from a rotator cuff aspect, but continued to have AC joint pain and a positive O'Brien's test. Dr. Mall indicated he could perform an AC joint injection at the next visit and, if she didn't improve, he recommended an MRI. (Px6).

Dr. Mall performed CTS release surgeries on the right on 8/4/15 and on the left on 8/18/15. (Px7). On 8/31/15, Petitioner reported ongoing right shoulder problems despite being off work following CTS surgery, and a right shoulder MRI was prescribed. Petitioner was continued off work for two more weeks. (Px6). A 9/15/15 right shoulder MRI arthrogram reflected no internal derangement findings and was essentially unremarkable. (Px8). Petitioner returned to Dr. Mall on 9/15/15 complaining of neck symptoms and headaches. Dr. Mall reported his review of the MRI revealed biceps tendonitis with fluid around the biceps and a spur on the acromion, but intact rotator cuff and superior labrum. A second subacromial injection was performed, and further therapy and cervical MRI were recommended. (Px6).

Cervical MRI testing on 10/16/15 revealed a small central C4/5 protrusion with no evidence of stenosis, a left paracentral 2 mm C5/6 disc protrusion with no significant canal or foraminal stenosis, a left paracentral C5/6 annular tear and probable bilateral foraminal annular tears at C6/7 with a small disc protrusion resulting in mild bilateral foraminal stenosis. (Px8). At follow up with Dr. Mall that same day, he noted "disc injuries" at C4/5 and C5/6 and referred Petitioner to Dr. Gornet. Petitioner was released to return to work as to CTS, and Dr. Mall injected the right biceps and recommended additional therapy. On 11/13/15, Petitioner reported ongoing right shoulder problems and that physical therapy had not been approved. Dr. Mall recommended at least one visit so she could learn a home exercise program. (Px6).

Petitioner underwent right shoulder and bicep therapy from 11/24/15 to 12/15/15 (6 visits). At the initial evaluation, Petitioner reported receiving steroid injections on 7/31, 9/15 and 10/16/15, which provided only two days of relief. The shoulder throbbed at rest with 5/10 pain, and there was 8/10 pain with overhead movements. Petitioner said she actively "popped" her shoulder after overhead range of motion noting a loud audible bony clunk, and that this relieves her pain. On 12/15/15, Petitioner denied numbness or tingling in the right arm but indicated tingling in the axilla with left neck rotation and left arm abduction, and mild axilla pain with left shoulder external rotation during left neck rotation. On that date, the therapist noted normal active range of motion but decreased strength in rotators and horizontal abduction and adduction of the right shoulder, but the strength had improved with therapy.

On 12/18/15, Dr. Mall indicated Petitioner reported only some temporary improvement with injections and that therapy hadn't resolved her symptoms. Diagnoses were biceps tendinitis, rotator cuff tendinitis and subacromial impingement. Dr. Mall recommended home therapy, noting "I do not feel a lot of dysfunction in the shoulder that we can make better with physical therapy." Based on the failure of conservative treatment, He recommended biceps tenodesis, subacromial decompression and acromioplasty. (Px6).

Petitioner presented to Dr. Gornet on 11/30/15 with complaints of right trapezial / shoulder / scapular and upper arm pain with intermittent tingling in the hand. He noted she was referred her to determine if her shoulder symptoms were of cervical origin. Petitioner noted she was on restricted duty as her symptoms were worse with reaching or pulling. She did not have significant pain down her arm. Neurologic exam was normal. X-rays were normal. Dr. Gornet noted the cervical MRI indicated an obvious small central herniation/annular tear at C5/6 and a smaller one at C4/5, and "both of these correlate with her continued shoulder symptoms and trapezial symptoms." He recommended that Petitioner exhaust all conservative shoulder care with Dr. Mall, and if that failed to consider cervical injections. Based on Petitioner's records and history being accurate, Dr. Gornet opined her symptoms were causally related to her work duties with Respondent. He stated: "Again, the current medical thought is that this is referred pain from the cervical spine itself as well as potential carpal tunnel and shoulder pathology." (Px10).

Petitioner visited Dr. Mall on 1/29, 4/8, 5/27, 6/27, 8/8 and 10/7/16 with continued complaints of posterolateral and anterior right shoulder pain, and he continued to recommend surgery. On 4/8/16, they discussed Petitioner's job duties in more detail, with Petitioner indicating her full-case picking job involved taking products from an "A" level, at stomach or chest height, and "B" level, above head. As a split case worker, she reported a belt that required her to push overhead buttons and grab products from overhead. On 5/27/16, Dr. Mall reviewed the report of Dr. Rende, and questioned Rende's belief that Petitioner had impingement due to multidirectional instability, as her main symptoms were over the biceps and unrelated to shoulder instability. (Px6).

On 6/27/16, Dr. Mall noted Petitioner reported she developed right elbow complaints in addition to the shoulder. Mall noted the shoulder was somewhat improved, but Petitioner's symptoms included lateral epicondylar tenderness and intermittent numbness in an ulnar distribution. Based on this, he obtained repeat EMG/NCV testing of the upper extremities with Dr. Phillips. (Px6).

Testing with Dr. Phillips on 6/27/16 indicated improvement to normal in the median nerve with normal ulnar nerve values. Dr. Phillips noted Petitioner indicated her symptoms resolved following her CTS surgeries but a month prior had a spontaneous onset of right greater than left lateral elbow pain with intermittent numbness of the last two fingers. She did not report neck or radicular pain. (Px5).

While there was no evidence of cubital tunnel on EMG/NCV, Dr. Mall made additional diagnoses of right lateral epicondylitis and cubital tunnel. Surgery was again recommended for the shoulder, and the right elbow was injected and she was prescribed bracing and therapy. On 8/8/16, Petitioner reported dramatic improvement in the elbow, but continued right shoulder pain. No further elbow treatment was recommended. On 10/7/16, Petitioner's only complaint was the right shoulder. (Px6).

Notes contained within Dr. Mall's records indicate he released Petitioner to full duty on 10/16/15, but restricted her to light duty on 11/13/15 and 12/18/15 through 1/29/16. She was again restricted to light duty from 4/8/16 through 8/8/16. (Px6).

Orthopedic surgeon Dr. Petkovich examined the Petitioner on 2/10/16 at the request of Respondent pursuant to Section 12 of the Act. He testified with regard to this visit via deposition (see below).

On 2/22/16, Dr. Gornet indicated "we believe she has a shoulder problem as well as some small disc protrusions at C4/5 and C5/6 and they correlate with some trapezial and shoulder symptoms." While she was on work restrictions from Dr. Mall, Dr. Gornet indicated Petitioner could perform full duty from a cervical standpoint. (Px10).

On 6/7/16, Petitioner returned to Dr. Gornet and brought the report of Dr. Petkovich for his review. He noted, in disagreement with Dr. Petkovich, that Petitioner's MRI supported his opinion of structural neck pain referred into the shoulder. He indicated these findings are known to cause pain, regardless of neurologic compression, and that Dr. Petkovich's diagnoses of muscular strain and degeneration "are simply incorrect." Dr. Gornet again recommended cervical injections, and if that failed, indicated that cervical surgery should be considered on an elective basis. (Px10).

Petitioner underwent further therapy in July 2016 for the right elbow on referral from Dr. Mall, who again diagnosed right lateral epicondylitis. The last note of 7/21/16 indicates Petitioner reported no complaints of pain with any functional activity. (Px6).

Epidural injections were performed per Dr. Gornet with Dr. Blake on 9/20 and 10/4/16 at right C4/5 and C5/6 respectively. Initial 9/10 pain scores were 5/10 after the second injection. (Px11). On 11/10/16, Petitioner reported only temporary relief with the injections and that Dr. Mall was recommending shoulder surgery. Dr. Gornet reiterated the MRI findings and that Petitioner's intermittent arm tingling was from nerve inflammation and inflammatory response. Dr. Gornet indicated cervical treatment was on hold pending shoulder surgery, but that he'd already requested disc replacement authorization in case it did not resolve Petitioner's symptoms. He also stated: "(Petitioner) continues to feel that her symptoms relate to repetitive lifting and throwing boxes as a split case/full case picker and utility worker." (Px10).

Dr. Mall, an orthopedic surgeon specializing in the upper extremity, was deposed on 10/28/16. He testified that he reviewed the records of Dr. Brown, as well as the report and deposition of Dr. Rende. With regard to history, symptoms (bilateral wrist pain, numbness into the fingers and right shoulder pain), exam findings, diagnoses and treatment recommendations, his testimony was consistent with his reports. When the Petitioner demonstrated her job duties throwing cases with Respondent, "she was bending at the waist and throwing cases across her body," with right arm adduction at 80 to 90 degrees. He testified that the shoulder becomes more involved at 60 degrees or greater, which is about chest height when standing, and "if they're bent over, it would still be a 90 degree angle and doing things sort of away from their body." He testified that while she worked bilaterally, it was likely she was probably putting more force on the right side since she was right handed. His examination reflected positive impingement signs, rotator cuff weakness, pain with tests stressing the AC joint and bicep, and was positive for CTS. Dr. Mall explained that the shoulder injection he performed demonstrated that at least part of her shoulder pain was from the subacromial space, indicating rotator cuff tendinitis or subacromial impingement. The injection would not have impacted or resolved any pain related to the AC joint, the biceps tendon or superior labrum. Dr. Mall reaffirmed his opinion that Petitioner's job duties for Respondent contributed to her bilateral CTS (gripping, grabbing, pushing, pulling) and right shoulder condition and symptoms. (Px14).

Petitioner reported she was able to tolerate her job with Addus, involving no lifting over 15 pounds and no overhead lifting, but that she had been unable to tolerate the lifting requirements of her work at General Tire prior to that. (Px14). Dr. Mall confirmed that following her CTS releases, Petitioner's numbness improved and she had no further complaints regarding her hands. (Px14).

As to the Petitioner's continued symptoms despite leaving the Respondent's employ, Dr. Mall explained that the inflammation can become chronic bursitis or tendinitis. Injection and therapy should be tried, and if this fails, possibly bursectomy surgery. Petitioner's initial temporary relief with injection indicated to Mall a chronic tendinitis or bursitis in the subacromial area. Dr. Mall testified that the 9/15/15 right shoulder MRI findings - fluid around the bicep, no labral or rotator cuff tears, and a spur on the acromion - "basically correlated" with her exam, which demonstrated irritation of the biceps tendon. He testified that impingement is mainly a clinical diagnosis and, "in my terms," indicates inflammation in the rotator cuff and in the bursa sac above the rotator cuff. He indicated the second subacromial injection again provided temporary, but substantial, improvement, which indicated to Dr. Mall a chronic bursitis or tendinitis. He continued to restrict Petitioner's work duties and to recommend shoulder therapy. Petitioner did develop right elbow symptoms at some point, which Dr. Mall described as symptoms of cubital tunnel (ulnar numbness), but improved relatively quickly with night bracing and "that was pretty much it." She also had signs of lateral epicondylitis, which resolved via an injection. (Px14).

Dr. Mall testified that Petitioner was reporting neck symptoms and headaches to him, "just mentioning that more so in passing", so he recommended a cervical MRI and referred her to Dr. Gornet. He testified that with shoulder symptoms, there is overlap between the shoulder and cervical spine. Any relief with the bicep injection was temporary, and he testified the Petitioner has essentially remained the same through 2015 with biceps and rotator cuff tendonitis, though her AC joint pain had resolved. He continued to treat Petitioner in 2016 and to recommend right shoulder surgery. As to Dr. Rende's concern for multi-directional instability, Dr. Mall testified he examined the Petitioner and found no sign of such instability. He disagreed with Dr. Rende's opinion that any surgery should include shoulder stabilization. Dr. Mall did not believe Petitioner would improve without surgery given the failure of conservative treatment to date, and questioned whether Dr. Rende even examined Petitioner's biceps. (Px14).

Dr. Mall was cross examined, and he agreed that Petitioner did not initially make any complaints about the neck, radicular symptoms or the right elbow. He was not aware of what Petitioner did at [Continental] Tire after leaving Respondent's employ, or how long she worked there, nor was he aware of her job duties with Addus. Dr. Mall agreed his initial diagnoses were based only on his exam findings and that the right shoulder MRI did not show any tears in the superior labrum, rotator cuff or glenoid. He also agreed that the MRI report does not note fluid around the bicep or bicep tendonitis, but said the radiologist didn't examine the biceps prior to contrast being injected. He agreed he did not initially examine her for shoulder instability, stating this would be a rare finding in a 33 year old. While he did not indicate it in his records, Dr. Mall agreed that after 12/18/15, any restrictions he issued would have been related to the right shoulder. (Px14).

Dr. Mall agreed he relied on Petitioner's history of developing symptoms while performing her job with the Respondent, and that his opinions could change if that history is not accurate. He agreed Petitioner had no elbow complaints until May 2016, and that Dr. Phillips reported a history of spontaneous onset of bilateral elbow pain with no neck or radicular pain. Dr. Mall agreed that treatment for multidirectional instability generally involves rotator cuff strengthening, not surgery. Dr. Mall agreed that findings of positive sulcus sign, posterior instability and evidence of subluxation would be suggestive of multidirectional instability, but that he did not have such findings in his examination of Petitioner. On redirect exam, Dr. Mall noted that Dr. Brown had initially noted reports of elbow symptoms, and that such symptoms can wax and wane, but agreed that for the most part there is no indication that any elbow condition would be related to Petitioner's work with Respondent, especially given the time gap before she brought it up to Mall. (Px14).

Orthopedic surgeon Dr. Gornet testified on 8/18/16, and testified consistent with his 11/30/15 report with regard to Petitioner's symptoms and Petitioner's belief that her problem began on or about 4/14/14 doing what she felt was

repetitive lifting and throwing of boxes. Dr. Gornet testified that shoulder symptoms can be due to shoulder or cervical pathology. He testified that reaching and pulling on something can cause injury to the shoulder and cervical spine, including cervical radiculopathy or nerve irritation. He testified that Petitioner performed repetitive lifting and throwing of boxes: "Well, that activity, basically you're – you're using your arms to apply a mechanical load and that mechanical load is transferred through your arm. That's why it could potentially injure your shoulder, but it also results in structural stresses and forces in the cervical spine and that type of force can easily, again, potentially aggravate an underlying condition or cause an injury." (Px13).

Petitioner's neurological exam was normal, but Dr. Gornet testified this did not mean there was not some minimal nerve irritation, and he confirmed that his review of the cervical MRI demonstrated a small herniation and annular tear at C5/6 and a smaller one at C4/5. There was no significant degeneration. Dr. Gornet testified that the C4/5 and C5/6 findings, per the medical literature, could easily correlate with her shoulder, upper arm and trapezius symptoms, as well as potential radiation into the thumb and index finger, which could overlap with CTS. Cervical injections were recommended for both therapeutic and diagnostic purposes. However, Dr. Gornet testified that Petitioner should exhaust shoulder care before moving on to any possible neck surgery, though the injections could be performed during the completion of shoulder treatment. As to the cervical spine, Dr. Gornet continued the Petitioner on full duty. (Px13).

At Petitioner's 2/22/16 follow up, Dr. Gornet explained to Petitioner that Dr. Petkovich's diagnosis of a cervical strain was inconsistent with her continued symptoms, as a strain would resolve rapidly, especially given the diagnostic films demonstrating C4/5 and C5/6 disc pathology. Once the shoulder was fully addressed, if Petitioner still has symptoms, Dr. Gornet testified a cervical surgery, likely disc replacements, would involve a brief time off work before a full duty return without any significant residuals. (Px13).

On cross examination, Dr. Gornet agreed that if Petitioner's stated history of her work duties was incorrect, his causation opinions could change, and if her symptoms did not begin until after she left the Respondent's employ, it would be important to know what her post-Respondent job activities were. However, he noted that Petitioner's report to him was that the onset of symptoms began with her work activity for Respondent. He agreed that objective cervical testing did not show any significant spinal cord or nerve root impingement. He did not believe the cervical MRI findings were degenerative given well preserved and hydrated discs. He agreed that his reports do not discuss possible disc replacement surgery. (Px13).

The deposition of orthopedic surgeon Dr. Petkovich, Respondent's cervical Section 12 examiner, was obtained on 9/1/16. (Rx2). He examined Petitioner on 2/10/16. Petitioner reported working as a full and split case picker for Respondent, which the doctor indicated involved picking full cases or taking individual items from full cases and putting them into order containers. Petitioner reported developing right neck and shoulder area discomfort and in both arms in March 2014 with no specific injury. She reported being terminated on 4/13/14 due to being 30 minutes late, after which she sought treatment with Dr. Reyes on 5/14/14 for bilateral hand/wrist numbness and tingling, with no neck or shoulder complaints. He noted EMG/NCV showed bilateral carpal tunnel and no evidence of radiculopathy. Dr. Petkovich testified that Petitioner reported after she went under the care of Dr. Mall for CTS, she was having some right shoulder discomfort. He reviewed the shoulder MRI report indicating no evidence of internal derangement, and was aware Dr. Mall performed three shoulder injections, referred Petitioner to Dr. Gornet for possible cervical involvement, and that Gornet had discussed possible epidural injections. (Rx2).

Dr. Petkovich testified that on 2/10/16 the Petitioner reported having no further cervical spine area pain and no discomfort, numbness or tingling in either upper extremity. Her only complaint of discomfort was in the right shoulder area. In his opinion, she did not report symptoms or complaints that were suggestive of possible cervical nerve root

involvement. Dr. Petkovich's examination of the Petitioner's cervical spine was totally normal, including a normal neurological examination throughout both upper extremities. Dr. Petkovich felt that at most, based on the Petitioner's stated history, she may have had a soft tissue cervical strain, but he noted there was no documentation of complaints in the records of either Dr. Reyes or Dr. Brown which would suggest this occurred at work. Petitioner denied a history of any specific injury. At the time of his examination, Dr. Petkovich opined that Petitioner had reached maximum medical improvement and needed no treatment or work restrictions relative to the cervical spine. (Rx2).

After reviewing the 10/16/15 cervical MRI films, Dr. Petkovich issued a 2/22/16 addendum report, and he testified that nothing in the films caused him to change his opinions. He noted mild disc protrusions at C4/5 and C5/6 and evidence of mild annular fissuring. He testified the films showed nothing more than mild age appropriate degenerative changes from C4 to C7 with no evidence of spinal cord or nerve root compression, and no other acute findings. Dr. Petkovich opined that the MRI findings were unrelated to Petitioner's employment with Respondent and represented normal degenerative processes that develop throughout life. Dr. Petkovich testified that the Petitioner could work with no need for physical restrictions. (Rx2).

On cross exam, Dr. Petkovich agreed he had only reviewed Dr. Reyes' two page 5/16/14 report, not the intake form. He had no opinions relative to the Petitioner's hands/wrists, elbows or shoulders. He had not reviewed any of Dr. Gornet's records from after 2/10/16. His review of the MRI films indicated mild degenerative disc disease with mild protrusions and some mild fissuring, but in his opinion no evidence of annular tearing. He could not say that Petitioner's subjective symptoms correlated with the cervical MRI findings because she had no subjective symptoms with regard to the cervical spine and no complaints of cervical radiculopathy. He agreed that Petitioner could have sustained a cervical strain doing the type of work she did for Respondent, and agreed that he opined she sustained a cervical strain, but testified he opined this solely based on her stated history, and that the initial records of Dr. Reyes and Dr. Brown did not support a work related cervical strain. Dr. Petkovich was not aware of any cervical treatment or diagnostic testing prior to 4/13/14. He agreed that an annular tear can potentially occur traumatically. (Rx2).

Testimony was obtained from orthopedic surgeon Dr. Rende on 7/18/16, who evaluated the Petitioner's right shoulder at the request of the Respondent. He testified he hasn't performed shoulder surgery himself since 2005. Petitioner reported working for a year as a full case picker, a year as a split case picker, and another approximate year in utility performing both of these jobs. Dr. Rende agreed with the radiologist's interpretation of the right shoulder MRI arthrogram, i.e. that it was essentially within normal limits, and showed Dr. Mall's initial pre-MRI diagnoses to be inaccurate. While the radiologist noted fluid around the bicep, Dr. Rende testified this would be a normally expected finding given contrast was injected and the bicep communicates directly with the shoulder joint, and that this did not reveal any pathology. His right shoulder examination noted normal range of motion and to some degree beyond normal, as the shoulder easily went all the way up to 180 degrees. The Petitioner demonstrated positive apprehension and sulcus signs which would suggest anterior instability. He also found 1.5 cm of posterior instability. She had negative Speed's test, which rules out biceps tendinopathy, and her O'Brien's and Kuhn's tests were both negative for a labral tear. She did have a positive test for impingement and reported pain in the subacromial space region, which is fairly typical for impingement. Based on these examination results, Dr. Rende was of the opinion that the Petitioner had multi-directional shoulder instability and translational or secondary impingement. (Rx1).

Dr. Rende testified that the cause of multidirectional instability is genetic due to weak shoulder ligaments, that it is more common in women than men, and that the proper treatment for this is balancing the shoulder through strengthening of the secondary muscles. A "secondary" impingement occurs with this type of instability, and in such case, arthroscopic subacromial impingement surgery can result in a worsening of the shoulder condition, which he had learned through performing such surgeries. Dr. Rende's review of Dr. Mall's records did not show that he tested the Petitioner for

multidirectional instability. Dr. Rende opined that this genetic instability was not work related, and further opined that the Petitioner did not require any work restrictions with regard to the shoulder. (Rx1).

Following MRI review, Dr. Rende issued a 2/23/16 addendum report noting there was no biceps pathology and no evidence of a primary impingement, and thus his opinions did not change. He further opined that the surgery recommended by Dr. Mall was not reasonable and necessary, and could leave the Petitioner worse off, regardless of any relationship to work: "It's a chronic condition for which there are easy fixes that would strengthen." (Rx1).

On cross exam. Dr. Rende testified that the first indication of right shoulder problems in the treating medical was in the initial report of Dr. Mall, but he agreed he did not review the intake form of Dr. Reyes noting a right shoulder complaint. He also agreed Dr. Brown documented that Petitioner complained of right shoulder symptoms on 9/28/14, but this didn't change his opinion because Petitioner's condition was shoulder instability. He was not aware of if Petitioner was right or left handed. He testified he was personally aware of what a picker does, and has previously reviewed job videos, but agreed he did not discuss Petitioner's job duties with her in any significant detail. He agreed a split-case picker would involve repetitive motion at shoulder height and above, and did not disagree he may have so testified in a prior case involving a split case picker working for Walgreens. Dr. Rende testified that he and Dr. Mall agree that that the Petitioner has right shoulder subacromial impingement, but disagreed with Mall's interpretation of the 9/15/15 right shoulder MRI. He did not find any left shoulder instability on exam, testifying that he would not expect to see it on the left side just because it was found on the right, noting he himself has multidirectional instability in only one shoulder. He agreed that an asymptomatic instability can become symptomatic from using the upper extremity more frequently. However, when asked if he thought that was the case here, he testified: "No, I suspect it's more reasonable that she got fired from her job and she suddenly developed symptoms." He opined that she likely had the condition for most of her adult life and had symptoms that weren't significant enough to seek treatment, which is the natural history of the instability condition. He saw no evidence that Petitioner had pre-April 2014 shoulder problems, but agreed he reviewed no medical records which predated May 2014. (Rx1).

Dr. Rende testified he would not be surprised if Petitioner had improvement with shoulder injections from Dr. Mall, as it means she had inflammation in the subacromial space. He reiterated that, unless you are talking about high performance athletes who may undergo reconstructive shoulder surgery, the proper treatment for multidirectional instability is therapy, not surgery, again testifying that surgery such as the acromioplasty / subacromial decompression surgery, recommended by Dr. Mall, could make it worse. Dr. Mall's surgical recommendation is based on subacromial impingement. His opinion is Petitioner needs aggressive therapy, but that such therapy would not be related to her employment. If that fails, "she would have to live with the symptoms", noting the results of such therapy are generally excellent for this condition. If Petitioner only had primary impingement, surgery would be reasonable, but in the face of secondary impingement due to instability, it is likely to make her worse. On redirect exam. Dr. Rende testified that with primary impingement there is a tight space between the acromion and the humeral head, and "because of their job duties, most specifically repetitive overhead lifting, they develop chronic fibrosis and inflammation in that region." (Rx1).

In the Petitioner's records from Anchor Staffing, she indicated she left her job working "on and off" at S & LB's Place from 2004 to 2015 because her unemployment ran out and she needed a good job. As to why she left the Respondent, she indicated: "went on maternity leave had points & road was bad and was late and got fired." (Rx4).

Respondent submitted records indicating Petitioner was employed with Addus Healthcare from 6/24/15 to 11/4/15. She noted she worked as a tire trimmer for Continental Tire from 2/27/15 to 4/13/15, and the job ended when her assignment was finished, but she also stated: "said I called in 5 times and didn't she was looking into it and never called

back." She was terminated due to "no return from leave." The records indicate she was earning $9.95 per hour and was reimbursed for travel expenses. (Rx3).

Tom Burgin testified that he worked as the Function Manager for Respondent and supervised Petitioner in the Spring of 2014 when she worked as a Utility Personnel. Petitioner never complained of symptoms in her hands, neck or right shoulder/arm and never requested medical treatment prior to her 4/13/14 termination, which occurred based on a point system. She did not appear to be impaired while working, and she never requested any job modifications. He had no knowledge of whether Petitioner complained of an injury or gave notice to Respondent of an injury subsequent to 4/13/14.

Mr. Burgin testified that he knows the duties of full and split case pickers. He agreed that it involves having to lift and move cases up to 50 pounds with the upper extremities, and that charcoal can weigh more than that, as well as that there is a quantity quota. He also agreed there are A and B levels as a full case picker, with the "A" level about 55" above ground level, and the "B" level at approximately shoulder height. He agreed you would assume Petitioner passed her pre-employment physical since she was hired.

Petitioner testified that her hands improved with the bilateral CTS releases, but that she continues to have unabated and worsening right shoulder pain. She testified that Dr. Rende's report indicating that she did not complain of her shoulder for a long time after the accident was not accurate, as supported by her medical records (the Arbitrator notes the Petitioner appears to be referencing Dr. Reyes' 5/19/14 intake form). She testified she has shoulder pain, it cracks all the time, and she does not have full rotation. The pain radiates to the right elbow. She wanted to undergo the recommended right shoulder surgery and hoped she would not need further cervical treatment.

Petitioner verified that the documents in Rx5 were from her Facebook account. At the time of hearing Petitioner had been working as a bartender at S & LB's Place in DuQuoin, Illinois for the past few months, testifying: "I sit in a chair". Petitioner testified that she had some college classes but had no advanced degrees or training. She agreed the Respondent had accepted and covered her CTS surgeries and the associated TTD benefits.

Petitioner testified she worked at Continental Tire via Anchor Staffing for about two months, and that her job there involved using both hands to trim tires as they spun. With regard to another job she held at Addus Healthcare, Petitioner agreed she passed their June 2015 agility testing. She testified she worked performing in-home care which included washing dishes and clothes, vacuuming, etc. – whatever her elderly clients needed. She agreed the job would include bathing them, but she testified she never had to do this with her clients. Her employment there ended when she underwent CTS surgery. She didn't work again after that until she started working at S & LB's Place a few months prior to the hearing date.

On further cross exam, Petitioner testified that because Dr. Brown did not treat shoulders, he referred her to Dr. Mall. Because her attorney advised her to treat with one doctor, she treated with Dr. Mall for her hands as well.
She agreed she did not complain of her neck to Dr. Brown, but testified that he was treating her for her hands.

Petitioner does do housework, including cleaning and laundry. When asked about Facebook pages indicating the following, she agreed she cleaned out her gutters in June 2016 and mowed her grass in July 2016, but testified she uses a riding lawnmower and denied using a weedwacker. As to an August 2016 post about rearranging furniture, she testified she watched her boyfriend do it. As to long hours staining her deck and balcony using a paint brush, Petitioner testified: "the hard labor was done by someone else."

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, 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 initially notes that when a claim involves allegations of repetitive trauma, the issues of accident "arising out of" the employment and causation are significantly intertwined. In this case, the Arbitrator also notes that the Respondent was not disputing these issues with regard to the Petitioner's bilateral CTS conditions. Based on the hand-intensive nature of the job, and a significant level of repetitiveness, and the opinions of Dr. Brown, to whom Petitioner was referred by the Respondent (who indicated Petitioner's job involved fairly repetitive, hand-intensive activity with picking between 60 and 100 times per hour), the Arbitrator concurs that the evidence supports the finding of accident and causation with regard to bilateral CTS. The Respondent does dispute that the Petitioner's work activities rose to a level of cumulative trauma, increased risk and causation with regard to the Petitioner's right shoulder and elbow, and her cervical spine.

With regard to accident, the Arbitrator acknowledges that the Petitioner's job with Respondent was significantly repetitive in that she performed general picking activities for the vast majority of her shift, utilizing her upper extremities. She testified that full-case picking involves constantly moving cases of various products onto a conveyor line, while split-case picking involves taking individual products from full cases and putting them into totes which then were moved to the conveyor line. As a utility floater, she could have been performing either job, though the Arbitrator notes there was no detail presented with regard to the other possible utility jobs she performed, which she testified included receiving and shipping. Petitioner testified the utility job basically involved working in the receiving area, and once that job was completed, a utility worker would essentially act as a "floater", filling in wherever needed, including full and split-case picking, shipping, order picker, etc. She further testified, with Mr. Burgin in agreement, that an hourly rate of production/quantity had to be maintained. At least with full case picking, the testimony of Petitioner and Mr. Burgin were consistent that the cases could weigh up to 50 pounds or more. Petitioner testified that products were located in either the "A" or the "B" areas, which were either at or above head level or at a lower level requiring her to reach up or bend down, and the conveyor was at waist level. Mr. Burgin testified the "A" level about 55" above ground level, and the "B" level at approximately shoulder height. For split-case work, Petitioner estimated full totes could weigh up to 25 or 30 pounds.

The Arbitrator finds that the preponderance of the evidence indicates work activities with the Respondent which were significantly repetitive and heavy enough so as to constitute an increased risk of injury, and thus that the Petitioner has fulfilled her burden of proof that an accident arose out of and in the course of her employment with Respondent on 4/13/14, her last day of work. The Arbitrator does note with interest, however, that it appears the utility job, which is the last job she had with Respondent, appeared, at least arguably given the greater variety of jobs, to involve the least amount of continuous repetitive activity, as well as that Petitioner had been working full duty without evidence of complaint until being terminated for cause on 4/13/14.

The Arbitrator initially finds that the right elbow condition is not related to her employment with Respondent. Even Dr. Mall agreed that the evidence did not support such a finding, and this was despite the Petitioner initially indicating complaints of pain through the elbows in the intake form completed for Dr. Reyes. The Arbitrator notes that other than that single documentation, there was no evidence of such complaints or any elbow treatment in Dr. Reyes' progress notes, and there was no indication in the records of elbow complaints until approximately 6/27/16, over two years after

the accident date. Dr. Phillips' report also notes that the Petitioner reported a spontaneous onset of elbow symptoms, and in fact indicated the complaints were bilateral.

The more contentious issues in this case between the parties are the causal relationship of the right shoulder and cervical spine, for which Dr. Mall and Dr. Gornet have prescribed respective surgeries.

Both the Petitioner and Mr. Burgin testified that the Petitioner did not report any physical complaints, request any medical treatment or seek any modifications in her job duties prior to her 4/13/14 termination for cause. While Dr. Reyes' intake form does note pain in her hands, elbows and right shoulder, with paresthesias and pain through the elbows, Dr. Reyes' progress note only notes the hand/wrist complaints, and there is no indication of neck complaints in either document. When the Petitioner was seen by Dr. Brown on 10/28/14, she reported that sometime in 2013 she noticed some symptoms in her hands with some cramping, some numbness and tingling, as well as some medial elbow pain, right greater than left, and right shoulder pain. She indicated her symptoms increased around April of 2014, the time of her termination. Dr. Brown's records and treatment thereafter were focused on CTS, but he did recommend she see a specialist for the right shoulder. It was not until the Petitioner was referred to Dr. Mall that any reference is made to cervical spine complaints, or that there was any significant focus on right shoulder complaints.

With regard to the right shoulder, there is a dispute between Dr. Mall and Dr. Rende as to whether there is multidirectional instability, the type of impingement Petitioner has and whether surgery is indicated, as well as whether there is a causal relationship to the job duties. Dr. Rende agrees with the radiologist's conclusions that there is no evidence of any significant pathology in the MRI, while Dr. Mall's review of the films indicated biceps tendonitis with fluid around the biceps and an acromial spur. The Arbitrator has some questions with regard to the findings of both physicians: Dr. Mall appears to have over-diagnosed Petitioner's initial condition and is now proposing a fairly significant right shoulder surgery despite MRI findings that do not appear to involve anything more than AC joint degeneration and tendinitis / inflammation, while Dr. Rende indicated a level of bias with his statement as to right shoulder causation that "I suspect it's more reasonable that she got fired from her job and she suddenly developed symptoms."

Overall, the Arbitrator finds that the preponderance of the evidence indicates that the Petitioner has sustained her burden of proof that she developed a level of strain and inflammation in the right shoulder as a result of her work activities with Respondent. However, the Arbitrator notes there is no evidence of any internal derangement of any kind per the MRI. The Arbitrator finds the opinions of Dr. Rende to be more persuasive in this case with regard to the treatment recommendations. This is significantly based on the lack of abnormal objective findings in the MRI.

The Arbitrator finds that there is no causal relationship between the Petitioner's work duties with the Respondent and any cervical condition. There was no evidence of any neck complaints until 9/15/15. While Dr. Mall and Dr. Gornet testify that shoulder problems can be referred from the cervical spine as well as the shoulder itself, the cervical findings on MRI appear relatively minimal. Dr. Gornet's opinion that there may be nerve irritation that is resulting in shoulder symptoms is not persuasive given that all physicians in this case have agreed that there is no evidence of nerve impingement. During EMG testing, Dr. Phillips specifically mentioned that the Petitioner had no cervical or radicular complaints. The idea that cervical surgery involving a double disc replacement is reasonable given the lack of neck symptoms, the lack of nerve impingement on MRI, the minimal objective shoulder findings and the inability of Drs. Gornet and Mall to discern which of their respective body parts (cervical spine and right shoulder) are even causing the problems, is not supported by the evidence in this case. Additionally, Dr. Gornet's indication that he sought cervical surgery authorization before there is any clear need for same, even in his own opinion, indicates to the Arbitrator that he has essentially already made the decision prior to his recommendation to exhaust shoulder treatment. The Arbitrator

finds that the greater weight of the evidence significantly supports the finding that any alleged cervical condition is not related to the 4/13/14 accident.

The Arbitrator notes with significant interest that the Petitioner had been performing her regular job through the time her employment with Respondent was terminated, and there is no evidence that she had complained of either right upper extremity symptoms or problems performing her job prior to her termination. She agreed that her termination was for cause, though she testified she did not report anything about her condition because she was afraid she would lose her job. The inference in this case, in the Arbitrator's view, is that whatever symptoms the Petitioner was having at that time of her termination were not very significant. For that to have blown up in this case into a situation where both shoulder and cervical surgeries are now being considered just does not appear to be the Arbitrator to make credible sense. Instead, it appears to the Arbitrator that it was likely the Petitioner would have continued performing her regular work duties had she not been terminated. In fact, the Petitioner seems to have complained of worsening symptoms after she terminated, which simply doesn't make logical sense to the Arbitrator once she was away from such activities.

The reality appears to the Arbitrator to be that neither Dr. Mall or Dr. Gornet really know what is causing the symptoms. Additionally, the Arbitrator believes questions exist with regard to the reliability of the Petitioner's subjective complaints in this case with regard to the right shoulder and cervical spine. In both cases, the MRIs reflect fairly minimal findings. The Petitioner, again, had been working without evidence of complaint through the termination date, and has been able to perform work since that time. There just does not appear to be any line of demarcation where something really changed with the Petitioner's condition versus her having relatively minor symptoms with regard to these body parts. To reiterate, the Arbitrator finds that the Petitioner's CTS condition and right shoulder are causally related to the accident, but that the right elbow and cervical spine conditions are not.

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

The Arbitrator finds that while any need for surgery is questionable with regard to the neck and right shoulder, the Petitioner's work up through the date of hearing was reasonable. As such, the Arbitrator finds that the Petitioner is entitled to the medical expenses contained in Px1 pursuant to Sections 8(a) and 8.2 of the Act.

Respondent is entitled to credit for the $20,611.44 in medical expenses paid prior to the hearing date.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that the right shoulder surgery recommended by Dr. Mall or the cervical surgery recommended by Dr. Gornet are reasonable and necessary pursuant to Section 8(a) of the Act.

With regard to both conditions, the Arbitrator finds that there is a paucity of significant objective findings with regard to both body parts.

Both Dr. Mall and Dr. Gornet have essentially opined that conservative treatment has failed with regard to the right shoulder and cervical spine, and therefore the only next step is surgery. While Dr. Gornet has indicated that the shoulder treatment should first be completed before moving on to cervical surgery, he took the liberty of requesting the cervical

surgery in advance. What the evidence indicates here, in the Arbitrator's view, is a significant push for surgeries from these physicians with very limited findings or abnormality on MRI. The Arbitrator has reviewed hundreds if not thousands of medical opinions with regard to such MRI findings, and in both the case of the right shoulder and the cervical spine, the MRI findings are quite minimal.

The Arbitrator also notes that while the benefit of the doubt is given to the Petitioner with regard to causation of the right shoulder, this is done despite some questionability in the Arbitrator's mind given that, again, the Petitioner appeared to be working regular duty with no complaints whatsoever for three years until she was terminated, with the last job she performed there involving the most rotation of jobs. The Petitioner has worked several jobs since leaving the Respondent's employ on a full duty basis. While she testified that she was unable to continue the tire job, records indicate that the job ended because her temporary assignment ended. The Arbitrator also has questions with regard to the Petitioner's statements of only having to lift 15 pounds with no overhead work at all wile she was taking care of elderly people in their homes. While the Facebook pages presented by Respondent are of minimal value in this case, they do evidence someone who generally appears to be living her life normally without significant problems, albeit with some entries that do indicate complaints of pain. However, the Petitioner's denials of some of the activities she indicated she performed in these records, such as moving furniture and weedwacking, do not seem very credible.

Overall, the Arbitrator questions the Petitioner's indications of the severity of her symptoms in the neck and/or right shoulder, and these questions are supported by minimal objective MRI findings. Taking this into account along with the opinions of Dr. Petkovich and Dr. Rende, the Arbitrator finds that the proposed surgeries are not reasonable and necessary. The Arbitrator found one of the physical therapy notes to be very interesting in this regard: Petitioner said she actively "popped" her shoulder after overhead range of motion noting a loud audible bony clunk, and that this relieves her pain. This would seem to support Dr. Rende's belief that the Petitioner has some level of shoulder instability.

The Arbitrator finds that the Petitioner has sustained her burden of proof that she sustained a strain/inflammation type injury to the right shoulder. The Petitioner has failed to prove that she sustained an injury to the cervical spine. The latter finding is supported by the lack of any neck complaints whatsoever by Petitioner until she started treatment with Dr. Mall, and the lack of any significant findings on MRI. While Dr. Gornet believes some minor bulges and annular tears are somehow causing Petitioner to have right shoulder symptoms that require cervical surgery, the Arbitrator finds the opinions of Dr. Petkovich to be more persuasive, particularly given the minor objective findings, that at most the Petitioner sustained a cervical strain that resolved well prior to hearing.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that the Petitioner, per the Request for Hearing, has not claimed TTD benefits in addition to the $4,535.90 paid by Respondent from 8/4/15 to 10/12/15. Petitioner is entitled to this period of TTD, and Respondent is entitled to the noted credit.

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

Karen Trask,

Petitioner,

vs.

NO: 11 WC 39566

Granite City School District #9,

Respondent.

18IWCC0754

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 49-year-old employee of Respondent, who described her job as interpreter for the hearing impaired. Petitioner was employed at Respondent in 2011. At the time of her injury she was assigned to a self-contained classroom and her duties were to go with certain students into the mainstream classroom; mostly the kindergarten classroom as a one-on-one interpreter. Petitioner did recall testifying previously, May 2012, regarding her injury and medical treatment to date in this case. She agreed the purpose of that hearing was to obtain an award for the treatment recommendation of Dr. Kennedy.

- On the date of accident, March 17, 2011, Petitioner testified that it was picture day and her job was to interpret for any situation the student was in. Petitioner testified that she was interpreting for the photographer who was arranging the children. Petitioner stated that

there were two siblings in the self-contained classroom getting their pictures taken together. Petitioner stated the children were sitting on stools and she had to get down to their level to interpret. Petitioner stated that she squatted down, lost her balance, fell backwards and sat on the photographer's light tripod, landing on it. Petitioner agreed that subsequent to the prior hearing where the surgery was awarded, she did have surgery with Dr. Kennedy on November 9, 2012. Petitioner testified that after the surgery she had continued problems with pain at or near the surgical site. Petitioner underwent therapy and eventually treated with Dr. Feinberg for her low back pain, thigh pain. Petitioner testified that the pain was initially in the surgical area but had since radiated on both sides, but predominantly to the right. Petitioner was ultimately given permanent restrictions by Dr. Kennedy of no lifting more than 10 pounds and no standing more than 5-10 minutes. Petitioner returned to work for Respondent as they had accommodated her restrictions. Dr. Kennedy referred Petitioner to Dr. Feinberg for pain management and she has been receiving that care ever since. Petitioner testified that she has been taking Hydrocodone, 5/325, every 6 hours. Petitioner stated that that was the only prescription she was prescribed regarding her back condition. Petitioner sees Dr. Feinberg monthly for med checks as the prescription is a controlled substance. Petitioner testified that injections had been recommended but the worker' compensation carrier had refused to approve them, so she had a limited number and she used her private insurance for those. She did not recall when she had her last injection, but thought it was several months prior. Petitioner testified her own private insurance paid for medications and injections.

- Petitioner testified that she was not currently working but that was not related to her back injury. Petitioner testified that currently, she still has low back pain on both sides, not always at the same time, that radiates into her thighs. If she has pain in her right lower back quadrant the pain goes to her right thigh and if the pain is in her left back the pain goes to her left thigh. Petitioner has difficulties with activities. Petitioner stated she can no longer vacuum at home, bend and clean the tub or go up and down stairs enough to do the laundry. Petitioner stated that usually someone will carry the laundry basket down for her. Petitioner stated that she cannot walk long distances without some aid. She stated when she goes shopping she grabs a cart for support. She stated that standing in one place is very painful after a few moments, and part of her job is monitoring students before school for about 50 minutes. Petitioner indicated that she has difficulty getting on the floor to play with her grandchildren and getting up she has to push up on something due to the back pain. Petitioner testified that she takes Hydrocodone daily for her pain. She takes no over-the-counter (OTC) medication for her back pain.

- On cross examination, Petitioner stated that she had some prior back issues which she did not consider that extensive. She had cortisone injections prior to the accident on March 17, 2011 (ESI with Dr. Graham). She did not recall when her last injection was prior to this injury. She did have prior chiropractic care (Dr. Eavenson at Multi Care Specialists) for her back and they referred her to Dr. Graham. She did not believe that she had physical therapy prior to this accident. She agreed that prior to the accident she was taking Tramadol for low back issues and fibromyalgia. She believed she was taking that at the time of the accident; she took it after the accident with no effect. She stopped taking that when the doctor found out she was taking both Tramadol and the Hydrocodone; they did not want

her taking both. She believed it was Dr. Feinberg who told her not to take the Tramadol. She stated her low back issues were not chronic before the accident. She stated her low back problems started in her mid to late 20's, out of nowhere. She stated she would see the chiropractor and the problem would be gone after 1-2 weeks. The symptoms would come for no reason and after chiropractic treatment or an injection she would be good to go. She was 49 at the time of the accident. Her back issues did go back to the mid to late 1980's. Prior to March 17, 2011 she had no low back injuries she could recall. She would agree if records showed chiro care at Multi Care beginning in 1997 for back issues.

- Petitioner started working for Respondent in 2001, full time in 2002. Petitioner acknowledged that the prior hearing was May 2012. At the time of that hearing she wanted the proposed L5-S1 surgery recommended by Dr. Kennedy (Petitioner did not recall the details as to levels other than back surgery). She would agree if Dr. Kennedy testified of the L5-S1 fusion surgery being recommended. She agreed at the prior hearing she was taking Tramadol, Lisinopril, Metformin, Citalopram/Celexa, Levothyroxine, Metoprolol, and Lyrica. She no longer took the Tramadol but was still taking the other medications and some additional medications.

- Petitioner agreed she was off work beginning September 24, 2012 when the doctor proposed the surgery and she was off work. She was not taking Hydrocodone the entire time. She believed Feinberg was who first prescribed the Hydrocodone for regular use; it was after surgery when she was referred there. The only prescription medication she was taking for her back was the Hydrocodone. She did not recall a long conversation with Dr. Kennedy on July 24, 2012 regarding fusion at L3-S1; she stated she recalled telling him to do what was needed as she needed relief and she agreed to the surgery. She did not recall him saying it was a different surgery then initially proposed; she just wanted the surgery. Petitioner testified that the 3-level fusion surgery she had did make her back issues better; it helped her mobility. She stated looking back it did not really relieve the pain, but it helped mobility as before she was stiff and unable to bend to the side or bend over and she can do that since the surgery. However, she still has the pain. She indicated it was hard to separate pain from motion, she did not know if the lack of mobility caused greater pain, but her mobility bending at the waist is better now and she can put on her shoes and lift her leg. She indicated the surgery did help with the radiating symptoms as before surgery the pain went all the way down her right leg, and now pain is only to her thigh and knee. Petitioner stated that she still has radiating pain to her legs; right more than left. She did not recall if she had left side radiating pain before. She told Dr. Kennedy about the pain and he referred her to Dr. Feinberg. Petitioner stated that she went to therapy after surgery and the pain did not get better, so she was referred to Feinberg for mainly the radiating leg pain. She did not recall hearing the term 'radiculopathy'. She had the surgery in November, so rehab started about February 2013. She did not see Dr. Eavenson for chiropractic care after surgery. She had received electro and ultrasound therapy on her back in addition to the physical therapy. She saw Dr. Eavenson every time she went for therapy. She stated he checked her mobility and gait; things like that, but he did not do therapy. Dr. Ashley worked with her in therapy and the therapist (Corey Voss) worked with her with stretching and she would see Dr. Eavenson. Petitioner agreed she also started receiving medical treatment for her right knee in February 2013. Dr. Choi was the knee surgeon. She had a volleyball injury to her left

knee in 2002 and had left knee surgery. She did not believe this injury had aggravated her knee while rehabbing. She believed rehab actually caused the knee, she could not pinpoint when. She did not know if her low back was aggravated when her knee was elevated after knee surgery. She indicated her altered gait added to her back pain; it got worse before that surgery due to the delay, her gait was altered for so long. She was injured February 2011 and did not have surgery until November 2012 and that had affected her gait. Petitioner indicated that they watched her gait and they tried to improve that after surgery. She did not see Dr. Ashley before surgery. Her gait was altered before the back surgery, from the injury, waiting so long for the back surgery. She did not know what caused her knee problem. The knee injury came after she had her back surgery, while going to therapy.

- Petitioner agreed she started receiving pain management from Dr. Blake at Regeneration Orthopedics for her low back in May 2013. She stopped going there as Petitioner had a bad experience with her; different points of view, and Petitioner did not think she could continue there. Petitioner did not see Dr. Blake for a long period; maybe 2 appointments. Petitioner did not recall an appointment (IME) with Dr. Petrovich on February 22, 2014 but she recalled seeing a doctor for Respondent; twice. She thought Dr. Blake referred her there February 2014. Petitioner did not recall telling the doctor (Petrovich) she wished she did not have the 3-level fusion surgery in November 2012. Petitioner stated she was still in pain then and she questioned whether it was something she should have done. Petitioner agreed her last appointment with Dr. Kennedy was about June 3, 2014. She did not recall ever taking Gabapentin; she was on Lyrica. Petitioner stated that she was aware Dr. Kennedy referred her to pain management (amended June 3, 2014 record July 15, 2014) but she did not know if the doctor amended the records. Petitioner agreed that the doctor placed her on restrictions. Petitioner still does follow the restrictions; she never lifts over 10 pounds and she has access to a chair for PE and recess periods.

- Petitioner stated that Dr. Don (last seen about 2014) had treated her for fibromyalgia in the past; he was no longer in practice and she had not seen a rheumatologist since. She believed Dr. Don placed her on Lyrica for that. She believed Tramadol was initially used for fibromyalgia pain. She was till taking Lyrica for the fibromyalgia pain; since about 2014. Petitioner indicated her pain subsides while on the Hydrocodone. While off work she takes it 3-4 times per day; when working it was at most 4 times per day. She stated she always had Hydrocodone in her system. When sitting she can be pain free taking 1-2. Her symptoms are better now as she does virtually nothing being off. She does some crafting; sitting in a chair, designing vinyl things. She does go to the craft store. Her last psoas injection was about December 5, 2016. After the last injection she had about 90% relief (pain 3-6/10 on hydrocodone). She indicated she has 30-60% relief now.

The Commission finds that Petitioner had a lumbar condition that a prior §19(b) hearing determined was causally related to the accident to the L5-S1 level. Petitioner had the awarded surgery and Dr. Kennedy added the L3-L5 levels to the fusion with the surgery. Dr. Kennedy's decision to add the additional levels for fusion was partially based on diagnostics with the repeat myelogram. Dr. Kennedy, in fact, recommended the additional levels prior to that diagnostic confirmation. Petitioner clearly had a pre-existing degenerative condition at multiple levels. The

L5-S1 pre-existing condition was found causally related with Dr. Kennedy opining that it was caused or aggravated by the accident and Dr. Petrovich opining that the L5-S1 fusion was reasonable (again previously found causally related). Medical evidence indicates Petitioner had significant problems at all levels that the surgery addressed. Petitioner's testimony is unrebutted and the evidence in this record supports Petitioner's testimony as to her ongoing condition of ill-being that ultimately led to Dr. Kennedy deciding to do the 3-level fusion decompression rather than his initial recommendation of only the L5-S1 level. Petitioner also had a fibromyalgia condition she treated for which likely created difficulty for Dr. Kennedy to determine an exact pain generator.

Dr. Kennedy opined that all the levels addressed were causally related to the accident (aggravation, acceleration). Medical opinions in many prior cases note that fusion at a level causes additional stress on adjacent levels that may eventually need to be addressed. Petitioner already had multiple levels of degenerative changes. Dr. Kennedy opined the other levels were also aggravated by the accident. Following the causal chain, if only the initial L5-S1 as initially recommended, was done, the adjacent levels would have been stressed more and would have needed to be surgically addressed (likely sooner than later given Petitioner's condition at those levels) so there is an ongoing causal connection between the accident and the ultimate multi-level fusion decompression that Dr. Kennedy performed. Dr. Kennedy's opinion is more persuasive than that of Dr. Petrovich, especially given the fact that the L5-S1 level had already been determined by prior hearings to be causally related and the additional levels addressed with the fusion appear as just a natural flow of the causal connection between the accident and her condition of ill-being and need for that surgery. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission finds that Respondent indicated temporary total disability (TTD), as an issue for Review, but did not address it in their Statement of Exceptions, the issue is therefore deemed as waived. Regardless, the Commission finds that, with Petitioner having had the previously awarded surgery (albeit expanded) and being authorized off work, Petitioner met the burden of proving entitlement to the TTD as awarded. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

The Commission finds that Respondent indicated prospective medical as an issue, but that was not addressed in Respondent's Statement of Exceptions, it is therefore deemed as waived. With the above finding of the ongoing causal connection, the Commission finds evidence of the reasonable and necessary treatment and medical bills to find Petitioner met the burden of proving entitlement to the award as is. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses/prospective medical.

The Commission, with the above finding of the ongoing causal connection, finds that Petitioner

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met the burden of proving entitlement to a fairly substantial permanent partial disability (PPD) award, but views the evidence slightly differently and finds the Arbitrators award somewhat excessive.

> §8.1(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.

The Commission notes that there was no impairment rating submitted by either party. Petitioner had been an interpreter for the hearing impaired and was 49-years old. Petitioner was not currently working but that was not related to her back injury. Petitioner had, however, been diagnosed with gastroparesis, a factor from the narcotics she had been on since her back injury; that was also given as a reason she was currently off work. There is no evidence indicating any effect of this injury on her future earning capacity as she had been otherwise working and is now primarily off due to other reasons. Petitioner required a multi-level fusion as result of her injuries. Petitioner testified that currently, regarding her back, she still has low back pain on both sides, not always at the same time, that radiates into her thighs. Petitioner has difficulties with activities. Petitioner stated she can no longer vacuum at home, bend and clean the tub or go up and down stairs enough to do the laundry. She stated that usually someone will carry the laundry basket down for her. Petitioner stated that she cannot walk long distances without some aid. She stated when she goes shopping she grabs a cart for support. She stated that standing in one place is very painful after a few moments, and part of her job was monitoring students before school for about 50 minutes. She indicated she has difficulty getting on the floor to play with her grandchildren and getting up she has to push up on something due to the back pain. She takes Hydrocodone daily for her pain. She takes no over-the-counter (OTC) medication for her back pain. Petitioner's condition of ill-being as a result of the accident is supported by her medical records. All things considered, Petitioner seems to have had a fairly good recovery. Given the factors considered under §8.1(b), the Commission finds that a more appropriate PPD award to be 30% loss of her person as a whole. The Commission finds the decision of the Arbitrator as not totally contrary to the weight of the evidence, as there is evidence of a fairly significant disability, but the Arbitrator's award is slightly excessive. The Commission, therefore, herein, modifies the PPD award to find that Petitioner suffered a loss of 30% loss of her person as a whole as result of her injuries.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $426.07 per week for a period of 64-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

18IWCC0754

the sum of $383.46 per week for a period of 150 weeks (total PPD - $57,519.00), as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 30% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $61,888.91 for medical expenses under §8(a) of the Act.

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

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

DEC 10 2018

DATED:
o-10/11/18
DLG/jsf
045

David Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRASK, KAREN
Employee/Petitioner

Case# **11WC039566**

GRANITE CITY SCHOOL DIST #9
Employer/Respondent

18IWCC0754

On 11/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.30% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

2396 KNAPP OHL & GREEN
ETHAN J WILLENBIRG
6100 CENTER GROVE RD POB 446
EDWARDSVILLE, IL 62025

STATE OF ILLINOIS)
)SS.
COUNTY OF **MADISON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KAREN TRASK
Employee/Petitioner

v.

GRANITE CITY SCHOOL DIST. #9
Employer/Respondent

Case # **11** WC **39566**

Consolidated cases: _____

18IWCC0754

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 28, 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 _____

18IWCC0754

FINDINGS

On **March 17, 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 **$33,233.20**; the average weekly wage was **$639.10**.

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

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

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

Respondent shall be given a credit of **$27,573.81** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$27,573.81**.

Respondent is entitled to a credit for all medical expenses paid prior to hearing pursuant to Sections 8(a), 8.2 and 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner's November 9, 2012 surgery with Dr. Kennedy, consisting of fusion surgery from L3 to S1, is causally related to the March 17, 2011 accident, and that the Petitioner's ongoing lumbar condition remains causally related to the accident.

Respondent shall pay Petitioner temporary total disability benefits of **$426.07 per week** for **64-5/7 weeks**, commencing **May 16, 2012 through August 11, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$27,573.81** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$16,220.78 to MultiCare Specialists, $378.00 to Missouri Baptist MC, $27,708.00 to Frontenac Surgery and Spine Center, $17,045.00 to Dr. Kennedy and $537.13 to Gateway Pain Center**, as provided in Sections 8(a) and 8.2 of the Act. However, notwithstanding this award, any of these expenses which are associated with Dr. Mark Eavenson's examinations of Petitioner during the time she was treating post-surgically with physical therapist Corey Voss at the same facility are denied as being unreasonable and unnecessary.

Respondent shall be given a credit of **$45,982.95** 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 is also entitled to credit for **any payments made via workers' compensation** pursuant to Sections 8(a) and 8.2 of the Act.

18IWCC0754

Respondent shall pay Petitioner permanent partial disability benefits of **$383.46 per week** for **187.5 weeks**, because the injuries sustained caused the **37.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **June 3, 2014** through **April 28, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

November 3, 2017
Date

NOV 13 2017

STATEMENT OF FACTS

A prior Section 19(b) hearing was held on this case on 5/15/12. On 6/18/12, the Arbitrator at that time determined that the Petitioner was entitled to prospective L5/S1 fusion surgery and associated medical treatment, noting she testified credibly and that all of the surgeons of record agreed the Petitioner needed the L5/S1 fusion. The Arbitrator also specifically found that Dr. Kennedy's opinions "are credible and persuasive in this regard." This determination was affirmed on review. (Px1). The main issue in the current matter involves whether the Respondent is liable for Dr. Kennedy's subsequent decision to instead fuse three levels of the Petitioner's lumbar spine, from L3 to S1 on 11/9/12.

The Petitioner testified that she started working for Respondent in 2002, and in 2011 was a one-on-one interpreter for the hearing impaired at the elementary school in the mainstream classrooms, mostly with a kindergartener. On picture day, 3/17/11, she was interpreting for a photographer. The students were sitting on stools, Petitioner squatted down, lost her balance, fell backwards and landed on the photographer's tripod.

Following the 3/17/11 accident, Petitioner treated at Gateway Occupational Health Services until 5/2/11. (Rx16). She then sought treatment with Dr. Mark Eavenson of Multicare Specialists on 8/4/11. (Rx16). Dr. Eavenson then referred Petitioner to Dr. Barry Feinberg for injections and eventually to Dr. David Kennedy for a surgical consultation. On 9/20/11, Dr. Kennedy recommended Petitioner undergo an L5/S1 fusion surgery and sought authorization to perform this surgery. (Rx13). Petitioner worked full duty for Respondent as an interpreter following the accident up to 9/26/11, when Dr. Kennedy restricted her from work. (Rx16).

Petitioner previously testified at the Section 19(b) hearing in May of 2012 that she wanted to undergo the L5/S1 fusion surgery proposed by Dr. Kennedy, which was supported by Respondent's examining surgeon, Dr. Petkovich, following his 12/6/11 examination. (Rx16). The prior Arbitration Decision, affirmed by the Commission, stated that "Respondent shall authorize the medical treatment recommended by Petitioner's treating physicians, including the L5/S1 fusion and the associated medical treatment therewith." (Rx3).

On 7/24/12, Dr. Kennedy changed his surgical recommendation to include a three level fusion from L3 to S1, and attributed the need for this surgery to the 3/17/11 work injury as well. (Px2; Rx13). His report did not specify a reason for the change, but Petitioner had a September 2011 CT myelogram that previously demonstrated multi-level abnormalities. (Px2; Rx12). However, at his March 2012 deposition he stated these imaging studies showed a herniated disc at L5/S1 and not much of anything at the other levels. (Rx12 & 13).

On 8/29/12, Petitioner underwent a repeat CT myelogram, and the radiologist noted degenerative disc disease with disc space narrowing and osteophytes from L3 to S1, with foraminal and spinal canal stenosis, findings indicated as not significantly changed from the previous 9/12/11 study. X-rays from the same date also indicated degenerative changes from L3 to S1, most prominent at L3/4. (Px4).

On 11/9/12, Petitioner underwent posterior L3 to S1 laminectomy and fusion surgery, and Dr. Kennedy's post-operative diagnosis was spinal stenosis from L3 to S1. (Px3). This surgery took place while the Respondent's appeal of the prior Section 19(b) Decision was pending.

Petitioner testified she continued to have post-surgical pain at the surgical site and was referred to pain management with the Drs. Feinberg, Barry and Rachel, for low back pain and specifically pain in the lower right quadrant into the right thigh. Petitioner testified she believed this was due to sciatica, noting the pain has since radiated into the bilateral legs, right greater than left, though this varies.

On 12/18/13, Petitioner reported ongoing ache and a feeling that her leg would give out. She was unable to use a bone stimulator due to having a pacemaker. On 1/31/13, Dr. Kennedy recommended Petitioner undergo physical therapy with chiropractor Dr. Mark Eavenson, and she remained off work through 3/21/13. X-rays obtained on this date noted stable alignment but a possible screw fracture at S1, though Dr. Kennedy noted the films were satisfactory with good bone formation. (Px2 & 4). Dr. Mark Eavenson and Dr. Ashley Eavenson are chiropractors at Multicare Specialists. Dr. Kennedy testified on 9/7/16 that he did not refer Petitioner to Dr. Mark Eavenson's office for chiropractic treatment but for physical therapy since Dr. Eavenson had a physical therapist in his office, Corey Voss. Dr. Kennedy also confirmed that he referred Petitioner to Dr. Ashley Eavenson for physical therapy and not chiropractic treatment. (Px7).

On 2/4/13, Petitioner began physical therapy with Corey Voss. Voss administered the physical therapy for Petitioner's low back and Dr. Mark Eavenson and Dr. Ashley Eavenson provided examinations until December of 2013. (Px10). At the hearing, Petitioner confirmed that Dr. Mark Eavenson did not provide any physical therapy services to her, but that Dr. Ashley Eavenson assisted in her physical therapy, and that Mark Eavenson examined her at each therapy visit. However, Petitioner confirmed that Physical Therapist Voss was her physical therapist for her low back. It is unclear if any chiropractic services were performed. The prescription notes of Dr. Kennedy state "modalities per therapist discretion."

Petitioner began receiving medical treatment, including physical therapy, for her right knee in February of 2013, and it appears lumbar therapy was put on hold. On 3/26/13, Dr. Kennedy noted Petitioner had undergone a right knee CT scan, and complained her left knee felt like it was going to go out on her three times. This was an odd note in that it discussed treatment directed to the knee but also that Petitioner was reporting aching pain from

her back radiating into the right knee. On 5/1/13, Petitioner underwent arthroscopic surgery on her right knee for a complex medical meniscus tear (Rx14), followed by physical therapy for her right knee starting on 6/6/13. (Px10).

On 5/7/13, Sejal Patel, a Nurse Practitioner (NP) in Dr. Kennedy's office, recommended that Petitioner resume physical therapy for her low back. The notes indicate Petitioner was taking oxycodone and hydrocodone. X-rays taken on that date revealed no lucency around the fusion site. Petitioner was held off work through 6/20/13. (Px2; Px4). On 6/20/13, Dr. Kennedy noted Petitioner "had an aggravation of her back pain when her knee was elevated and following arthroscopic surgery," and that: "There definitely was additional aggravation of her back by virtue of altered gait due to her knee pain." She had improvement, however, with right SI injections and therapy. Dr. Kennedy noted CT scanning showed a solid fusion. Therapy and off work were continued through 8/6/13. On 8/6/13, Petitioner reported a lot of left-sided SI joint inflammation and difficulty with push/pulling and standing. Left SI injection and continued therapy were prescribed, and NP Patel allowed Petitioner to return to modified work as of 8/12/13. Respondent was able to accommodate the restrictions, and Petitioner testified she returned to work at that time. (Px2; Rx13).

On 8/15/13, Petitioner underwent bilateral SI joint injections at Frontenac Surgery and Spine Care with Dr. Feinberg, noting she had last been there in August 2011. Petitioner reported treating with Dr. Eavenson with therapy and injections with Dr. Blake at Dr. Eavenson's offices. (Px5). Petitioner agreed she initially had a few pain management visits with Dr. Blake in May 2013 before changing to Dr. Feinberg, testifying she remembered having a "bad experience" with Blake, and that they had "basically different points of view."

On 9/19/13, Dr. Kennedy noted Petitioner reported only slight improvement since her surgery. She had intermittent right foot numbness. She also felt that physical therapy was not helping her, so Dr. Kennedy discontinued therapy and advised her to perform exercises as tolerated. Light duty was continued. (Px2). On 10/29/13, Petitioner reported her insurance would not cover the injections, but she would still be seeing Dr. Feinberg for them. She reported ongoing pain, particularly with prolonged standing, noting she was working 8 hour days as a teacher and she felt fatigued after work. She had resumed Vicodin. She was to continue restricted duty and complete her treatment with Dr. Feinberg. (Px2). On 11/4/13, Petitioner underwent bilateral SI joint injections. Before these injections, Petitioner complained of low back pain radiating down both of her legs. On 11/21/13, Petitioner underwent bilateral sacroiliac injections. On 12/4/13, Petitioner underwent a right SI joint injection. (Px5).

On 12/17/13, Petitioner reported short term relief with Dr. Feinberg's injections. The diagnosis of Dr. Kennedy was chronic strain. On 12/23/13, Petitioner underwent bilateral SI joint injections. (Px5). Before these injections, Petitioner stated that her pain was the same as it was before the surgery in November of 2012, but that her mobility was better. (Px5).

Petitioner followed up with Physical Therapist Voss for her low back on 12/23/13, which appears to have been her last session of physical therapy. (Px10). On the same date, Dr. Mark Eavenson also treated her for neck pain, right upper extremity pain, and right shoulder pain and provided chiropractic manipulation of Petitioner's SI joints. (Px10).

On 1/27/14, Petitioner underwent bilateral SI joint injections with Dr. Feinberg. (Px5).

On 2/4/14, Petitioner reported "facet" injections provided temporary relief, and that Dr. Feinberg wanted to try radiofrequency ablation (RFA), which Dr. Kennedy agreed with along with continuing work restrictions. (Px2). On 3/28/14, Petitioner underwent ablation of her sacroiliac joints. Before this treatment, Petitioner complained

of low back pain that radiated into her bilateral buttock and down her bilateral posterior thighs to the back of her knees. (Px5).

On 4/1/14, NP Patel examined Petitioner, noting a Section 12 examiner supported her treatment to date. She still complained of increased gluteal pain with radiating symptoms down her left leg into her calf and down her right leg to the knee. Patel renewed Petitioner's prescriptions of Tramadol and Norco. However, Patel stated that a spinal stimulator was contraindicated because of Petitioner's pacemaker. (Px2).

On 5/5/14, Petitioner followed up with Dr. Irl of Rheumatology and Internal Medicine Associates. Petitioner reported that her fibromyalgia was getting worse, and Dr. Irl recommended that she continue taking Lyrica and prescribed Amitriptyline for her fibromyalgia. (Rx8).

On 5/20/14, Petitioner complained of increased pain with standing or sitting for over 5 minutes, improved with changing positions. She reported previously being placed on medications for fibromyalgia. Petitioner reported the inability to sit was a *new* symptom since undergoing RFA. Lumbar facet joint injections were performed bilaterally at L5/S1. (Px5).

Dr. Kennedy last examined Petitioner on 6/3/14. His report noted that Petitioner had no "net" improvement with injections or ablation, and he opined Petitioner had reached maximum medical improvement. Petitioner continued to complain of low back pain and difficulty with standing or sitting for more than a few minutes. He stated Petitioner needed access to Norco and Gabapentin for her low back. Dr. Kennedy also provided the following permanent restrictions: 1. No lifting over 10 pounds; 2. No prolonged standing more than 15 minutes; and 3. Access to a chair for recess and PE periods. Respondent accommodated these work restrictions. On 7/15/14, Dr. Kennedy issued an addendum to this note, stating that Petitioner needed ongoing pain management, including injections, medications and RFA. (Px2).

Petitioner then returned to Dr. Feinberg, complaining of ongoing back pain that radiated down her right thigh into her knee, and on 10/17/14 RFA was again performed, bilaterally at L4, L5, and S1. She reported taking pain medication before bed, but often waking up at 4 a.m. and having to take more. She also was prescribed hydrocodone. On 5/13/15, Dr. Feinberg performed a right epidural steroid injection at L5/S1. Before the injection, Petitioner complained of right buttock pain and right leg pain, and reported that she had improvement with the last procedure but had thereafter worsened. On 6/1/15, Dr. Feinberg indicated Petitioner noted 75% improvement with the last epidural, but a separate portion of the same report notes she had "at least" 35-40% improvement. She received an epidural injection at L5/S1 and a left psoas compartment block. On 7/21/15, Petitioner underwent bilateral SI joint injections. She complained of low back pain and bilateral leg pain before the injections, and indicated she said she receives only one day of relief after receiving injections. (Px5).

On 11/30/16, Dr. Rachel Feinberg examined Petitioner for medication management. Petitioner complained of "increasing right low back pain into right buttock, right lateral/anterior thigh, into calf and foot." Petitioner reported taking less of her Lyrica for her fibromyalgia since she believed she was doing better, and Dr. Feinberg advised her to take her regular dose. She returned on 12/5/16 with complaints of right low back pain down her right leg. Dr. Feinberg administered a left psoas compartment block of the lumbar plexus. On 3/9/17, Petitioner followed up with Dr. Rachel Feinberg for medication management. Petitioner gave a history of 90% relief of her symptoms following the psoas injection. Dr. Feinberg also noted that she had increased functional capacity. (Px6). At the hearing, Petitioner testified that this injection provided her with approximately 30% to 60% relief. As of the last visit with Dr. Feinberg on 4/10/17, it appears that Feinberg was handling Petitioner's medication management, which included hydrocodone. It also appears that Petitioner was being seen essentially on a monthly basis between 11/30/16 and 4/10/17. (Px6)

Dr. Kennedy, a board certified neurosurgeon, was initially deposed prior to the Section 19(b) hearing. Dr. Kennedy reviewed Petitioner's lumbar CT scan from 2011 and testified this demonstrated "quite a bit of disc space collapse at L5/S1 with foraminal encroachment on both sides in addition to a disc bulge which was further narrowing the foramen at L5/S1 bilaterally." Dr. Kennedy opined that Petitioner's myelogram study from September of 2011 showed a disc herniation impacting both the right and left nerve roots at L5/S1. Dr. Kennedy's review of 2011 CT/myelogram scans did not show "much of anything at L3/4", and he did not believe that Petitioner's pain was being generated by the L3/4 segments. Dr. Kennedy opined that Petitioner's low back pain and nerve root compression seen on the myelogram study were causally related to the 3/17/11 work accident. At that time, Dr. Kennedy recommended an L5/S1 fusion surgery on Petitioner. On cross-examination, Dr. Kennedy testified that he did not believe Petitioner's degenerative changes from her lumbar CT scan in August of 2011 were caused by the work accident. Dr. Kennedy confirmed the narrowing at L3/4 was degenerative disc disease. (Rx12).

Dr. Kennedy was again deposed on 9/7/16. He agreed that he had recommended an L5/S1 fusion surgery in September of 2011 but later performed a three-level fusion surgery from L3 to S1 in November of 2012. He testified the original L5/S1 fusion surgery was recommended based on the 2011 lumbar myelogram, but following a repeat study in August of 2012, Dr. Kennedy testified that "things evolved", and opined that Petitioner's discs at L5/S1, L4/5, and L3/4 were significantly abnormal. The radiologist who performed the study reported that the 2012 lumbar myelogram study was not significantly changed from the 2011 lumbar myelogram study. Dr. Kennedy testified that all three discs could have been contributing to Petitioner's symptoms. There was nerve compression at L3/4 and to a lesser degree at L4/5, as well as scoliosis. He felt the single level surgery would rapidly deteriorate the L4/5 level, especially given the scoliosis. Dr. Kennedy also felt that if he only fused Petitioner's L5-S1 level, then Petitioner would have deterioration of the adjacent segments, so he performed a more definitive procedure. (Px7).

As to Petitioner's recovery following the three-level fusion surgery, Dr. Kennedy testified Petitioner had an ongoing issue with back pain but her leg pain was largely improved. He opined that Petitioner had reached MMI as of 6/3/14. Dr. Kennedy believed Petitioner needed additional treatment after he released her from care on 6/3/14 since it keeps her symptoms under control, but testified that he would defer to the treating pain specialist, Dr. Feinberg, for the types of pain control. (Px7).

On cross-examination, as to what changed his recommendation for Petitioner's surgery to a three-level fusion, Dr. Kennedy testified the lumbar myelogram study from August of 2012 showed more prominent abnormalities than the September 2011 films, and that Petitioner's other levels may have been symptomatic, and Petitioner had some scoliosis present. Dr. Kennedy did confirm that he was aware that Petitioner had some scoliosis present before his 3/28/12 deposition, and was previously aware of abnormalities at L3/4, but felt they were more prominent after the 2012 myelogram. Dr. Kennedy then confirmed that he indicated he changed the planned surgery to a three level fusion on 7/24/12, which was prior to the repeat lumbar myelogram of 8/29/12. Dr. Kennedy could not state that anything had structurally changed in Petitioner's lumbar spine between the March 2012 and July 2012 surgical recommendations. Dr. Kennedy testified that the delay in Petitioner undergoing the lumbar surgery had nothing to do with him performing Petitioner's three-level fusion surgery from L3 to S1. (Px7).

Dr. Kennedy testified on cross exam that he could not be sure whether all three surgical levels were related to the accident, but that L5/S1 definitely was and that L3 to L5 may have been symptomatic all along as well. On redirect, he testified that the surgery itself is related to the accident, and that all of the levels could have been aggravated by the accident. Dr. Kennedy opined that Petitioner's three-level fusion surgery from L3 to S1

largely resolved Petitioner's radiculopathy, but agreed he hadn't seen or reviewed any of Petitioner's medical records since 2014, and didn't know whether she reported ongoing radicular pain down both of her legs. Dr. Kennedy testified that he referred Petitioner to Multicare Specialists for physical therapy on 1/31/13 with their therapist, and did not refer her there for chiropractic treatment. With regard to the additional note in July 2014 which added a pain management recommendation, Dr. Kennedy testified someone may have contacted him to do so, he could not recall for sure. (Px7).

Dr. Barry Feinberg was deposed on 1/26/16. Dr. Feinberg is a board certified physician in anesthesiology and pain management. Dr. Feinberg began treating Petitioner in August of 2011. Dr. Feinberg testified that Petitioner's complaints when he first saw her on 8/8/11 were low back pain and right leg pain. Dr. Feinberg confirmed that she essentially had these same complaints, in addition to left leg symptoms, following the three-level fusion surgery. He believed the ongoing problems were due to scar tissue, incomplete fusion or mechanical sequelae due to limited range of motion, in Petitioner's case the SI joints. Dr. Feinberg administered injections in 2011 and believed the source of Petitioner's pain was at her L5/S1 segments. Dr. Feinberg testified that Petitioner still needs medication management, occasional injections since she has continued complaints of pain, primarily in the SI joints, and RFA every 6 to 12 months. He testified that the need for this ongoing pain management is due to Petitioner's three-level fusion surgery from November of 2012. (Rx8).

Respondent's expert, board certified orthopedic surgeon Dr. Frank Petkovich, was deposed on 3/28/16. Dr. Petkovich examined the Petitioner on 12/6/11 and 2/19/14. Following the initial exam, Dr. Petkovich opined that a fusion surgery at L5/S1 was reasonable and necessary for Petitioner's lumbar spine condition. Following the repeat examination, Dr. Petkovich did not feel the Petitioner had reached maximum medical improvement following her November 2012 surgery. He testified that Petitioner's three-level fusion surgery from L3 to S1 was not reasonable and necessary for her 3/17/11 work accident. Dr. Petkovich testified that the work accident did not exacerbate, aggravate or accelerate the degenerative changes higher up Petitioner's spine at the L3/4 or L4/5 segments. Dr. Petkovich believed the Petitioner had reached maximum medical improvement as of 7/28/14 and did not need any further medical treatment for her low back. (Rx2).

Petitioner believes that the three-level fusion surgery she underwent on 11/9/12 helped her mobility, but did not really help her pain. She testified that she still has radiating symptoms down to her knees but predominantly on the right side. Petitioner testified that she takes several medications, but only takes Hydrocodone for her low back issues. She noted her permanent work restrictions from Dr. Kennedy of no prolonged standing more than 15 minutes and access to a chair at PE and recess, which Respondent accommodated and which she worked within, but that she was not currently working for Respondent for reasons unrelated to her low back injury.

Petitioner continues in pain management with Drs. Barry and Rachel Feinberg. She takes hydrocodone every 6 hours. Injections have been recommended, but the Respondent has denied authorization. She has been able to obtain her medications and some injections through her private insurance.

Petitioner testified she can no longer take care of her home, including vacuuming, cleaning the bathtub and using stairs to do laundry. She cannot walk long distances without a walking aid. When she shops, she uses a cart for support. Standing becomes painful after a short time. Monitoring kids before school for about 50 minutes is part of her job. She has difficulty getting up and down from the floor. She doesn't take any other medications for back pain.

On cross exam, Petitioner acknowledged some preexisting low back issues going back to her mid to late twenties (late 1980's), but testified it was not a chronic problem. She denied any prior injuries involving her back. Her symptoms would come out of nowhere, she would get a week or two of chiropractic treatment or one

injection, and it would resolve for long periods of time. She agreed she had undergone lumbar injections with Dr. Graham, and chiropractic treatment with Dr. Eavenson back to at least 1997 prior to the accident. She was also taking tramadol prior to the accident for her back and for fibromyalgia and continued to take it after the accident, but she believed it was Dr. Feinberg who advised not to take both hydrocodone and tramadol.

Petitioner agreed she was takin the following medications at the time of her prior 3/17/11 testimony, and continues to do so, except the Tramadol: Tramadol, Lisinopril, Metformin, Entocort, Citalopram, or Celexa, Levothyroxine, Metoprolol and Lyrica. Dr. Feinberg prescribed the Hydrocodone following the surgery.

With regard to the surgery, the Petitioner's recall is that Dr. Kennedy may have discussed specifics with her regarding the lumbar levels that would be addressed, but she has limited knowledge of the spine, and she told him that he should do whatever he felt she needed.

The 11/9/12 surgery did help her mobility, but it didn't really relieve her pain. After the accident she had stiffness and an inability to bend over or to the side. Surgery also helped relieve her radiating pain to some degree, as the pain now only radiates to the thigh/knee and not below that level. It is bilateral, but predominantly the right. The Petitioner testified she did not recall whether she had left leg symptoms before the surgery or not. She noted that at some point, she wasn't improving with therapy and reported continued back pain into the legs, and that's when Dr. Kennedy referred her to Dr. Feinberg.

Petitioner denied having any post-surgical chiropractic treatment, but agreed chiropractor Dr. Eavenson did provide electrical and ultrasound type treatment after the surgery. She saw him every time she went in for physical therapy, and he would examine her for range of motion, gait, etc. She testified: "Dr. Ashley (Eavenson) worked with me in the physical therapy part. You know, Corey (Voss) would do the stretching but Dr. Ashley (Eavenson) actually worked with me in the physical therapy and she would have me walk and check my gait, you know, and then I would go into the exam room and I would see Dr. (Mark) Eavenson." So while Corey Voss was the physical therapist, Dr. Ashley Eavenson would participate in the therapy and would also examine Petitioner, after which she would be examined by Dr. Mark Eavenson.

Petitioner agreed she started to treat for her right knee with Dr. Choi in February 2013, and underwent arthroscopic surgery in May 2013. She had undergone left knee ACL and meniscus surgery in 2002 following a volleyball injury. Petitioner agreed with Dr. Kennedy's 6/20/13 report indicating her back pain was aggravated following right knee surgery due to an altered gait.

With regard to whether she told Dr. Petkovich that she wished she wouldn't have undergone her fusion surgery, Petitioner testified: "I don't believe I would have said that I wished I had not. I might have said that I wasn't sure that -- you know, looking back because of the fact that it -- you know, I still was in pain that I was questioning whether that was something I should have done." The Petitioner was aware Dr. Kennedy referred her to pain management, but not whether it was via a 7/15/14 addendum to his original 6/3/14 report.

Petitioner testified she last treated with rheumatologist Dr. Irl for fibromyalgia in 2014. She has treated for fibromyalgia since before they identified it, and continues to take Lyrica for it.

Petitioner testified she has times of being pain free as long as she is taking Hydrocodone, stating the drug is always in her system. She has improved since she stopped working, as her activities are minimal. Petitioner agreed her last injection was to the psoas on 12/5/16, which did provide her with pain relief.

Petitioner received TTD benefits for the period from 5/16/12 to 8/11/13. (Rx1). Respondent's group health carrier paid $45,982.95 in medical benefits for Petitioner's low back treatment. (Rx15). Petitioner is claiming unpaid medical bills in the amount of $16,220.78 from Multicare Specialists, $378.00 from Missouri Baptist Medical Center, $27,708.00 from Frontenac Surgery and Spine Care, $17,045.00 from Dr. David Kennedy, and $537.13 from Gateway Pain Center. (Px9).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (E), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, and WITH RESPECT TO WHETHER THE SURGERY PERFORMED BY DR. KENNEDY IS REASONABLE ANDNECESSARY, THE ARBITRATOR FINDS AS FOLLOWS:

The key issue in this hearing, as noted above, is whether the three level fusion surgery performed by Dr. Kennedy is both causally related to the 3/17/11 accident, and whether it was reasonable and necessary treatment. The Arbitrator finds that the preponderance of the evidence supports that the surgery is causally related to the 3/17/11 accident, and that it was reasonable and necessary treatment under the circumstances of this case.

From the Arbitrator's perspective, the Petitioner's lumbar condition prior to her surgery with Dr. Kennedy has been previously determined to be causally related to the work accident based on a prior decision. Thus, the only issue regarding causation is whether the added surgical levels are causally related to the accident, and whether adding those levels to surgery somehow terminated such causal connection relationship. The Arbitrator finds, for the reasons indicated below, that the surgery performed by Dr. Kennedy on 11/9/12 is causally related to the accident, and that the addition of those levels did not terminate the causal connection of the Petitioner's lumbar condition to the 3/17/11 accident.

Dr. Kennedy's testimony was brought into question by the Respondent with regard to the basis for his determination to modify his surgical recommendation. While he testified this was based on his review of an August 2012 repeat lumbar myelogram, he acknowledged that his 7/24/12 note indicated he had already made this modified recommendation prior to the repeat myelogram being performed. This in itself raises a reasonable dispute by the Respondent with regard to the issue of the relationship and necessity of the L3 to S1 fusion.

At the same time, the Arbitrator believes that the diagnostic findings in the lumbar spine prior to the last hearing date indicates that there were significant problems at all three operative levels, L3/4, L4/5 and L5/S1. While much of these appear to be degenerative, this would include the L5/S1 level which the prior decision indicated was causally related to the accident. Dr. Kennedy credibly testified that it was possible that the L3/4 and L4/5 discs were not injured at the time of the accident, but also that her symptoms could have been related to all three levels all along. The fact that the conditions at L3/4 and L4/5 may have involved significant degenerative findings does not mean that those degenerative conditions were not aggravated by the accident. Again, it appears that the prior Arbitrator, following review of evidence which included the opinions of Dr. Kennedy and Dr. Petkovich, determined that the L5/S1 condition was caused or aggravated by the accident.

There is often no exact science with regard to the determination of which spinal levels may require treatment. Whether a spinal level is a specific pain generator or not does not always dictate a surgical plan. The Arbitrator has reviewed many medical depositions which indicate that a fusion can provide additional stress to adjacent non-fused levels, and if those levels are already weak enough, an adjacent level may also wisely be fused. Therefore, the Arbitrator does not believe that whether a spinal level is a pain generator is the "be all, end all"

for whether a surgery may be recommended. The Arbitrator recognizes that the Respondent has a fair argument that Dr. Kennedy's recommendation changed without any apparent significant difference in the information he relied on in initially recommending L5/S1 fusion. However, his testimony that, upon further review, he felt it was a better choice to fuse three levels is reasonable in the Arbitrator's view. This is regardless of the fact that Dr. Kennedy attempted to bolster his opinion by citing to a myelogram that occurred after he had already changed his mind. Again, while that does call his opinion into question to some degree, the Arbitrator believes that the greater weight of all of the evidence in this case still indicates that this determination was reasonable.

While the law cited in the *Weyer* case by Respondent is accurate, the factual circumstances in that case differ from the case at bar. In *Weyer*, a shoulder condition had originally been determined to be causally related to a work accident via a 19(b) hearing, and then in a subsequent hearing was determined, including a newly diagnosed SLAP tear, to no longer be causally related to the accident. Here, there is no real distinct difference between the Petitioner pre and post hearing conditions, and there was no gap in the period of time where the claimant's low back condition related to the accident resolved and causation ended. The L5/S1 surgery has already been determined to be reasonable and necessary by the prior Arbitrator. Ultimately, the evidence would support both Dr. Kennedy's initial and revised recommendations. The Arbitrator here sees no significant difference between this case and a case where an initial L5/S1 fusion surgery is performed, there are ongoing symptoms, and a second surgery is done which adds to that fusion level.

The Petitioner is a difficult patient in that she had a preexisting lumbar condition, as well as a prior fibromyalgia diagnosis. Thus, her pain complaints appear to be more difficult to parse out than the typical back patient. The Arbitrator must assume that Dr. Kennedy is fulfilling his vow to do no harm, and would not have added the additional lumbar levels to his surgical determination unless he believed it was the right thing to do by the time he made that determination. Nothing stopped him from recommending the three-level fusion prior to the last hearing date. While it appears nothing significant changed between the 2011 and 2012 myelogram studies, it is also reasonable in the Arbitrator's mind for Dr. Kennedy to have given the surgery more thought, decided to add the other two levels to the fusion, and then determined that this was supported by the August 2012 myelogram. At a minimum, Dr. Petkovich agreed that the L5/S1 surgery was reasonable. That another surgeon may differ in terms of the ultimate procedure performed, this does not take away from the fact that both the treating and examining physicians at least agreed that a lumbar surgery was reasonable and necessary.

Overall, the Arbitrator finds that the greater weight of the evidence supports the determination that the L3 to S1 fusion performed by Dr. Kennedy was reasonable and necessary, and was causally related to the 3/17/11 accident.

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

The Arbitrator, for the reasons noted above, finds that the following medical expenses are causally related to the accident and involve the reasonable and necessary treatment of the Petitioner, with one caveat noted below:

Multicare Specialists: $16,220.78
Missouri Baptist Medical Center: $378.00
Frontenac Surgery and Spine Care: $27,708.00
Dr. Kennedy: $17,045.00
Gateway Pain Center: $537.13

Notwithstanding the noted awarded expenses, any of these expenses which are based on examinations of the Petitioner by Dr. Mark Eavenson following the Petitioner's November 2012 surgery are denied. Dr. Kennedy's testimony makes clear that the Petitioner was referred to that facility for purposes of physical therapy with Corey Voss. Additionally, there are some records of chiropractic treatment being performed by Eavenson, which included unrelated neck and arm conditions. There was no recommendation for chiropractic care, nor for repeated examinations of the Petitioner at each visit. The Arbitrator finds these examinations and chiropractic treatment, and the costs associated with them, are excessive and not reasonable and necessary pursuant to Section 8(a), and the expenses related to them are specifically denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner was temporarily totally disabled from 5/16/12 through 8/11/13. This period covers the time from the day after the prior Section 19(b) hearing date through the day before the Petitioner returned to work with the Respondent pursuant to the release from Dr. Kennedy's office.

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

As the Petitioner's accident occurred prior to 9/1/11, §8.1b of the Act is not applicable to this case.

The Petitioner has undergone a three level fusion from L3 to S1. Despite this, she continues to have significant ongoing pain complaints. This includes her back as well as her legs. While the Arbitrator believes the Petitioner's complaints are significant, it also appears that there may be some interrelationship with fibromyalgia, as well as a right knee condition that she ended up having surgery for during the recovery from the noted lumbar fusion. Thus her pain picture is rather complicated, and the back surgery appears to be a portion, though a significant portion, of those ongoing complaints.

The Petitioner also has permanent work restrictions which include a 10 pound weight restriction and no prolonged standing. The Respondent has been able to accommodate the restrictions.

There is some level of question in the Arbitrator's mind with regard to Petitioner's ongoing complaints, as it appears that neither the surgery nor much of the pain management treatment provides significant lasting benefit. Yet, the Petitioner appears to remain relatively functional, at least with her job prior to going off work for unrelated reasons.

Based on the above factors, the record taken as a whole and a review of prior Commission awards involving similar injuries and outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 37.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dawn Wuorinen,

Petitioner,

vs. NO: 13 WC 32427

XPAC,

Respondent.

18IWCC0755

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On May 22, 2013, Petitioner had worked for Respondent for 2 years. She was hired as a Packer. She received three promotions during her time working for Respondent. Her duties included gathering small John Deere parts as well as parts weighing up to 50 pounds, examining them than determining if they should be re-packed, left the same, or disposed of.

2. On the date in question Petitioner worked the 4a.m. to 2:30p.m. shift. At around 2p.m. she was told to make sure everything was on her roller, which allowed her to roll her boxes of products on top of a metal stand. The boxes could weigh between 500 and 2000 pounds. The roller was waist high to Petitioner. Petitioner had completed her

shift and had finished cleaning her area when she noticed one box on her roller was not on correctly. She forcefully attempted to push it into place with her hand when she heard her right-hand pop and felt a little pain at the base of her thumb.

3. Petitioner immediately looked for her supervisor, but he was in a meeting. She spoke with a coworker and told her what had happened, then went home. At the time she thought maybe she had just suffered a sprain or had just jammed her hand. Once at home she took some Tylenol and Ibuprofen and rested. Her mattress was on the floor and she was asleep with her hand out when her 21-year old son came in and hit her on her side. Petitioner jumped and rolled over to push him off her leg.

4. The next morning Petitioner was disrobing to take a shower and noticed extreme hand pain and swelling. She went straight to the emergency room (ER). She called Respondent's office and left a voicemail that she was heading to the hospital due to a work injury. Petitioner was unable to write for herself, so the hospital completed the injury history form on her behalf. She did not see that the physicians documented that her injury occurred while wrestling her son at home. Had she reviewed these records, she would have corrected them.

5. Petitioner was referred to Dr. Hussain who reviewed her ER x-rays, diagnosed a broken hand, and opined that surgery was a possibility. However, Dr. Hussain did not believe Petitioner's reported mechanism of injury and consistently questioned her about "what really happened." After multiple questions, which eventually led to tears being shed by Petitioner, she just relented and agreed with Dr. Hussain's mechanism of injury of falling at home.

6. Petitioner was placed in a stable cast and told to call Iowa City to make an appointment. She then took her limited duty restrictions to Respondent, which were accommodated. Respondent asked her to label boxes with her left hand.

7. Petitioner was scheduled to treat in Iowa City June 4, 2013 with Dr. Lawler. On that day her supervisor called her into the office and terminated her for falsifying information. They told her that she lied about how she injured her hand.

8. Petitioner's final performance review occurred one day before she was terminated. Her review indicated she was doing a really good job and that she was about to receive a promotion.

9. Later that day Petitioner treated at Iowa City with Dr. Lawler's Physician's Assistant (P.A.). She informed the assistant of how she injured her hand at work. X-rays revealed a fracture at the base of Petitioner's thumb. Dr. Lawler later reviewed the findings with her P.A. and opined that the work accident, especially if it was an axial load type injury, would fit the mechanism of injury. Surgery was recommended and performed two days later on June 6, 2013. Petitioner was diagnosed with a Bennett fracture post-op. She had three screws placed in her hand, was taken off work, placed in an arm cast and sling and given pain medication.

10. Dr. Lawler stated that feeling immediate pain was consistent with a Bennet fracture. Dr. Lawler noted that the *History of Present Illness* section of the ER records indicated that Petitioner felt a pop at the base of her thumb while at work at the time of accident and had immediate pain. This is consistent with what Petitioner told Dr. Lawler's P.A.

11. Dr. Lawler stated that a Bennet fracture is not typically caused by horseplay or tickling. She opined that Petitioner did suffer her injury at work. She stated that a punching motion which leads to a subluxation of the thumb could cause a Bennett fracture. This being consistent with Petitioner's mechanism of injury, Dr. Lawler opined that Petitioner did indeed suffer her injury at work.

12. Petitioner was released to work after physical therapy on August 1, 2013. She applied for unemployment and then embarked on a job search. After 6 months she found employment as a Telemarketer.

13. Currently Petitioner has difficulty pushing, vacuuming, twisting things, gripping and pushing down with her right hand. She is not currently employed but is looking.

The Commission affirms the Arbitrator's rulings on accident, causal connection, temporary total disability benefits and permanent partial disability benefits. However, the Commission modifies the award for medical expenses.

The Commission notes that it is stipulated that a breast ultrasound bill of $114.00 should not be included in the medical expenses award. Accordingly, this amount shall be subtracted from the medical expenses award of $16,733.87, leaving a total award of $16,619.87. The Commission also notes that Respondent shall receive credit for any medical bills paid to date.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner did suffer an accident arising out of and in the course of her employment with Respondent, and that her current condition of ill-being is causally connected to said accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $272.73 per week for a period of 9 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 $245.46 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 her right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $16,619.87 for medical expenses under §8(a) of the Act.

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

18IWCC0755

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,300.00. 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: DEC 10 2018
O: 10/11/18
DLG/wde
45

David L. Gore

Stephen Mathis

DISSENT

I respectfully dissent from the Decision of the majority. Following the successful surgical repair of Petitioner's right hand Bennett fracture, she was released back to full duty work effective August 2, 2013. Although Petitioner was looking for employment at the time of arbitration, there was no direct evidence that she suffered a loss of future earning capacity as a result of her injury. The treatment records also do not contain enough evidence of disability to justify the permanency award of 10% of the right hand. Petitioner has not required further treatment for her injury since 2013.

In analyzing these factors, as well as the record in its entirety, I would have found Petitioner established permanent partial disability of 5% loss of use of the right hand and modified the award accordingly. For the reasons stated above, I respectfully dissent from the Decision of the majority.

DLS/met
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WUORINEN, DAWN
Employee/Petitioner

Case# **13WC032427**

XPAC
Employer/Respondent

18IWCC0755

On 12/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

1060 CHRISTINE A KEYS PC
224 18TH ST
SUITE 300
ROCK ISLAND, IL 61201

0507 RUSIN & MACIOROWSKI LTD
JIGAR DESAI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

Dawn Wuorinen
Employee/Petitioner

v.

XPAC
Employer/Respondent

Case # **13** WC **32427**

Consolidated cases: **N/A**

18IWCC0755

An *Application for Adjustment 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 **4/5/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/22/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,273.20**; the average weekly wage was **$409.10**.

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

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$16,733.87**, as set forth in Petitioner's exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$272.73**/week for **9** weeks, commencing **5/30/13** through **8/1/13**, 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 **$245.46**/week for a further period of **20.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the right hand.**

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

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

12/6/17
Date

ICArbDec p. 2

FINDINGS OF FACT

On May 22, 2013 Petitioner was at her job station on a conveyor system. The system consisted of a series of rollers on which large boxes were placed. The rollers were at the approximate level of Petitioner's mid abdomen. Near the end of her shift a box had gotten hung up and would not move on the rollers. Petitioner described the box which had gotten stuck as a coffin box approximately 5 feet long and weighing about 100 pounds. Petitioner shoved on the box several times being unable to move it squarely onto the rollers. When attempts so push the box into place failed she tried to move it by striking the box with the palms of her hands in a jarring fashion like "punching the box with the palm of my hand." While doing so, she heard a pop and felt pain in her right hand. Petitioner demonstrated the exact location on the palm side of her right hand at the base of her thumb, where she felt the impact, the pop, and the pain.

Petitioner testified that she attempted to track down her supervisor, Nate, in order to report the accident, but was not able to locate him on the day of her injury. She later spoke to him and learned he had been in a meeting on the day of her accident. Petitioner's testimony in this regard is unrefuted. She then went home thinking she sprained or strained her hand. After she arrived home, she took Tylenol and fell asleep.

She testified that later that evening, after she was startled and awoken by her 22 year-old son, she rolled over on her mattress and realized how badly her right hand was hurting. Petitioner told her son to leave her alone, took some more Tylenol, and went back to sleep. Petitioner's son was not able to testify as he was picking up Petitioner's sister from the hospital in Chicago.

The Arbitrator found the Petitioner's testimony forthright and credible in all regards.

Upon waking in the morning, Petitioner noticed how swollen her hand had become overnight and while unsuccessfully attempting to take a shower for work, realized she needed medical attention. On May 23, 2013, Petitioner went to Genesis East Emergency room on May 23, 2013. She went early in the morning. Petitioner could not write as she is right hand dominant and the hospital personnel had to complete the intake information for her. The History of Present Illness in the hospital records specifically recounts the work accident. Petitioner advised the hospital personnel, almost verbatim to her testimony, the facts surrounding her work-related injury. Petitioner advised: she had right hand pain from the day before; that "she felt a pop at the base of her thumb while at work yesterday and had mild pain at that point. Last night the pain became worse while wrestling with her son last night. . . She took 800 mg IBU last night. . . . The location where the incident occurred was at work." (PX 1, p.1) It is not lost on the Arbitrator that the X Ray report from that date lists the history as "wrestling injury." However, the Arbitrator finds this history was simply the result of hospital personnel condensing the initial history Petitioner had provided. Petitioner was advised she needed an orthopedic consultation.

Between the emergency room visit and the orthopedic consultation, Petitioner advised her employer of the work accident and the medical appointment.

Petitioner was referred to Orthopedic & Rheumatology Associates (hereinafter ORA) for a surgical consult. That visit occurred May 24, 2013, with Dr. Suleman Hussain. Again, Petitioner was assisted with the intake process by ORA personnel as she was still not able to use her right hand to write. The question asking

when her problem started and what was the date? was completed with: "5-22-13 @ work" (PX 2). When asked "If there was a specific injury, please describe what happened was completed with the following narrative: "wed @work about 2:30 pm, was pushing a heavy roller and felt a pop and pain @ R thumb. went GE Thursday am, x-rays done. placed in splint for R thumb fx. Norco given. f/u [with] ortho." Id.

Petitioner testified that she gave the same narrative history to Dr. Hussain, however the doctor repeatedly asked Petitioner when she fell. Petitioner testified that after she denied falling several times, she sarcastically responded "whatever." The Arbitrator notes that according to his own report, Dr. Hussain engaged in an interrogation of Petitioner instead of simply noting the history which was provided. The Arbitrator does not believe there was any fall involved in Petitioner's injury. Dr. Husain took Petitioner off work and referred her to the University of Iowa, in Iowa City, Iowa.

Petitioner was then seen at Quad City Occupational Health on May 24, 2013. She was evaluated by Physicians Assistant Aaron Schulze. Petitioner reported a history of injuring her thumb when, while working on a conveyor belt, she forcefully pushed a box and experienced a "pop" in her hand. Petitioner reported that she went home and did not do anything the night of the injury. She stated that she woke up the following morning and had swelling and pain in her right hand. Petitioner also confirmed being seen by Dr. Hussain at ORA Orthopedics. She noted that she was referred by Dr. Hussain to Iowa City for further treatment. Petitioner was placed on restricted duty work restrictions. (RX 3)

Based upon the report of Dr. Hussain Petitioner's employment was terminated. As of May 30, 2013 restricted work was no longer offered.

Petitioner presented to University of Iowa on June 4, 2013. She was seen by Dr. Ericka Lawler's physician's assistant, Jennifer. The history provided to the PA was consistent with the other medical reports that gathered History of Present Illness. Petitioner reported her injury date of May 22, 2013. Petitioner's injury occurred at work, at XPAC. Petitioner advised she was pushing a heavy roller and felt a pop of her thumb. She then began to have pain in her thumb. She stated she tried to report the accident to her supervisor, but thought that maybe initially she sprained her thumb. Petitioner also advised the PA that she was told by Dr, Hussain that the mechanism of injury was not consistent with this type of fracture and that usually it is from a fall. She reported she got sarcastic with Dr. Hussain and agreed to a fall even though that was not the case. As a result of Dr. Hussain's note, she was terminated from her employment. (PX 4)

Petitioner underwent surgery performed by Dr. Lawler on June 6, 2013 which involved open reduction of her fracture. She then underwent a course of post-operative care and therapy and was eventually released to full duty work effective August 2, 2013. (PX 4)

CONCLUSIONS

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

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner sustained her burden of establishing that she sustained an accident which arose out of and in the course of her employment with Respondent on May 22, 2013.

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

Petitioner established causal connection between the work accident and her current state of ill-being through the deposition testimony of Dr. Ericka Lawler, the treating orthopaedic surgeon. (PX 7) Dr. Lawler testified that she believed Petitioner hurt herself at work. Dr. Lawler explained the injury as a fracture at the base of the metacarpal, which, because it goes into the joint and based on the fracture pattern leaves one small portion of the bone in place and the remainder of the bone actually subluxates, which is a partial joint dislocation, which is known as a Bennett's fracture. Id. at 8. Dr. Lawler opined that the work accident, especially if it was an axial load type injury, would fit with the mechanism that could cause this fracture. Id. An axial load is described as a blow on a partially-flexed first metacarpal, such as would occur during the delivery of a blow such as Petitioner described.

The Arbitrator finds the testimony and opinions of Dr. Lawler much more persuasive than the opinoions of Dr. Hussain.

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 work accident of May 22, 2013.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (K): What temporary benefits are in dispute?

Respondent did not dispute the reasonableness or necessity of the medical care provided nor did they dispute the period of total incapacity. Respondent simply disputed liability to pay benefits based upon the issues of accident and causation.

Based upon the Arbitrator's findings with regard to issues C and F, the Arbitrator concludes Respondent is responsible for payment of Petitioner's medical expenses and for payment of TTD benefits.

Respondent shall pay reasonable and necessary medical services of $16,733.87, as set forth in Petitioner's exhibit 8, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $272.73/week for 9 weeks, commencing 5/30/13 through 8/1/13, 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 neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was an assembly line worker, and although terminated by Respondent, was ultimately released without restriction. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 39 years old at the time of her injuries. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The treating orthopedic surgeon described the injury as located in the joint of the thumb at the base. Surgical intervention was necessary. Open reduction with internal fixation with the insertion of three (3) pins in the first metacarpal occurred on June 6, 2013. Removal of the three (3) pins occurred on August 1, 2013. Dr. Lawler went on to add that the thumb is a key portion involved in grip and fractures that enter the joint, especially this type of fracture, cause pain which can then alter strength. Dr. Lawler went on to testify that is likely this fracture would lead to arthritis. Petitioner testified she has arthritis in this joint and she still has a loss of grip strength. 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 10% loss of use of the right hand pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathryn Diercouff,
Petitioner,

vs.

NO: 15 WC 02437

Village of Richton Park,
Respondent.

18IWCC0751

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 9, 2018, is hereby affirmed and adopted.

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

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

DATED: DEC 10 2018
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DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DIERCOUFF, KATHRYN
Employee/Petitioner

Case# **15WC002437**

16WC030232

VILLAGE OF RICHTON PARK
Employer/Respondent

18IWCC0751

On 3/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% 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:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
TIM ALBERTS
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

Kathryn L. Diercouff
Employee/Petitioner

v.

Village of Richton Park
Employer/Respondent

Case # 15 WC 02437

Consolidated cases: 16 WC 30232

18IWCC0751

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Chicago**, on **December 5, 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 12/1/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $52,690.81 ; the average weekly wage was $1,013.28.

On the date of accident, Petitioner was 53 years of age, *single* with 0 dependent children.

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

Respondent *has 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 $35,915.28 under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner temporary total disability benefits in the amount of $675.52/week for 12-6/7 weeks, for the period of 7/23/2015 through 10/20/2015, which is the period of temporary total disability for which compensation is due.

- Respondent shall pay the further sum of $52,690.81 for necessary medical services as provided in Section 8(a) of the Act for payment of the medical bills from ILBJ ($7,796); Premier Orthopaedic ($7,322.30); University of Illinois ($27,919.51): UIC Physician Group ($7,849); South Suburban Hospital ($794); and Neurology Consultants ($1,010). The medical bills are awarded subject to payment pursuant to Section 8(a) and the Medical Fee Schedule. The payment shall be sent directly to Petitioner's attorney in accordance with Section 7080.20 of the Rules Before the Illinois Workers' Compensation Commission. Respondent shall receive an 8(j) credit for payments made by the group carrier and Respondent shall hold Petitioner harmless in connection with the payments.

- Respondent shall pay Petitioner the sum of $607.97/week for a further period of 14.25 weeks, as provided in Section 8(e)9 of the Act, because the injuries sustained to the right hand caused a 7.5% loss of use to the right hand.

- Respondent shall pay Petitioner the sum of $607.97/week for a further period of 14.25 weeks, as provided in Section 8(e)9 of the Act, because the injuries sustained to the left hand caused a 7.5% loss of use to the left hand.

- Respondent shall pay Petitioner the compensation accrued from 12/1/2014 through 12/5/2017 and shall pay the remainder of the award, if any in weekly payments.

- See Rider attached hereto and made a part of hereof.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 9, 2018
Date

Arbitrator Decision Paragraphs

MAR 9 - 2018

Kathryn L. Diercouff v. Village of Richton Park
Case Number: 15 WC 02437
D/A: 12/1/2014

18IWCC0751

RIDER TO ARBITRATION DECISION

I. Introduction

Evidence in the above-captioned claim was presented to Arbitrator Glaub on December 5, 2017. On that date, the Arbitrator heard the testimony of Petitioner and Respondent's witness. The Arbitrator also received into evidence various exhibits, which included: 1) Applications for Adjustment of Claims; 2) medical records from multiple providers; 3) diagnostic study reports; 4) operative reports; 5) transcript of the evidence depositions of Dr. Mark Gonzalez and Dr. Bryan Neal; 6) medical bills; 7) job description; 8) payroll report; 9) FMLA documentation; and 10) correspondence from Blue Cross Blue Shield. The Arbitrator is considering the disputed issues of accident, medical causation, payment of medical bills, temporary total disability benefits and nature and extent of the injury.

A second case was filed for the date of accident of June 9, 2015. That case is pending under claim number 16 WC 30232. The exhibits and testimony was jointly presented in connection with both claims; however, the Arbitrator will make separate finding of law as it relates to both cases.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. Findings of Fact

A. Work History

Petitioner was 53 as of December 1, 2014. Petitioner testified that she is right handed. Petitioner was employed by Respondent on December 1, 2014. She began working for Respondent in 1993. Petitioner was employed by Respondent as an accounting clerk for the first eight (8) years of her employment. Petitioner then worked for three (3) years as an accountant. For the ten (10) years preceding December 1, 2014, Petitioner was employed by Respondent as the assistant finance director.

Petitioner testified regarding her job duties as an accounting clerk for Respondent. Petitioner performed payroll, took care of the accounts payable and performed IRMA liability claim processing. Petitioner prepared bank deposits, balanced the cash drawer and sold commuter parking permits. Petitioner used a computer, keyboard and a ten (10) key adding machine. Petitioner operated the adding machine with her right hand. She keyboarded with both hands. Petitioner worked five (5) days per week, seven (7) hours per day. During a work day, Petitioner operated the keyboard or adding machine for approximately five (5) to six (6) hours. In every hour that she worked, Petitioner keyboarded or used the adding machine for approximately thirty (30) to forty (40) minutes. Petitioner did not have any ergonomic improvements to the keyboard.

As an accountant for Respondent, Petitioner prepared and entered journal entries into the computer system, completed payroll, balanced the cash drawer and reconciled the insurance. Petitioner used the keyboard and adding machine. Petitioner worked about the same hours as she did when she was employed as an accounting clerk. She operated the keyboard and adding machine for the same amount of time as she previously did working as an accounting clerk.

Petitioner became the assistant finance director for Respondent in 2004. A job description for assistant finance director was admitted into evidence. (RX 4). Petitioner reviewed the job description and agreed that it was accurate. The job description set forth the position was full time. (RX 4). The assistant finance director assisted in planning, directing, managing and overseeing the activities of the Finance Department personnel and assisted the director with budgeting, receiving accounting for Village assets, preparation of financial reports and performed payroll duties. (RX 4). The Essential Job Functions listed job duties including preparation of financial reports and account analysis, manage payroll operations, prepare payroll reports and tax forms, review the work of other Finance Department employee and assist with the annual audit. (RX 4). The list included in the Essential Job Functions was not exhaustive. (RX 4). The physical demands of the job were listed as work in an office setting with hand eye coordination, operation of computers, ability to focus and hear, use hands and fingers to handle, feel or operate objects, tools or control and reach with hands and lift up to twenty (20) pounds. (RX 4).

While Petitioner was employed as the assistant finance director, she used an ergonomic, or split, keyboard. The keyboard was split so that there was less pressure on the wrists. Petitioner used a standard office chair and wrist guards on the keyboard. Petitioner used the adding machine to balance lengthy journal entries, such as payroll, audit adjustment and bank reconciliation. Petitioner used a cash register. Petitioner worked approximately forty (40) to 45 hours per week, five (5) to six (6) days per week. In July 2011, Petitioner's hours increased. Petitioner was assigned the task of outsourcing payroll and performing all of the payroll duties. Petitioner used the adding machine and keyboard. In general, Petitioner worked six (6) hours per day on the keyboard and an hour on the adding machine. Petitioner would be imputing information with the keyboard for approximately (40) minutes per every hour worked. Petitioner operated the adding machine with her right hand, over a forty (40) minute period per every hour worked. Petitioner operated the mouse with her right hand.

Petitioner supervised six (6) employees. Petitioner reviewed paperwork from other employees, bank statements and invoices. Petitioner took bathroom and lunch breaks. Petitioner was also involved in meetings. Petitioner did not participate in six (6) uninterrupted hours of keyboarding. Petitioner would send and respond to emails during the day. Petitioner testified that she was at her desk for seven (7) hours per day and typing for six (6) of those hours.

Petitioner testified that prior to 2011 she sewed. Petitioner used a sewing machine and cut fabric. Prior to 2011, she sewed approximately three (3) to four (4) hours per week. After 2011, Petitioner sewed three (3) to four (4) hours per month until December 1, 2014. Petitioner's sewing did involve the use of her hands.

B. Prior Medical Treatment

Petitioner testified that she was diagnosed with diabetes in 1997. She is insulin dependent and has had an insulin pump since 2014. She was diagnosed with Crohn's Disease in 1996. Petitioner is currently receiving medical treatment for both conditions. Petitioner was diagnosed with glaucoma in 1996 and 1997. Petitioner also has high cholesterol and fatigue. She was diagnosed with high cholesterol approximately fifteen (15) years ago. Petitioner received treatment for depression starting in 1996.

Petitioner is on medication for depression. None of her conditions affected her ability to perform her job duties for Respondent. Petitioner was diagnosed with high blood pressure; however, she no longer has that diagnosis and is not on medication for high blood pressure. Petitioner smoked a pack a day from 1981 to August 2017.

Petitioner was seen at Advocate South Suburban Hospital on October 12, 2012. (RX 8). Petitioner complained of numbness and tingling in her hands and feet which was present for a couple of years. (RX 8). An EMG was performed on October 12, 2012. (PX 1); (RX 8). The EMG study was normal. (PX 1); (RX 6). Following the EMG study, no medical treatment was recommended following the EMG.

Petitioner received medical treatment at Premier Orthopedic & Hand Center for a left shoulder condition. (RX 7). Dr. Labana performed surgery on the left shoulder on June 21, 2013. (RX 7). Petitioner was also evaluated in 2013 for right shoulder pain. (RX 7). Petitioner's last office visit in connection with her bilateral shoulder condition was October 15, 2013. (RX 7).

Petitioner testified that prior to December 1, 2014, she had not been diagnosed with carpal tunnel syndrome. No surgery had been recommended following the EMG of October 12, 2012. Further, no splints were recommended and no additional medical treatment was recommended.

C. Work-Related Repetitive Trauma Accident of December 1, 2014

Petitioner testified that in the thirty (30) days prior to December 1, 2014, she experienced tingling and numbness in her right and left hands and wrists. Petitioner testified that it was difficult to perform her job duties for Respondent; however, Petitioner continued to perform her job duties. While she was working, she experienced pain in her hands and wrists. When Petitioner operated a keyboard, she experienced pain and numbness in her wrists and fingers. The symptoms were worse when she was keyboarding.

Petitioner scheduled an office visit with her primary care physician, Dr. Debre, on December 1, 2014. (PX 2). Petitioner scheduled the appointment because of the increased pain, numbness and tingling in her hands and wrists. The symptoms had increased to the point where Petitioner needed relief. Petitioner's symptoms had been increasing over several months prior to December 1, 2014.

Petitioner applied for leave under the FMLA. (PX 10). The FMLA paperwork confirmed that Petitioner was unable to work from July 25, 2015 until released by her physician. (PX 10). It stated that the condition was due to work. (PX 10). The paperwork was completed by Dr. Gonzalez. (PX 10). The Application of Adjustment of Claim and Amended Application for Adjustment of Claim for case number 15 WC 02437 for the accident date of December 1, 2014 was admitted into evidence. (RX 1).

D. Work-Related Repetitive Trauma Accident of June 9, 2015

On June 9, 2015, Dr. Gonzalez, Petitioner's treating physician, diagnosed her with De Quervain's Disease. This was the first time that Petitioner was diagnosed with De Quervain's Disease by Dr. Gonzalez. The Application for Adjustment of Claim for case number 16 WC 30232 for the accident date of June 9, 2015 was admitted into evidence. (RX 2).

E. Testimony of Respondent's Witness, David Savier

Respondent presented the testimony of David Savier. Mr. Savier was the finance director for Respondent for the last eight (8) months that Petitioner worked for Respondent. Mr. Savier began working for Respondent on May 3, 2015. He was Petitioner's supervisor.

Mr. Savier testified regarding Petitioner's job duties while she was working for him. Petitioner's job duties included payroll, accounts receivable, accountable payable, reconciling the budget and audits, answering emails and using an adding machine. He also attended meetings with Petitioner. Mr. Savier testified that the job description was accurate. (RX 4).

Mr. Savier testified Petitioner's job duties were not 75% typing. Petitioner also supervised the staff. Following her return to work, Petitioner did not make any complaints of pain in her wrists. Petitioner took off one day because her hands were swollen. Mr. Savier testified that he spent some time in Petitioner's office addressing specific problems that arose at work. He was not in her office on a daily basis. Mr. Savier testified that he monitored his staff, but could not confirm how long he spent observing Petitioner work. Mr. Savier did not have personal knowledge as to how long Petitioner spent typing per day. Mr. Savier testified that he believed that the job required between 25% and 50% of the day typing.

This amounted to two (2) to four (4) hours of the day typing. Mr. Savier did not have any personal knowledge as to how Petitioner performed her job duties prior to May 2015.

F. Medical Treatment

Petitioner sought medical treatment for her hands following December 1, 2014. Petitioner was examined by Dr. Debre, her primary care physician, on December 1, 2014. (PX 2). Dr. Debre documented complaints of numbness and tingling in both hands which were worsening. (PX 2). He recommended an EMG study and referred Petitioner to an orthopedic surgeon. (PX 2).

Petitioner underwent the recommended EMG study on December 12, 2014 at Advocate South Suburban Hospital. (PX 3). The EMG report noted that Petitioner had intermittent numbness and tingling in her fingers which worsened over the last several months. (PX 3). THE EMG study revealed left and right carpal tunnel syndrome without evidence of cervical radiculopathy, brachial plexopathy or ulnar mononeuropathy. (PX 3).

Petitioner was examined by Dr. Gonzalez on January 13, 2015. (PX 4). Dr. Gonzalez noted a history that Petitioner was an accountant with bilateral hand numbness in the median nerve distribution for two (2) to three (3) months. (PX 4). He set forth an assessment of bilateral carpal tunnel syndrome. (PX 4). Dr. Gonzalez stated that being an accountant with a lot of typing aggravated her condition with repetitive activity. (PX 4). He recommended surgery. (PX 4).

Petitioner continued to have follow up examinations with Dr. Gonzalez while she waited to undergo surgery. (PX 4). On June 9, 2015, Dr. Gonzalez set forth a diagnosis of bilateral carpal tunnel syndrome and De Quervain's. (PX 4). He set froth that both conditions were aggravated as a result of repetitive work and compensable under workers' compensation since the condition was aggravated in the work environment. (PX 4). Dr. Gonzalez recommended physical therapy for the De Quervain's. (PX 4).

Petitioner was evaluated by Dr. Labana on June 16, 2015. (PX 7). Dr. Labana set forth an assessment of carpal tunnel syndrome and De Quervain's. (PX 7). He stated that Petitioner was working six (6) days per week for three (3) years and does a lot of typing and other paper handling which requires repetitive wrist and hand position changes. (PX 7). Therefore, he stated that the case should be handled

under workers' compensation. (PX 7). Dr. Labana recommended physical therapy. (PX 7). Petitioner participated in physical therapy at Premier Orthopedic and Hand Center from June 19, 2015 through July 8, 2015. (PX 7).

Petitioner underwent the recommended right hand surgery on July 23, 2015 at University of Illinois Hospital. (PX 5). Dr. Gonzalez performed a right endoscopic carpal tunnel release and De Quervain release. (PX 5). The post-operative diagnosis was right carpal tunnel syndrome and De Quervain tenosynovitis. (PX 5). Petitioner continued under the post-operative care of Dr. Gonzalez. (PX 4).

Petitioner underwent left hand surgery on August 13, 2015 at University of Illinois Hospital. (PX 6). Dr. Gonzalez performed a left carpal tunnel and De Quervain's release. (PX 6). The post-operative diagnosis was left carpal tunnel syndrome and de Quervain tenosynovitis. (PX 6).

Petitioner remained under the post-operative care of Dr. Gonzalez. (PX 4). Post-operative care included follow up appointments, physical therapy and activity modification. (PX 4). Petitioner participated in physical therapy from September 9, 2015 through October 16, 2015 at Premier Orthopedics. (PX 7).

Petitioner was last examined by Dr. Gonzalez on October 20, 2015. (PX 4). Dr. Gonzalez noted increase pain at the incision area for the carpal tunnel syndrome. (PX 4). Petitioner's numbness and tingling were improved. (PX 4). Dr. Gonzalez released Petitioner to return to work. (PX 4).

G. Medical Opinions of Dr. Mark Gonzalez

The evidence deposition of Dr. Gonzalez was completed on September 27, 2016. (PX 8). Dr. Gonzalez is a board certified orthopedic surgeon with an added qualification in hand surgery. (PX 8 at 6). Dr. Gonzalez is a professor at University of Illinois at Chicago in orthopedic surgery and mechanical engineering. (PX 8 at 8). Dr. Gonzalez has authored many papers in connection with medical treatment for the hand and carpal tunnel syndrome. (PX 8 at 10). Dr. Gonzalez has performed more than 1000 carpal tunnel surgeries. (PX 8 at 14).

Dr. Gonzalez documented a history that Petitioner had bilateral hand numbness for two (2) to three (3) months with relief from splints. (PX 8 at 19). Petitioner was right hand dominant and worked as an

accountant. (PX 8 at 20). On physical examination, Petitioner had positive Phalen's test, positive Tinel's and positive Durkan's, which all suggested a diagnosis of bilateral carpal tunnel syndrome. (PX 8 at 20). Petitioner did not have compression of the ulnar nerve or at the neck. (PX 8 at 20-21). Dr. Gonzalez testified that the physical examination was consistent with the EMG. (PX 8 at 22). Dr. Gonzalez stated that the EMG revealed left and right sided mononeuropathy as seen in carpal tunnel syndrome. (PX 8 at 23).

Dr. Gonzalez's diagnosis was bilateral carpal tunnel syndrome. (PX 8 at 23). He recommended that Petitioner undergo surgery. (PX 8 at 23). Dr. Gonzalez set forth a further diagnosis of De Quervain's tenosynovitis on June 9, 2015. (PX 8 at 24). He recommended that Petitioner undergo surgery for the carpal tunnel syndrome and De Quervain's. (PX 8 at 26).

Dr. Gonzalez explained that carpal tunnel syndrome is an increase in pressure which decreases blood supply to the median nerve. (PX 8 at 29). He noted that repetitive activity causes the pressure to rise. (PX 8 at 29). The pressure causes the symptoms in the median nerve. (PX 8 at 30). Dr. Gonzalez testified that following the surgery of July 23, 2015, Petitioner would not have been able to use her right hand. (PX 8 at 33). Following the second surgery of August 13, 2015, Petitioner would not have been able to work for six (6) to eight (8) weeks. (PX 8 at 34). Petitioner would have been able to perform limited work and no typing from July 23, 2015 through October 20, 2015. (PX 8 at 37).

Dr. Gonzalez testified that repetitive activities, such as typing, can aggravate carpal tunnel syndrome and De Quervain's tenosynovitis. (PX 8 at 41). He clarified that when people have to perform activities it can cause a rise in pressure of the carpal tunnel. (PX 8 at 42). Dr. Gonzalez testified that there is no medical literature that studies an aggravation of the carpal tunnel syndrome. (PX 8 at 43). The aggravation causes the patient to come in for medical treatment. (PX 8 at 45).

Dr. Gonzalez reviewed the 2012 EMG. (PX 8 at 44). He noted that Petitioner had a normal EMG. (PX 8 at 45). The EMG changed while Petitioner was working. (PX 8 at 45). He testified that the positive EMG indicated an aggravation of symptoms which caused Petitioner to seek medical treatment. (PX 8 at 45).

Dr. Gonzalez testified that the fact that Petitioner had diabetes did not affect his opinion that the carpal tunnel syndrome was aggravated by the work activities. (PX 8 at 46). He also reviewed the report of Dr. Neal. (PX 8 at 46). He stated that he did not understand Dr. Neal use of "temporary aggravation" since the condition was aggravated to the extent that Petitioner sought medical treatment. (PX 8 at 47). Dr. Gonzalez testified that Petitioner's symptoms were consistent throughout his evaluation. (PX 8 at 48). He stated that the medical treatment provided to Petitioner was reasonable and necessary. (PX 8 at 48). Dr. Gonzalez testified that the bilateral hand and wrist condition was permanent. (PX 8 at 48).

Dr. Gonzalez testified that females in their 50s could have a higher prevalence of carpal tunnel syndrome. (PX 8 at 52). Diabetes can also be a risk factor in developing carpal tunnel syndrome. (PX 8 at 52). With regard to causation, Dr. Gonzalez relied on the activity that causes the pain and what makes it better. (PX 8 at 57). Dr. Gonzalez found it significant that a person can stop performing a hobby, but could not stop working, if the symptoms persist. (PX 8 at 59). Dr. Gonzalez reviewed the studies related to carpal tunnel syndrome and found that they did not adequately study an aggravation of the symptoms. (PX 8 at 63).

Dr. Gonzalez testified that Dr. Neal stated that Petitioner had ongoing complaints in her hands. (PX 8 at 68). He testified that the symptoms documented in Dr. Neal's report were consistent with the diagnosis of carpal tunnel syndrome and De Quervain's. (PX 8 at 68). Dr. Gonzales testified that carpal tunnel syndrome and De Quervain's were aggravated by work activities such that they became symptomatic and Petitioner sought medical treatment. (PX 8 at 72).

H. Medical Opinions of Dr. Neal, Respondent's Section 12 Physician

The evidence deposition of Dr. Neal was completed on January 10, 2017. (RX 3). Dr. Neal completed two Section 12 examinations and an AMA impairment rating in connection with Petitioner's bilateral hand condition. (RX 3 at 9). The reports were dated May 1, 2015 and June 3, 2016. (RX 3 at 9).

Dr. Neal first examined Petitioner on April 29, 2015. (RX 3 at 10). Dr. Neal reviewed the EMG study from October 13, 2012. (RX 3 at 12). He stated that the EMG was normal and that Petitioner had diabetes and both upper and lower extremity paraesthesias. (RX 3 at 12). He noted that Petitioner had long standing complaints of neuropathic symptoms. (RX 3 at 12). Dr. Neal found it significant that Petitioner had diabetes. (RX 3 at 14). Dr. Neal explained that diabetes is associated with neuropathies and that carpal tunnel syndrome is a common neuropathy. (RX 3 at 14-15). He testified that the EMG of December 12, 2014 revealed that Petitioner had carpal tunnel syndrome. (RX 3 at 17).

Dr. Neal documented that Petitioner's job duties included preparing journal entries, work on a computer, payroll work and data entry. (RX 3 at 20). Petitioner worked on a computer six (6) hours per day or 75% of the time. (RX 3 at 22). Dr. Neal testified that Petitioner's subjective complaints correlated with a diagnosis of carpal tunnel syndrome. (RX 3 at 27). Dr. Neal confirmed that Petitioner's diagnosis on the right hand was carpal tunnel syndrome, CMC joint osteoarthritis and De Quervain's disease. (RX 3 at 34). With regard to the left hand, Petitioner had left carpal tunnel syndrome, De Quervain's disease and CMC joint arthritis. (RX 3 at 35). Dr. Neal set forth that the diagnosis on the right and left side were not causally connected to the work activities. (RX 3 at 35-36). The basis of his opinion was that Petitioner had multiple risk factors including that the condition was common, advancing age, female, obesity and diabetes. (RX 3 at 36-37). Dr. Neal also testified that the literature does not support a finding that keyboarding activities cause carpal tunnel syndrome. (RX 3 at 38). Dr. Neal relied on the literature in support of his findings. (RX 3 at 39). The literature states that a causal relationship between repetitive work, such as keyboarding, and carpal tunnel syndrome has not been proven. (RX 3 at 40). Dr. Neal stated that Petitioner work was not vibratory or forceful. (RX 3 at 45).

Dr. Neal further found that the De Quervain's disease was not casually related to the work activities. (RX 3 at 45). He noted that De Quervain's appears sporadically for a short period of time. (RX 3 at 46). He stated that diabetes predisposes a person to De Quervain's. (RX 3 at 46). Dr. Neal stated that the literature does not support a finding of causation. (RX 3 at 46). He also noted that Petitioner worked a long time without developing De Quervain's and developed it bilaterally, which suggested a systematic

underlying cause. (RX 3 at 46). He testified that the CMC arthritis appeared on x-rays and is common in females between the ages of 50 and 70. (RX 3 at 48).

Dr. Neal testified that the cause of the carpal tunnel syndrome was idiopathic in combination with the risk factors of diabetes and obesity. (RX 3 at 49). He also stated that since Petitioner had neuropathic symptoms in her lower extremity, this would support a finding that Petitioner had an underlying systemic cause of the symptoms combined with poorly treated diabetes. (RX 3 at 49). Dr. Neal testified that the work did not aggravate or accelerate the condition. (RX 3 at 50).

As of April 29, 2015, Dr. Neal testified that Petitioner had not reached maximum medical improvement. (RX 3 at 52). He testified that further medical treatment, including splinting, steroids and surgery, would be reasonable. (RX 3 at 53). He confirmed that Petitioner did not require work restrictions. (RX 3 at 54).

Dr. Neal conducted a second examination on June 1, 2016. (RX 3 at 56). Dr. Neal documented that Petitioner had right sided tingling and intermittent day time symptoms and pain and on the right side, she had the same symptoms on the left side. (RX 3 at 60). Dr. Neal set forth the diagnosis of right and left sided pain and paraesthesias status post carpal tunnel release and De Quervain's release and CMC arthritis. (RX 3 at 62). Dr. Neal confirmed that the subjective complaints were consistent with the objective findings. (RX 3 at 65). He stated that Petitioner had reached maximum medical improvement. (RX 3 at 65). He testified that Petitioner could return to work without restrictions. (RX 3 at 66).

Dr. Neal set forth an impairment rating. (RX 3 at 67). He set forth a rating of 1% upper extremity impairment on the right and 4% on the left from the carpal tunnel syndrome. (RX 3 at 67). Dr. Neal set forth an impairment rating of 1% on the right and 1% on the left for the De Quervain's. (RX 3 at 68). The combined impairment rating was 2% upper extremity impairment on the right and 5% on the left. (RX 3 at 68). The combination of both hands was 7% impairment of the upper extremity convertible to a 4% of the person as a whole. (RX 3 at 69).

Dr. Neal testified that the impairment rating was based on the diagnosis and not the treatment. (RX 3 at 77). The definition of disability is different than impairment. (RX 3 at 78). He acknowledged that the impairment rating was not intended to intercede in the judicial process. (RX at 78).

Dr. Neal admitted that the document he reviewed was a position description and not a physical job description. (RX 3 at 93). He admitted that the description was not complete and Petitioner performed more job duties than were listed in the report. (RX 3 at 95). Dr. Neal confirmed that prior to December 1, 2014, there was a suspicion of carpal tunnel syndrome, but no diagnosis. (RX 3 at 102). He acknowledged that there was no diagnosis of carpal tunnel syndrome in 2012. (RX 3 at 103).

Dr. Neal testified that not everyone with numbness and tingling in their hands has carpal tunnel syndrome. (RX 3 at 111). He agreed that the treatment provided to Petitioner was reasonable and necessary. (RX 3 at 112). He also acknowledged that every person with diabetes does not have carpal tunnel syndrome. (RX 3 at 115). Dr. Neal testified that the first diagnosis of carpal tunnel syndrome was December 12, 2014. (RX 3 at 116). He noted that Petitioner had symptoms consistent with carpal tunnel syndrome in 2012 and on December 1, 2014. (RX 3 at 116).

Dr. Neal stated that he did not know how Dr. Gonzalez used the word aggravated. (RX 3 at 118). Dr. Neal testified that some literature set forth that there were occupational causes of carpal tunnel syndrome. (RX 3 at 119). He stated that there is little controversy over the fact that forceful gripping and "funny" wrist positions or extreme wrist positions can cause carpal tunnel syndrome; however, he stated that there is little support for keyboarding causing carpal tunnel syndrome. (RX 3 at 121). Dr. Neal testified that keyboarding is not cumulative and repetitive. (RX 3 at 122). Dr. Neal acknowledged that some studies state that keyboarding can cause carpal tunnel syndrome. (RX 3 at 123). Dr. Neal admitted that forceful and highly repetitive physical demands increase the risk of a person developing carpal tunnel syndrome. (RX 3 at 125). He stated that typing presents a minimal risk. (RX 3 at 125). Dr. Neal acknowledged that it is difficult to formulate a perfect study to determine whether carpal tunnel syndrome is caused by keyboarding. (RX 3 at 128). Dr. Neal testified that not all people with diabetes have De Quervain's

disease. (RX 3 at 128). Dr. Neal testified that Petitioner's work could temporarily exacerbate her carpal tunnel syndrome. (RX 3 at 133).

I. Medical Bills

Several medical bills were admitted into evidence. (PX 9). The medical bills from ILBJ ($7,796); Premier Orthopaedic ($7,322.30); University of Illinois ($27,919.51); UIC Physicians Groups ($7,849); South Suburban Hospital ($794); and Neurology Consultants ($1,010) were admitted into evidence. (PX 9). The total charges for the medical bills were $52,690.81. (PX 9). Petitioner paid $200.02 out of pocket. (PX 9). The group insurance carried paid $35,915.28. (RX 9); (RX 10).

J. Current Subjective Complaints

Petitioner worked for Respondent until July 23, 2015. Petitioner did not perform any work activities between July 23, 2015 and October 20, 2015. Petitioner used her sick time for the period that she was not able to work for Respondent. A payroll report was admitted into evidence. (PX 5). The payroll report was for the period of August 23,2015 through September 5, 2015. (PX 5).

Petitioner returned to work for Respondent on October 21, 2015. She performed work duties for Respondent from October 21, 2015 through February 2016. Petitioner retired in February 2016. Petitioner testified that he job duties were a little less than prior to December 1, 2014 because she was transitioning her job duties to another clerk. Petitioner was keyboarding and using the adding machine. She was using the keyboard a little less that prior to December 1, 2014. Petitioner experienced some soreness in her hands. Petitioner has not sustained any new accidents or injuries involving her hands.

III. Conclusions of Law

In support of the Arbitrator's decision relating to "C," did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner sustained accident injuries on December 1, 2014 that arose out of and in the course of her employment with Respondent. The accidental injuries arose out of and in the course of a repetitive trauma which manifested itself on December 1, 2014. In support of this decision,

the Arbitrator relies on the credible and unrebutted testimony of Petitioner, the medical opinions of Dr. Gonzales and the job description.

The Arbitrator considered the testimony of David Savier and does not find it relevant to the instant case. Mr. Savier began working for Respondent on May 3, 2015, after the manifestation of Petitioner's work related accident and after Petitioner received medical treatment for the work-related condition. Petitioner specifically testified that her job duties decreased when she returned to work on October 21, 2015. Accordingly, Mr. Savier's testimony is not relevant to Petitioner's job duties prior to December 1, 2014. The Arbitrator finds that Petitioner's testimony regarding her job duties prior to December 1, 2014 was unrebutted and credible.

An injury occurs in the course of the employment when the injury occurs at a place where the Claimant might have reasonably been performing his job duties and while the Claimant is at work. *Caterpillar Tractor Company v. Indus. Com'n*, 129 Ill.2d 52, 541 N.E.2d 655 (1989). "For an injury to arise out of one's employment, it must have an origin and some risk connected with or incidental to the employment, so that there is a causal connection between the employment and the injury." *Lakeside Architectural Metals v. Industrial Commission*, 267 Ill.App.3d 1058, 642 N.E.2d 796 (1st Dist. 1994).

The phrase arising out of refers to a causal connection between the employment and the accidental injury and is satisfied when a claimant establishes that the accident has some origin in a risk connected with or incidental to the employment. *Young v. Illinois Workers' Compensation Com'n*, 383 Ill.Dec. 131, 13 N.E.2d 1852 (4th Dist. 2014). An injury arises out of employment if at the time of the occurrence, the claimant was performing acts he was instructed to perform by his employer or acts which he could reasonably be expected to perform incident to his assigned duties. *Id.*

In *Peoria County Belwood Nursing Home*, the court had that "the risk of injury from repeat trauma and exposure endured by truck drivers, CRT operators, chemists and others must be recognized." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026, 1029 (1987). In repetitive trauma cases, the claimant must "meet the same standard of proof as other claimants alleging

accidental injury." *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

For repetitive trauma cases, "the date of an accidental injury in a repetitive-trauma compensation case is the date on which the injury manifests itself." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026, 1029 (1987). In *Durand v. Industrial Commission*, the Illinois Supreme Court clarified the issue of manifestation date. 224 Ill.2d 53, 862 N.E.2d 918 (2006). In *Durand*, the Court set forth that, "in short, courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment or the date on which the employee can no longer perform work activities. The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee." *See General Electric Co., v. Industrial Commission*, 190 Ill.App.3d 847, 546 N.E.2d 987 (1989).

With regard to the date that the injury manifested itself, the courts have emphasized flexibility and that the facts of each case should be closely examined. *Durand*, 224 Ill.2d 53. In *Durand*, the court stated that the holding in *Peoria County* was broad enough to accommodate many "unique scenario presented in different cases and the Commission should weight many factors in deciding when a repetitive-trauma injury manifests itself." *Id.* According to Professor Larson's workers' compensation treatise, cited by the Supreme Court in *Durand*, the date of accident could be identified with "the onset of pain occasioning medical attention, although the effect of the pain may have been merely to cause difficulty in working and not complete inability to work." *Id.* Therefore, the court concluded that various factors typically set the manifestation date on the date which the employee required medical treatment or the date which the employee can no longer perform work activities. *Id.* The court also noted that requiring notice of a potential disability is useless since the employer is not adversely affected until the claimant becomes actually disabled. *Oscar Mayer & Company v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (4th Dist. 1988).

The Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of her employment. In the instant case, Petitioner's unrebutted testimony established that her job as the assistant finance director required repetitive and continuous typing. Petitioner typed for 75% of the day, or six (6) hours in the eight (8) hour day. She also used the adding machine. Petitioner typed forty (40) minutes for every hour worked.

The Arbitrator finds that Petitioner established that her job for Respondent is repetitive. She performed typing for 75% of the day and six (6) hours. Further, Petitioner typed more than the general public. From a quantitative standpoint, Petitioner's job duties subject her to an increased risk due to the amount of typing that she performed and the continuous basis on which she performs it. *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, 38 N.E.3d 587 (2d Dist. 2015). Additionally, the injuries were sustained while performing her specific job duties for Respondent. *See Young*, 383 Ill.Dec. 131. Accordingly, the Arbitrator concludes that Petitioner's accidental injuries arose out of and in the course of her employment. Lastly, the accidental injuries clearly occurred in the course of her employment, since the injuries arose out of the repetitive work performed at work.

The Arbitrator finds that the manifestation date was December 1, 2014, the date that Petitioner first sought medical treatment for her hands and was diagnosed with carpal tunnel syndrome. Although Petitioner experienced symptoms in her hands in 2012, the EMG was negative. Following the EMG, Petitioner was not provided a diagnosis of carpal tunnel syndrome and was not prescribed any medical treatment. Accordingly, a reasonable person would not be aware of the current condition or its relation to her employment. It was not until December 1, 2014 that Petitioner was aware of her diagnosis and further medical treatment was recommended. Based on the medical records and Petitioner's testimony, the manifestation date was December 1, 2014.

The Arbitrator notes that Petitioner alleged a second manifestation date of June 9, 2015, when she was first diagnosed with De Quervain's Disease. Although Petitioner was first diagnosed with Dr Quervain's Disease on June 9, 2015, the totality of the evidence established that Petitioner's condition in her hands manifested on December 1, 2014. Petitioner's condition was aggravated such that she sought

medical treatment and was aware that the condition was related to work. The fact that she was diagnosed with a further condition at a later date is not relevant. The manifestation date was December 1, 2014.

Based on the medical records, accident report and the testimony of Petitioner, the Arbitrator finds that Petitioner sustained a repetitive trauma accident to her hands that arose out of and in the course of her employment with Respondent and with a manifestation date of December 1, 2014. The Arbitrator's finding is consistent with the case law and does not prejudice Respondent.

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

The Arbitrator concludes that Petitioner's current condition of ill-being in connection with her bilateral hands and wrists, including the carpal tunnel syndrome and De Quervain's, is causally connected to the repetitive trauma accident with manifestation date of December 1, 2014. The Arbitrator relies on Petitioner's credible testimony and the medical opinions of Dr. Mark Gonzalez. It is significant that Dr. Labana also stated that the carpal tunnel syndrome and De Quervain's resulted from work and should be compensable under workers' compensation.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Id.* The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Id.* (emphasis in original).

A. Medical Opinions of Dr. Mark Gonzalez

The Arbitrator finds that Petitioner established that the current condition of Petitioner's bilateral hands, including carpal tunnel syndrome and De Quervain's, is causally connected to the repetitive trauma accident with manifestation date of December 1, 2014 through the medical opinions of Dr. Gonzalez.

Dr. Gonzalez testified that while the etiology of the petitioner's condition is unclear, repetitive activities, such as typing, can aggravate carpal tunnel syndrome and De Quervain's tenosynovitis. Dr. Gonzalez explained that carpal tunnel syndrome is an increase in pressure which decreases blood supply to the median nerve. He noted that repetitive activity causes the pressure to rise. The pressure causes the symptoms in the median nerve. The aggravation caused the patient to seek medical treatment. With regard to causation, Dr. Gonzalez relied on what causes the pain and what makes it better. Dr. Gonzalez found it significant that a person can stop performing a hobby, but could not stop working, if the symptoms persist. Dr. Gonzales testified that carpal tunnel syndrome and De Quervain's were aggravated by work activities such that they became symptomatic and Petitioner sought medical treatment.

Dr. Gonzalez is a highly qualified orthopedic physician with a subspecialty in hand surgery. His opinions regarding medical causation are consistent with Petitioner's testimony and job description. Dr. Gonzalez considered the facts of the case and the literature and used his experience to render a well-reasoned opinion. Accordingly, based on the opinions of Dr. Gonzalez, the Arbitrator finds that the current condition of ill-being in connection with Petitioner's bilateral hands is causally related to the repetitive trauma accident of December 1, 2014.

B. Medical Opinions of Dr. Bryan Neal, Respondent's Section 12 Physician

Dr. Neal, Respondent's Section 12 physician testified in agreement with Dr. Gonzalez on several issues. Both physicians did not believe the petitioner's job duties caused the petitioner's underlying medical condition. Both physicians agreed that the petitioner had or suffered from many factors that pre-disposed her to develop carpal tunnel syndrome. Dr. Neal also agreed with Dr. Gonzalez regarding the Petitioner's diagnosis of bilateral carpal tunnel syndrome and De Quervain's. Dr. Neal testified that the medical treatment performed by Dr. Gonzalez in this case was appropriate.

Dr. Neal opined however that the petitioner's underlying medical condition was not causally connected to the work activities. The basis of his opinion was that Petitioner had multiple risk factors including that the condition was common, advancing age, female, obesity and diabetes. Dr. Neal also

testified that the literature does not support a finding that keyboarding activities cause carpal tunnel syndrome.

Dr. Neal testified that Petitioner's job activities could have temporarily exacerbated her carpal tunnel syndrome. Dr. Neal further testified that this temporary exacerbation did not aggravate her underlying medical condition. However, he fails to explain why Petitioner's symptoms increased while she was working and were less when she was not. Further, Dr. Neal fails to address the fact that Petitioner's objective and subjective complaints were continuous until she received medical treatment and that the aggravation during her work activities caused Petitioner to seek medical treatment. Accordingly, Dr. Neal's opinion that the condition was temporarily exacerbated is not consistent with the facts since Petitioner's symptoms became continuous.

In rejecting Dr. Neal's opinions, the Arbitrator also relies on the holding in *Sisbro* that the accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." Dr. Neal's testimony that Petitioner's job duties exacerbated her bilateral hand condition is consistent with the holding in *Sisbro* and a finding of medical causation.

The Arbitrator further finds it significant that Dr. Gonzalez reviewed the report of Dr. Neal and rejected his opinions. Dr. Gonzalez stated that he did not understand Dr. Neal use of "temporary aggravation" since the condition was aggravated to the extent that Petitioner sought medical treatment.

Based on the facts of the case, case law and opinions of Dr. Gonzales, the Arbitrator finds that Petitioner established that her current condition of ill-being was causally connected to the work-related accident of December 1, 2014.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions:

The Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bills admitted into evidence. Since the Arbitrator has already found that that Petitioner sustained a compensable accident and Petitioner's

current condition of ill-being is causally connected to the work-related accident of December 1, 2014, the Arbitrator awards payment of the medical bills admitted into evidence.

Respondent shall pay the sum of $52,690.81 for necessary medical treatment. This represents payment of the medical bills from ILBJ ($7,796); Premier Orthopaedic ($7,322.30); University of Illinois ($27,919.51): UIC Physician Group ($7,849); South Suburban Hospital ($794); and Neurology Consultants ($1,010). Respondent shall receive an 8(j) credit for payments made by Petitioner's group insurance carrier to the extent of $35,915.28. Respondent shall hold Petitioner harmless for payments made by the group insurance carrier.

The Arbitrator finds that the medical bills are subject to adjustments consistent with the provisions of the Medical Fee Schedule. 820 ILCS 305/8.2. The Arbitrator orders Respondent to calculate the exact amount of benefits owed to the medical provider pursuant to Section 8.2. Any further disputes relating to the adjustment of the bill may be addressed at further proceedings, consistent with this decision. The Arbitrator further orders Respondent to make payment of the medical bills to Petitioner's attorney pursuant to the Illinois Medical Fee Schedule after applying the appropriate 8(j) credit regarding the medical bills paid by the group carrier or insurance.

In support of the Arbitrator's decision relating to "L," temporary total disability benefits, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner is entitled to payment of temporary total disability benefits from July 23, 2015 through October 20, 2015. The Arbitrator relies on Petitioner's credible and unrebutted testimony and the medical records and opinions of Dr. Gonzalez. Respondent's defense in connection with payment of temporary total disability benefits is accident and medical causation. Having found that Petitioner sustained a compensable accident and that Petitioner's current condition of ill-being is causally connected to the repetitive trauma accident of December 1, 2014, the Arbitrator awards payment of temporary total disability benefits from July 23, 2015 through October 20, 2015.

In *Freeman United Coal Mining Company v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144 (2001), the court set forth that "a claimant is entitled to TTD when a 'disabling condition is

temporary and has not reached a permanent condition.'" (quoting *Manis v. Industrial Commission*, 172 Ill.Dec. 95, 595 N.E.2d 158 (1st Dist. 1992)). The dispositive test for determining whether a claimant is entitled to TTD is whether the condition has stabilized. *Id.* In *Freeman United Coal Mining Company*, the court held that the condition of the petitioner's knee had not stabilized and that the claimant was thus entitled to TTD benefits. *Id.* The court based its decision on the fact that the claimant had not been released to full-duty work and future medical care was being considered by the claimant's treating physicians. *Id.*

In the instant case, Petitioner was under the active medical care of Dr. Gonzalez and not released to return to work from July 23, 2015 through October 20, 2015. Petitioner underwent surgery for her right hand on July 23, 2015 and surgery for her left hand on August 13, 2015. Dr. Gonzalez set forth that Petitioner would be unable to perform her job duties, specifically typing, following surgery, until October 20, 2016. Accordingly, the medical evidence established that Petitioner was entitled to payment of temporary total disability benefits from July 23, 2015 through October 20, 2015.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator makes the following conclusions:

The Arbitrator concludes that as a result of the work-related accident of December 1, 2014, Petitioner sustained permanent partial disability to the extent of a 7.5% loss of use of the right hand (based off 190 weeks) and a 7.5% loss of use of the left hand for carpal tunnel syndrome (based off 190 weeks) pursuant to Section 8(e)9 of the Act.

The Arbitrator's finding is consistent with the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider certain factors and criteria in assessing permanent partial disability, including, the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no

single enumerated factor shall be the sole determinant of disability. With respect to the factors, the Arbitrator finds the following:

A. Level of Impairment under the AMA Guides

Respondent submitted an impairment rating into evidence. Dr. Neal, Respondent's Section 12 physician, set forth an impairment rating. He set forth a rating of 1% upper extremity impairment on the right and 4% on the left from the carpal tunnel syndrome. Dr. Neal set forth an impairment rating of 1% on the right and 1% on the left for the De Quervain's. The combined impairment rating was 2% upper extremity impairment on the right and 5% on the left. The combination of both hands was 7% impairment of the upper extremities which Dr. Neal converted to a 4% of the person as a whole.

Dr. Neal testified that the impairment rating was based on the diagnosis and not the treatment. The definition of disability is different than impairment. He acknowledged that the impairment rating was not intended to intercede in the judicial process.

The Arbitrator accords this factor the appropriate weight. The Arbitrator finds that Dr. Neal testified that the impairment rating was based on the diagnosis. Further, the Arbitrator acknowledges that impairment is not disability.

B. Occupation of Petitioner

At the time of the work-related accident, Petitioner was employed by Respondent as the assistant financial director. Petitioner claimed that her job duties required to utilize a keyboard up to approximately 80% of the day. However, the Arbitrator also notes that while Petitioner's pre-accident job duties required constant and repetitive use of her hands, that the petitioner voluntarily retired from the work force despite a full duty release. The Arbitrator accords the proper weight to the fact that Petitioner has chosen to voluntarily leave the work force.

C. Age of Petitioner

At the time of the accident, Petitioner was 53. At the time of the hearing, Petitioner was 56 years old. The Arbitrator notes that the petitioner is relatively close to end of her work life and in fact, has voluntarily decided to retire and leave the work force. The Arbitrator accords this factor the appropriate weight.

D. Future Earning Capacity

No evidence was presented regarding how Petitioner's future earning capacity. Accordingly, the Arbitrator accords this factor no weight.

E. Evidence of Disability Corroborated by the Treating Medical Records

The unrebutted medical evidence presented in this case establishes that the petitioner's job duties did not cause the petitioner's medical condition. The unrebutted medical evidence presented establishes that the petitioner had multiple risk factors which pre-disposed to carpal tunnel syndrome. These factors included her age, gender, obesity, hypertension, smoking and uncontrolled diabetes. The medical testimony of Dr. Gonzalez was that the petitioner's job duties aggravated this pre-existing condition that was not caused by her job. The medical records of Dr. Gonzalez establish that Petitioner sustained bilateral carpal tunnel syndrome and De Quervain's which required surgery. The diagnosis was corroborated by the objective diagnostic studying, operative report and medical records. The Respondent's Section 12 physician agreed with the diagnosis.

The post-operative progress note of Dr. Gonzalez dated October 20, 2015 indicates that petitioner reported that she is doing very well. Petitioner also reported that her numbness and tingling have much improved since the surgery. Dr. Gonzalez does not record any subjective complaints of pain at this final visit to his office. The petitioner was released to full duty work and placed at maximum medical improvement.

The Arbitrator accords this factor great weight. The Arbitrator finds it significant that all of the medical doctors that testified on this case believe that the cause of the petitioner's medical condition was related to her job duties. Dr. Gonzalez the treating surgeon opined that petitioner's job duties aggravated

this unrelated medical condition to the point where petitioner required treatment and surgery. However, the medical procedures performed on the petitioner not only resolved that symptomology according to the medical records but also resolved her underlying and unrelated medical condition.

Based on all of the factors listed above, the Arbitrator finds that Petitioner sustained the permanent partial disability to the extent of 7.5% loss of use of the right hand (based off 190 weeks), and a 7.5% loss of use of the left hand (based off 190 weeks).

STATE OF ILLINOIS)
) SS.
COUNTY OF VERMILLION

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Paris,

Petitioner,

vs. No. 08 WC 03951

Quaker Oats/Pepsico,

18IWCC0757

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTION 8(a)

Timely Petition for Review under section 8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of further medical expenses, and being advised of the facts and law, grants the 8(a) petition for the reasons set forth below.

On September 2, 2009, the Arbitrator filed a decision awarding medical expenses in the amount of $330.00 as provided in Section 8(a) of the Act and permanent partial disability benefits corresponding to a 10% loss of use of the person as a whole under Section 8(d-2) of the Act.

On September 29, 2017 Petitioner timely filed a petition for review under section 8(a) asking the Commission to enter an order for unpaid medical expenses related to Petitioner's ongoing medical bills for control of his continued pain related to the work accident of December 20, 2007.

In his brief on review, Petitioner asks the Commission to award additional medical expenses in the amount of $1,296.44 related to transforaminal epidural steroidal injections and prescription pain medications. Dr. Ferdinand Ramos, Petitioner's long-time treating physician has treated his low back condition before and subsequent to the arbitration hearing in 2009. The treatment protocol administered by Dr. Ramos has included opioid prescription medications and epidural steroid injections at L5-S1 and L4-5 every few months. Dr. Ramos' diagnosis of

18IWCC0757

chronic low back pain, lumbar disc protrusion at L4-5 and L5-S1 with lumbosacral radiculopathy has remained consistent over the course of years of treatment. Petitioner testified at hearing that he has not sustained any further injury since the December 20, 2007 work injury.

The symptoms expressed by Petitioner have been consistent since he began treatment for his low back injury on December 20, 2007. The medical records entered into evidence entirely support Petitioner's testimony that he continues to experience low back pain and bilateral leg pain that is relieved by periodic transforaminal epidural steroid injections administered by Dr. Ramos and daily use of hydrocodone.

Respondent had Petitioner examined by Dr. James Stiehl pursuant to Section 12 on July 18, 2017. Dr. Stiehl diagnosed Petitioner with "low grade chronic mechanical low back pain and opined that he would not have authorized any further treatment after April 27, 2009 at which point he found Petitioner to be at MMI." The Commission does not find the opinion of Dr. Stiehl to be persuasive. There is no evidence of any intervening event or injury that has changed or worsened Petitioner's condition. With the benefit of this treatment Petitioner has been successful in maintaining his employment without absence or sick leave.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §8(a) is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills incurred for treatment by Dr. Ferdinand Ramos M.D. in the amount of $1, 296.44 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 removal of this cause to the Circuit Court by Respondent shall be fixed at $1400.00. 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.

DEC 10 2018

DATED:
o-10/10/18
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHAYNE HOWELL,

Petitioner,

vs. NO: 17 WC 12433

STATE OF ILLINOIS MENARD CORRECTIONAL CENTER,

18IWCC0756

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19 (b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, and prospective medical expenses and being advised of the facts and law, modifies and otherwise affirms and adopts the Decision of the Arbitrator pursuant to sections 19(b)/8(a) which is attached hereto and made part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of further benefits, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Commission modifies the Arbitrator's Decision to deny the prospective medical care awarded to evaluate Petitioner for the possible existence of left thoracic outlet syndrome as recommended by Dr. Raskas. Petitioner is a correctional officer who sustained a facial injury on March 10, 2017 when he was assaulted by an inmate who was restrained in handcuffs. Petitioner was subsequently treated for headaches and left sided neck pain. During the first several months of treatment Petitioner expressed no symptoms of left extremity weakness or numbness.

Petitioner first reported left upper extremity symptoms to Dr. Raskas on May 16, 2017. On September 1, 2017 Dr. Raskas ordered an EMG study that did not report any evidence of left thoracic outlet syndrome. The Commission does not find the award of prospective medical care

18IWCC0756

to evaluate the Petitioner for the possibility of left thoracic outlet syndrome to be reasonable, necessary and causally connected pursuant to Section 8(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 1, 2018 herein, is hereby modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses contained in Petitioner's Exhibit 1 as provided under §8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit for payments made on any awarded medical bills pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and Respondent shall hold Petitioner safe and harmless for any credited medical expenses. Respondent may pay any unpaid causally related medical expenses contained within Petitioner's Exhibit 1 directly to the applicable providers.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is vacated.

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

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

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

Pursuant to Section 19 (f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: DEC 10 2018
o-10-11-18
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

HOWELL, SHAYNE
Employee/Petitioner

Case# **17WC012433**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

18IWCC0756

On 3/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
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 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

MAR 1 - 2018

DONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0756

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

SHAYNE HOWELL
Employee/Petitioner

v.

STATE OF ILLINOIS / MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # **17** WC **12433**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 10, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being, that being possible thoracic outlet syndrome, *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$53,519.29**; the average weekly wage was **$1,029.22**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$ALL PAID** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$ALL PAID**.

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

ORDER

The Arbitrator finds that the Petitioner has shown by a preponderance of the evidence that an evaluation for left thoracic outlet syndrome based on left arm symptoms is causally related to the March 10, 2017 accident. The Arbitrator specifically notes that this finding is limited to the possible existence of thoracic outlet syndrome, as noted by Dr. Raskas, and that no specific determination is being made with regard to the causal relationship of left thoracic outlet syndrome should such condition be found to exist. The Arbitrator finds that such a finding would be premature at this time pending such possible diagnosis.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize a thoracic outlet syndrome evaluation with Dr. Thompson, as recommended by treating orthopedic physician Dr. Raskas.

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 27, 2018
Date

MAR 1 - 2018

STATEMENT OF FACTS

The Petitioner testified that he works for Respondent as a correctional officer (CO). On 3/10/17, he escorted an inmate to court in Randolph County. When he returned he was taking him to get an updated ID card photo. Because the inmate was an elevated security risk, additional staff was required when he was moved. While he was still handcuffed in the front of his body, the inmate attacked another CO. The Petitioner stepped in to help and was elbowed in the left side of his head. He testified that he had no prior injuries or treatment to the left head or neck.

The Form 45, dated 3/10/17, notes Petitioner was struck in the head by an aggressive inmate, resulting in headache and dizziness. The initial on-site medical report noted diagnosis of "mental status change." The initial Supervisor's Report of J. Mileur notes "Head injury upper body", while the Supervisor's Report from Major Westfall notes Petitioner was struck in the face with a closed fist and received head injuries. The Notice of Injury, signed by Petitioner on 3/13/17, indicates "head injury Upper body." An Incident Report notes a co-worker was struck by the inmate in the left face with both fists and handcuffs, and when Petitioner stepped in he was struck in the left side of the head by the inmate's elbow, noting the altercation continued until the inmate could be restrained, and the Petitioner arose feeling disoriented and had a severe headache, then dizziness and nausea. Mace had been used as well. (Rx1).

The Petitioner testified that he reviewed his medical records prior to his testimony, and confirmed that they are accurate with regard to what he reported to the physicians he saw.

Following the injury, Petitioner presented to Chester Memorial Hospital on 3/10/17 with a history of being struck in the head near the left eye by an inmate wearing metal cuffs. Her complained of vision disturbances, nausea, difficulty focusing, neck stiffness/pain, and head pain. CT scans of the head, face and cervical spine were unremarkable. He was diagnosed with closed head trauma and prescribed medication and referred to his primary provider. (Px3).

Petitioner returned to the ER, this time at Southern Illinois Hospital on 3/12/17. He reported a worsening headache, noting he had been struck by an inmate at work and didn't remember the incident. He also reported persistent dizziness. Left trapezius and sternocleidomastoid tenderness was noted on exam. Neurologic exam was within normal limits. A repeat CT scan of the head showed no acute findings. Petitioner was diagnosed with concussion syndrome and he was prescribed Norflex, advised to remain off work for a week and to follow up with his primary provider the next day. (Px4).

Petitioner sought follow-up care at the SIH Work Care Occupational Health Clinic on 3/13/17, where he reported the incident at work and that he had a one or two-minute gap where he doesn't remember, including getting hit in the head – his recall returned when he was on the floor restraining the inmate with others. He reported he also had been maced in the face, and that when he started washing his face he noticed disorientation, dizziness, balance issues and severe headache. He had broken his glasses, and wasn't sure if his dizziness was associated with this versus the head injury. He had nausea on the way to the hospital. He reported mild headache, dizziness with sudden movements and that his nausea was controlled with medication. Florinal he obtained at the ER helped his headache. He noted mild neck discomfort and no other pain complaints. He could not test his vision because he needed new glasses. He noted difficulty sleeping and concentrating, but was managing his symptoms with medication and rest in a quiet, dark room. He was noted to be working full duty in one part of the report, and then another noted he hadn't been driving and hadn't been working. Examination appeared normal other than some difficulty with balance with heel-to-toe walking, and no bruising or abrasion was noted on the head. He had a history of depression that was medicated and controlled. The diagnosis was concussion without loss of consciousness. Petitioner was held off work. (Px5).

On 3/16/17, Petitioner reported ongoing headache and difficulty concentrating, and that his wife told him he had short term memory loss. He was continued off work and advised to rest his brain and to use ice for pain and swelling. On 3/20/17, Petitioner reported increased emotional issues, and his concussion SCAT screening score had increased since the last visit, but scores on memory and concentration had improved. Ondansetron was prescribed and he remained off work and was referred for a neurological consultation. On 3/23/17, Petitioner reported his main symptoms were constant headache and pressure in the head, but also noted ongoing problems with dizziness, balance, concentration and memory. SCAT testing indicated concentration was significantly improved. His blood pressure had been and remained elevated, and he was advised to see his primary provider given that this could be causing headache. (Px5).

Petitioner saw neurologist Dr. Ward at the SIH Brain and Spine Institute on 3/24/17. Petitioner reported daily incapacitating left temporal headaches that were unchanged. It appears that a history of migraine was noted, as well as left elbow surgery and bilateral carpal tunnel syndrome. Dr. Ward noted Petitioner denied problems with dizziness and memory, but did have nausea that he felt was worsening, and a separate entry in this report indicates he did report he has had short term memory problems. It should be noted that portions of this report are redacted. Examination noted no neck pain. Following examination, Dr. Ward noted subjective left arm numbness, no weakness and non-physiologic difficulty with tandem walking. Dr. Ward noted post-traumatic headaches could be contributing to his symptoms, and if he slept better at night and had better headache control, his symptoms should improve. He was advised to stop the 4 pain medications he was taking and to take only ibuprofen if he had an unbearable headache that prevented activity. (Px6). A disability statement from Dr. Ward on this date notes subjective symptoms of headache and numbness on the left side, with normal head CT scan and normal neurological exam. Diagnoses were concussion, post-traumatic headache and post-concussion syndrome. He was limited to sedentary duty with no climbing, and the Arbitrator again notes portions of this document are redacted

On 4/6/17, Petitioner followed up at SIH and reported that the Amitriptyline prescribed by Dr. Ward and blood pressure medication prescribed by his primary provider helped his headaches and condition. It was noted that Dr. Ward was obtaining a neuropsychological evaluation before attempting a return to work, though this was not noted in Ward's report. SCAT testing and cognitive testing again showed improvement, but he continued to report issues with concentration and memory. Work restrictions were deferred to Dr. Ward, however a note from this facility indicated Petitioner's physical impairment was class 5, meaning sedentary. (Px5).

On 4/18/17, Petitioner returned to Dr. Ward and indicated improvement in his headaches, but that it would worsen with reading or concentrating. Examination was normal other than headache, and balance and gait were noted to be normal. Dr. Ward expected further improvement and that he should be able to return to work in two weeks. Follow up was set for 6 weeks. (Px9). The Disability statement notes diagnoses of post concussive syndrome with attention deficit and headache, but that Petitioner was now capable of medium activity and that he was capable of returning to work on 5/2/17. (Px9).

On 5/16/17, Petitioner sought treatment with orthopedic surgeon Dr. Raskas. Petitioner reported being elbowed in the left temple area, and that he noticed a headache and posterior neck pain at that time. He reported that two days later he started noticing worsening neck pain that went into both of his shoulders, and that he went back to the ER due to worsening headaches. He reported left arm pain began to develop a week after the incident, a sharp stabbing pain that extends into the entire left arm with numbness and tingling. Petitioner noted prior CTS and ulnar nerve entrapment on the left that involved release surgeries in 2014. The report notes Petitioner affirmatively indicated low back pain, memory loss, anxiety and depression. However, this same inventory notes headache was denied. Examination noted some left tricep weakness, decreased sensation along the left tricep, bicep, and forearm, and along the left thenar and index finger compared to the right. Grip strength was normal. Petitioner was slightly off balance while tandem walking, but performed heel and toe walking without difficulty. Dr. Raskas' reviewed of the 3/10/17 cervical CT indicated no signs of an acute process, with some foraminal narrowing and osteophytes at C5/6 and C6/7. His assessment was neck pain and left arm symptoms following a work-related injury, and he recommended a cervical MRI, holding Petitioner off work pending same. (Px7).

The MRI was done on 6/9/17 and showed a C6/7 minimal disc bulge without spinal canal or foraminal stenosis, and mild disc desiccation from C2 to C5. (Px8). Dr. Raskas reviewed the scan on 6/9/17 and noted no large discs or nerve compression, and nothing that would indicate surgery. Petitioner reported that he exercises regularly with both strength and cardio training 4 times per week. Dr. Raskas believed the Petitioner had a cervical strain with some radiculitis and prescribed physical therapy. He was continued off work. (Px7). Therapy was performed from 6/13 to 7/13/17, and resulted in some improvement. (Px10)

On 6/13/17, Petitioner returned to Dr. Ward with complaints of somewhat worsening headaches, pain medication three to four times per week, Tylenol at night and Celebrex for neck pain, noting he had been taken off work for the neck by Dr. Raskas. Petitioner indicated he had not received a call about getting a neuropsych evaluation, and he continued to have issues with short term memory and attention. Petitioner noted headaches were "down" to a few times a week, but reported progressive left hand weakness and left arm numbness and tingling. Dr. Ward ordered a brain MRI "to look for cause of left sided hand weakness although it is more likely that this is related to the headaches on the left." Medications were prescribed for headache and attention deficit disorder. (Px9).

On 7/7/17, Petitioner underwent neuropsychological testing with Dr. Rupert, the report indicating it was on referral from Dr. Ward. Dr. Rupert noted the history of the injury and a history of headaches, low testosterone, hypertension, anxiety and depression. Petitioner reported ongoing pain in his neck and tingling in his left arm. Petitioner reported a brief loss of memory after being struck, vague memory of being evaluated on premises, and then clearer memory of being at the ER. He noted he went back to the ER two days later due to ongoing headaches "and some confusion noticed by his family and friends at church." He noted no significant improvement with therapy, and that he continued to have headaches once or twice a week since the injury. He noted ongoing memory and concentration problems. His wife noted short term memory and confusion for the first few days after the injury, and while this improved it had not returned to a baseline level. Petitioner notes difficulty retaining information, focusing on what he reads and sustaining concentration. Petitioner also noted an approximate one and a half year history of depression, after is third child was born, and that antidepressant

medication had improved this. He noted anxiety in his job having to deal with inmates, but reported no fear of this and denied any fear of returning to work. (Px9).

Following multiple testing batteries, Dr. Rupert noted results notable for deficits on measures of verbal learning, verbal working memory and verbal fluency. He had variable performance on processing speed measures with isolated relative weakness on a test of confrontation naming. He had relatively preserved performance of visual construction, delayed verbal recall, visual learning and memory, cognitive flexibility and novel problem solving. Delayed memory improved with recognition cueing. In sum, Dr. Rupert reported that the Petitioner's cognitive profile was "mildly abnormal and primarily characterized by isolated deficits on measures of verbal learning/attention and variability on measures of processing efficiency." He believed this pattern suggested a possible subtle left frontal/temporal dysfunction, but that the etiology of this pattern is not known, as this was "not a typical cognitive pattern four months post-concussion for a relatively young and healthy person." He opined that he would have expected the Petitioner to have a full or near full cognitive recovery at this point post-injury. Dr. Rupert stated: "I think it will be important to monitor (Petitioner) with follow-up assessment to see if he is still in the process of an unusually protracted cognitive recovery from his injury. Mild depression and anxiety symptoms could contribute to this pattern, but I do not think such symptoms totally account for this pattern." He advised consideration of a brain MRI to rule out any focal left frontal/temporal abnormality that could explain this pattern. He opined that if the weaknesses indicated in the evaluation are residuals of the accident, it is expected that he would continue to improve over the next weeks and months with an eventual return to baseline. He recommended a gradual return to work, and follow up in three to six months. (Px9).

Petitioner testified that he complained of excessive headaches with numbness and weakness down his left arm, and that his attorney recommended that he see Dr. Raskas.

Petitioner reported continuing neck and left arm symptoms at a 7/25/17 follow up visit with Dr. Raskas. He noted that Petitioner's grip strength had been worsening on the left even with assistance of physical therapy, and that Petitioner he still experienced left arm numbness with no improvement. Just as with the last examination, Dr. Raskas noted a "little bit of as positive" left Spurling's maneuver, but otherwise normal neurological examination. Dr. Raskas believed that Petitioner maybe experiencing symptoms of thoracic outlet syndrome, and recommended EMG/NCV testing to rule out any carpal tunnel or ulnar nerve entrapment prior to referring Petitioner out for thoracic outlet syndrome evaluation. He released Petitioner to return to work with a 25 pound restriction on lifting, pushing, and pulling, and a prohibition on cell extraction activity. (Px7).

Cervical MRI was repeated on 8/18/17 noting a history of neck pain, and again reflected a minimal diffuse annular bulge at C6/7 without stenosis, unchanged from 6/9/17. It is unclear why an additional MRI was obtained just over two months after the initial one was obtained, and just six months after a cervical CT scan was performed. (Px8). 9/1/17 EMG/NCV testing with Dr. Hurford was normal. (Px7).

Petitioner underwent a brain MRI on 9/8/17, prescribed by Dr. Ward. The history noted left arm numbness and weakness. Testing did not reflect any noted abnormalities. (Px4).

Petitioner last saw Dr. Raskas prior to the hearing on 9/19/17. He noted that since Petitioner had returned to work, his neck and shoulder pain had worsened along with some elbow and hand numbness with a feeling of left arm weakness. Examination noted some give-way strength in the left tricep, but otherwise normal motor power. EMG was negative for any significant pathology, and MRI was normal. Dr. Raskas did not believe he had anything further to offer Petitioner, noting that "While he may have some subjective complaints of pain that are real, I do not see a surgical option for him. It is safe to return him to work at regular duties." The only

remaining possibility Dr. Raskas noted is that Petitioner might benefit from evaluation by Dr. Thompson at Barnes Hospital for thoracic outlet syndrome. He was released to follow up as needed. (Px7).

The Petitioner testified that physical therapy didn't resolve his numbness or weakness. His headaches are improved, but he continues to have neck pain and numbness and weakness in his left arm. The Petitioner testified he hasn't had any new accidents or incidents since 3/10/17 that aggravated his condition in any way.

He testified that he wants to follow up on Dr. Raskas' recommendation for thoracic outlet syndrome evaluation because he wants to return to his pre-injury condition. His biggest current complaint is the numbness, noting this is impacting him emotionally because he can't hold his children with his left arm.

On cross examination, the Petitioner testified he returned to light duty in July 2017, and has returned to his full work duties since 9/20/17. Petitioner testified that he went back to lifting weights when he was released to light duty, and he continues to lift weights three to four times per week. He testified he followed his restrictions and didn't lift anything over 25 pounds until he was released to full duty. He agreed that he lifts free weights, but testified he is getting away from using them due to fear of his left arm going numb. On redirect examination, Petitioner indicated he takes precautions to lift weights safely, and he has decreased the weights he lifts by about 40%. He did concede that he has done overhead barbell presses with free weights.

Petitioner testified he has a visit scheduled with Dr. Ward in early 2018, following up from a late 2017 visit. He has no further planned visits with Dr. Rupert. Again, he wants to at least see Dr. Thompson one time.

CONCLUSIONS OF LAW

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

The Arbitrator notes that the key issue that brought this case to hearing is the Petitioner's desire to obtain a thoracic outlet syndrome evaluation based on a referral from Dr. Raskas.

The Arbitrator also notes that this determination was difficult in this case, as both sides had solid arguments for their positions. Ultimately, the Arbitrator finds that the Petitioner's current left arm condition appears to be causally related to the work accident of 3/10/17.

The Respondent argues in its proposed decision that the Petitioner did not make any complaints regarding the left arm until he saw Dr. Raskas in May 2017. However, the Arbitrator notes that the initial accident reports submitted by Respondent note complaints of "Head injury Upper body." Arguably, this could include the shoulder/arm area. At Chester Hospital on the date of accident Petitioner's complaints included neck stiffness and pain, and a cervical spine CT scan was obtained. At the SIH ER on 3/12/17, the report notes left trapezius and sternocleidomastoid tenderness on exam. At SIH Work Care on 3/13/17, while Petitioner didn't specify left arm symptoms, he does still note mild neck discomfort at that time.

Most significantly, in the Arbitrator's view, the 3/24/17 report of neurologist Dr. Ward notes subjective complaints of left arm numbness, though there was no neck pain at that time. It is accurate to say that Dr. Ward's focus after that time was the Petitioner's mental state more than his physical condition.

The Petitioner did then see Dr. Raskas, albeit at his attorney's suggestion, on 5/16/17, at which time he reported initially having posterior neck pain at the time of the accident, two days later noted the pain radiating to both shoulders, and about a week after the accident noticed left arm pain. Dr. Raskas noted various abnormal left arm findings on exam, including weakness and loss of sensation.

Based on these records, the preponderance of the evidence supports the finding that the left arm complaints are related to the accident. The reports of Dr. Raskas support this.

On the other hand, it is also clear that the treatment directed to the Petitioner prior to seeing Dr. Raskas was almost exclusively directed to the head and brain after the initial ER visits. The Petitioner has had prior surgeries involving the ulnar nerve at the left elbow and median nerve at the left wrist, which complicates this case. The Arbitrator also notes that EMG/NCV testing did not support any ongoing cubital or carpal tunnel conditions. The Arbitrator also notes with significant interest that the Petitioner admitted that he has continued to lift free weights, and that this includes overhead barbell presses. This certainly seems to indicate a generally functional claimant with regard to the left arm, and leaves his testimony that he emotionally has difficulty from being unable to lift his children with his left arm a bit disingenuous.

Taking all of the above into accident, the Arbitrator finds that by a small preponderance of the evidence, the Petitioner has shown that a thoracic outlet syndrome (TOS) evaluation for left arm complaints is related to the 3/10/17 accident. As no physician has yet commented on whether such TOS condition is or is not causally related to the accident, this issue remains open and depending on expert opinions should such condition ultimately be diagnosed.

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

The Arbitrator finds that the Petitioner is entitled to the medical expenses contained within Petitioner's Exhibit 1 pursuant to Sections 8(a) and 8.2 of the Act.

The Respondent is entitled to credit for payments made on any awarded bills pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and the Respondent shall hold the Petitioner safe and harmless from any claims for reimbursement or payment of any credited medical expenses. The Respondent may pay any unpaid causally related medical expenses contained within Petitioner's Exhibit 1 directly to the applicable providers.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the findings above related to causation, the Arbitrator finds that a left thoracic outlet syndrome evaluation is reasonable and necessary pursuant to Section 8(a) of the Act. Therefore, the Arbitrator finds that the Respondent shall authorize a thoracic outlet syndrome evaluation with Dr. Thompson, as recommended by Dr. Raskas. The Arbitrator notes that this award is specific only to a thoracic outlet syndrome (TOS) evaluation, and not any other possible left arm condition evaluations. No other diagnoses have been made with regard to the left arm other than possible radiculitis, which Dr. Raskas has already indicated is not a surgical problem. The Arbitrator makes no findings with regard to the causal relationship of any other possible left arm diagnoses, and causation remains an open issue with regard to left TOS should such condition be diagnosed.

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

Dana Wease,
Petitioner,

vs.

NO: 15WC 37666

United Methodist Village,
Respondent.

18IWCC0758

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, benefit rate, 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 14, 2018 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: DEC 11 2018
o120418
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEASE, DANA
Employee/Petitioner

Case# **15WC037666**

UNITED METHODIST VILLAGE
Employer/Respondent

18IWCC0758

On 3/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0695 GOSNELL BORDEN ENLOE & SLOSS
DEREK W McCULLOUGH
815-12TH ST
LAWRENCEVILLE, IL 62439

2795 HENNESSY & ROACH PC
JENNIFER YATES WELLER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

18IWCC0758

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DANA WEASE
Employee/Petitioner

v.

UNITED METHODIST VILLAGE
Employer/Respondent

Case # 15 WC 37666

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 **Mt. Vernon**, on **June 7, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0758

FINDINGS

On **July 22, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$19,676.80**; the average weekly wage was **$378.40**.

On the date of accident, Petitioner was **51** years of age, *single* with **0** dependent children.

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

Respondent *has 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

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that she sustained an accident which arose out of and in the course of her employment on July 22, 2015. 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

March 8, 2018
Date

MAR 14 2018

STATE OF ILLINOIS)
) ss
COUNTY OF JEFFERSON)

18IWCC0758

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DANA WEASE
Employee/Petitioner

v.

Case #: 15 WC 37666

UNITED METHODIST VILLAGE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties agreed that Petitioner sustained an accident on July 22, 2015, which resulted in injuries to her left leg. Respondent disputed that the accident arose out of and in the course of her employment. Respondent further disputed causation, medical bills, temporary total disability, and permanent disability, but stipulated that the dispute as to those issues stemmed from accident only.

On July 22, 2015, Petitioner was 51 years old, single, and had no dependent children. She had been a Certified Nursing Assistant (CNA) for about 15 years and had been employed in that capacity by Respondent for about two years. Her job involved direct care with residents and her duties included assisting with showers, feeding, dressing, and basic daily activities.

Petitioner testified that on July 22, 2015, her shift began at 6:00 a.m. On her way to work that morning she experienced car trouble, and when she pulled into the south parking lot she noticed that her brakes had gone out. This was at approximately 5:30 a.m. She began her shift and waited for her local mechanic to open his business for the day. She called him at about 8:00 or 8:30 and asked him to come and pick up her car from the parking lot. At about 9:00 or 9:30 she noticed that the mechanic and his employee were pulling into the north parking lot on the other side of the building. She asked Heather Sherman, one of the nurses, if she could go outside to give the mechanic her car keys. She noted that her supervisor had not yet arrived for the day.

Petitioner testified, "So I went outside, handed him the keys, and as I started to go back in, I had stopped and talked to the guy that had moved the car. And while I was talking to him, that's when—that's when I got hit." Petitioner explained that the person she handed her keys to and who had moved her car was an employee of the mechanic. The mechanic was driving the truck that was going to haul her car back to the shop, and he had pulled into the south parking lot. The truck was not a regular tow truck, but rather a truck with a trailer on the back.

Petitioner testified that she went out to the parking lot strictly to hand the keys to the mechanic and was on her way back into work. She did not go out for any purpose related to her employment or on behalf of Respondent. She was not on a break, was still on the clock, and had gotten permission from the nurse to go out to the parking lot. She testified employees are allowed to go out to the parking lot on their breaks, but otherwise are allowed to do so only if they need something from their car, such as to get change for a soda or something.

Petitioner testified that she was required by Respondent to park in the employee parking lot on the south side of the building and that the parking lot on the north side of the building was for the general public and visitors. She testified that if she were to park in the visitor's parking lot, she would be asked to move her car to the employee lot. She noted that the employee parking lot was smaller than the visitor lot and there was "not as much room to park and back in and out". Petitioner agreed that, although the south lot is designated for employees, it is accessible to the general public and there are no gates or other obstacles to restrict access to the lot. She also agreed that it would be hard for a tow truck and trailer to maneuver in any parking lot.

Petitioner testified that she did not really know how the accident occurred. She was standing next to her car talking to the mechanic's helper and had her back to where the mechanic had parked his truck. She did not know how he hit her because she could not see it, and did not know if she was hit by the truck or by the trailer part. She testified she had gone to the parking lot only to give her keys to the mechanic, and her intent was to return back into work after she did so. She was out in the parking lot speaking to the employee for no more than five minutes. She testified that as far as she knows, "the facility" (Respondent) owns the parking lot, which is located right next to the building.

Petitioner testified that following the accident she was taken by ambulance to Lawrence County Memorial Hospital. It was determined she had a fracture to her left leg. She was discharged and a few days later she came under the care of Dr. Patrick Laboe with Carle Clinic. She had surgery on her leg, which included insertion of a steel plate and screws. After release from the hospital following surgery, she was in a nursing home for two months to convalesce. She eventually returned to work part time on January 27, 2016, and returned to full time in late April. She was released from Dr. Laboe's care in April 2016 and has not returned.

Petitioner testified that currently she still has a lot of pain in her leg, she cannot walk as far as she used to, and she has trouble with stairs. She is no longer under active medical care but she continues to take pain medication on an as needed basis, which is prescribed by her primary care physician. She testified that prior to the accident she worked 12-hour shifts five days a week and now is restricted by her primary physician to only an 8-hour shift.

On July 28, 2015, Petitioner presented to Dr. Patrick Laboe of Carle Physician Group. He noted, "She was at work and went outside where her car was being towed, the tow trailer ended up hitting her left leg and she had immediate pain and deformity." She was evaluated at the local ER and found to have a left lateral split depression tibial plateau fracture. Dr. Laboe agreed with that assessment and advised she needed surgical fixation. PX1, Dep.PX2.

On July 30, 2015, Petitioner underwent open reduction and internal fixation for left unicondylar tibial plateau fracture. She remained in the hospital until August 3, 2015, at which time she was transferred to United Methodist Village convalescence. PX1, Dep.PX3.

Petitioner followed up with Dr. Laboe on August 17, 2015, and was instructed to work on active and active assisted range of motion of the knee. She was to continue to be nonweightbearing for about ten weeks. She returned on September 15, 2015, and was doing well. She had no tenderness to palpation and had pain-free range of motion to about 90 degrees of flexion. She was nonweightbearing and used a walker or a wheelchair to get around. When she returned Dr. Laboe on October 27, 2015, she was doing well with minimal pain and was eager to start weightbearing. She was allowed to do so as tolerated and was instructed to continue physical therapy to work on strengthening, conditioning, gait training, and range of motion. She returned to Dr. Laboe on January 27, 2016, and reported she was doing well, with minimal discomfort. She was still working on strengthening the leg and still walked with a bit of a limp. She advised she wanted to return to work but was not sure she could return full-time yet. She was allowed to return to work at 20 hours a week and was to continue her exercises and activity as tolerated. PX1, Dep.PX2.

On April 27, 2016, Petitioner followed up with Dr. Laboe and reported she was doing well. She was back to work but was still limiting her hours due to some achiness. She was able to walk for about an hour or two before she started having pain in the knee. She noted that the pain went away with rest and that she did not need any pain medication. On examination, the knee range of motion was full and was stable to varus and valgus stress. Dr. Laboe noted,

> *"Ms. Wease can return to activity as tolerated. She is doing very well right now. She can return to work. I wrote a note for her to work eight hours at a time for a shift until the end of May, at which point she can return to longer shifts if she desires. We will see her back on an as-needed basis.* PX1, Dep.PX2.

Dr. Laboe testified by way of deposition on October 12, 2016. He testified consistent with his treating records. 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 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; *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 201 (2003); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present at the time of the

claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

An injury "arises out of" one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work or that he or she is exposed to the risk of injury to a greater degree than the general public. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill.App.3d 149, 162 (1st Dist. 2000).

The Arbitrator finds that Petitioner's injuries were not the result of an employment related risk nor a personal risk. Rather, the risk was neutral.

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. 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. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 990 N.E.2d 284, 290 (4th Dist. 2013).

In this case, Petitioner attempted to establish a qualitative increased risk. She testified that the south parking lot was owned by Respondent and that employees were required to park in the south lot, which was smaller and not as wide as the visitors' north lot. She testified that that there was "not as much room to park and back in and out as there is on the other side". She opined that, as between the north and the south parking lots, it would have been easier for the tow truck and trailer to pull into the north lot, as it was bigger. She insinuated that the size and shape of the parking lot, which was owned by Respondent, made it more difficult for the tow truck to maneuver, thereby qualitatively increasing her risk of injury. The Arbitrator is not persuaded by this argument.

Petitioner candidly testified that she did not know how or why the tow truck hit her, as she had her back to the truck. There are any number of reasons this accident may have occurred—inattention of the driver, inattention of Petitioner, equipment failure, or miscalculation of distance by the driver, to name a few. Certainly the driver, who presumably was familiar with his own vehicle, was experienced in pulling that vehicle in and out of parking lots in order to pick up disabled cars. There are no facts in evidence to establish that the size and/or configuration of the parking lot played any part in this accident.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident on July 22, 2015, 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. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Stadelbacher,
Petitioner,
vs.

NO: 16 WC 24411

Choate Mental Health,
Respondent.

18IWCC0759

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical, 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 July 11, 2017 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: DEC 12 2018

Charles J. DeVriendt

Joshua D. Luskin

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CJD/rlc
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18IWCC0759

DISSENT

Petitioner bears the burden of establishing her injury arose out of and in the course of her employment. *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶ 35. "In the course of" speaks to the time, place, and circumstances of the occurrence of the injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 52, 57, 541 N.E.2d 665 (1989). "Arising out of" speaks to risk. "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. [citation omitted]." *Id.* at 58. "Thus, an injury is not compensable if it resulted from a risk personal to the employee rather than incidental to the employment." *Orsini v. Industrial Commission*, 117 Ill. 2d 38, 45, 509 N.E.2d 1005 (1987). Petitioner's injury occurred while leaving her office at day's end. T. 11. Petitioner was in the course of her employment. I believe Petitioner failed to prove her injury arose out of her employment. Accordingly, I dissent.

Petitioner testified she exited through the blue door, an exit only, onto a concrete slab then into a grassy area where she stepped into a hole causing injury to her left knee. T. 12. Petitioner testified the exit she utilized was an exit only from the employee lounge. T. 18. Petitioner testified the tan door also exits from the employee lounge directly to the staff parking area but requires a longer walk due to a retaining wall. T. 22. Two other exits were provided- "a door just down from it [the exit Petitioner utilized]" and a door at the end of the building to which Petitioner and a co-employee had exclusive access. T. 18-19. Petitioner testified she utilized the blue door to exit because it was closest to her car, and if she used the alternative exits, she would be required to walk further. T. 23. On cross-examination, Petitioner testified the tan door exits onto a paved sidewalk which provides access to the paved parking lot. T. 42-43. Petitioner reiterated she used the blue door exit as it was a more convenient exit. T. 44.

Petitioner testified she believed other employees used the blue door to exit, and she was never advised by Respondent not to use the blue door as an exit. T. 21. Petitioner witnessed persons using the blue door to exit to 1) smoke as well as 2) housekeepers to shake out dust mops. *Id.* Petitioner testified she was aware of the holes in and around the concrete slab as she stepped into one on a previous occasion. T. 27.

Mr. Chris Doctorman was called to testify on Respondent's behalf. Mr. Doctorman testified he was employed as the chief engineer for Respondent and had been so for the past nine years. T. 53. Mr. Doctorman testified the tan door was the main entrance to the building, and the blue door could not be used as an entrance. T. 54. Mr. Doctorman testified the blue door was necessary as an exit in order to maintain code compliance for the appropriate number of exits from the employee lounge. T. 56. Mr. Doctorman testified the tan door exit proved a paved access directly to the parking lot. T. 57.

Mr. Doctorman testified that he was unaware if prior to Petitioner's accident, employees were advised not to use the blue door exit, and he had not personally advised any employees of the same. T. 60. Mr. Doctorman testified he was not aware of employees using the blue door as an exit. T. 60-61.

I believe Petitioner exposed herself to an unnecessary personal risk when she voluntarily chose to take an unpaved route to her vehicle solely for her own convenience. As such her injury did not arise out of her employment. I believe the matter of *Dodson v. Industrial Commission*,

308 Ill. App. 3d 572, 720 N.E.2d 275 (1999) is directly on point, and unlike the majority, I fail to see how it is distinguishable.

In *Dodson*, claimant after completing her shift fell en route to her car located in the employee parking lot. Claimant left the paved sidewalk instead opting to utilize a grassy slope due to the inclement weather. The Commission denied compensation benefits. In affirming the Commission's denial, the Appellate Court held claimant was in the course of her employment, but she failed to prove her injury arose out of her employment. In so holding, the Court found "an injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. *Orsini, 117 Ill. 2d at 47*." *Dodson* at 576. The Court further noted:

> To accept claimant's argument would require employer to make the grassy slope safe for pedestrian use even though employer already provided a safe route to the parking lot. Furthermore, if other employees chose different paths, employer would be required to make these routes safe as well. The result would amount to the tail wagging the dog. Employees rather than employer would dictate ingress and egress routes, thus allowing the individual whim of each employee to be the impetus for establishing multiple new paths. *Id.* at 577.

In the present matter, Respondent provided a paved entry/exit which allowed Petitioner direct access to the parking lot. Petitioner utilized this safe path to enter her work premises but chose to utilize an unsafe path when exiting the building for her own convenience despite the safe route being provided by Respondent. Petitioner chose this path knowing she might confront an uneven surface with holes. Petitioner testified to her knowledge other employees used the same route to exit but only testified to observing co-employees using the exit to smoke or perform cleaning duties not traversing the grass to their vehicles. Mr. Doctorman testified that Respondent was unaware the unsafe route was being used by its employees. Even if Respondent was aware of the use of an unsafe route by its employees, as the Court noted in *Dodson*, "'Employer acquiescence alone cannot convert a personal risk into an employment risk.' citing *Orsini, 117 Ill. 2d at 47*." *Dodson*, 308 Ill. App. 3d 572, 577.

The majority attempts to distinguish *Dodson* by its misplaced reliance on the presence of an alleged "defect" on Respondent's premises. There is no defect. It is grass; by its nature it is uneven which is why Respondent provided a paved sidewalk with direct access to the paved parking lot.

For the reasons stated above, I would find Petitioner failed to prove she sustained an accident which arose out of her employment. Accordingly, I dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

STADELBACHER, MICHELLE
Employee/Petitioner

Case# 16WC024411

CHOATE MENTAL HEALTH & DEVELOPMENTAL CENTER
Employer/Respondent

18IWCC0759

On 7/11/2017, 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 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0355 WINTERS BREWSTER CROSBY & ETAL
LINDA CANTRELL
111 W MAIN ST PO BOX 700
MARION, IL 62959

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
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CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUL 11 2017

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

18IWCC0759

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)/8(a)

MICHELLE STADELBACHER
Employee/Petitioner

v.

CHOATE MENTAL HEALTH & DEVELOPMENT CENTER
Employer/Respondent

Case # 16 WC 24411

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 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 _____

FINDINGS

On the date of accident, **June 23, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$109,213.78**; the average weekly wage was **$2,100.27**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$0** 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 PAID** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment with the Respondent on June 23, 2016. The Arbitrator further finds that the Petitioner's left knee condition of ill-being is causally related to the June 23, 2016 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$1,398.23 per week**, the maximum allowable statutory rate, for **5/7 weeks**, for intermittent dates as indicated in Petitioner's Exhibit 16, as provided in Section 8(b) of the Act.

Respondent shall pay the causally related reasonable and necessary medical service expenses contained in Petitioner's Exhibits 5, 7, 9, 11 and 13, as provided in Sections 8(a) and 8.2 of the Act. Pursuant to stipulation, the Respondent shall pay the awarded expenses directly to the providers pursuant to Sections 8(a), 8(j) and 8.2 of the Act. Respondent shall be given a credit for any awarded 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

June 27, 2017
Date

JUL 11 2017

STATEMENT OF FACTS

Petitioner, a Respondent employee since 1988, testified she has been a public service administrator and training director, since 1999. As PSA, she manages the administrative department, and as training director, she is responsible for planning, implementing and conducting training for employees. There are a number of buildings on Respondent's grounds, and she has been in the main building in the training department since 1999.

To leave the building from the second floor, she has to go down stairs, and most days she exits through the employee lounge. From there she exits a blue door, ascends several steps, and reaches a concrete slab. She testified that she has used this door for 17 years.

On 6/23/16, she was leaving work around 4:35 p.m., went downstairs and exited through the blue door in the lounge. She went to step off the concrete slab into the grassy area and stepped into a hole that was not visible with her left foot, twisting her left knee. The next morning her knee was swollen and she couldn't walk, so she came to work and completed an injury packet, after which the unit nurse and physician, Dr. Eck, saw her and took her off work. She then sought treatment with her primary care provider, Dr. Ribbing, that afternoon at Rural Health.

The Tristar Notice of Injury states that Petitioner was leaving work for the day, walked up the steps to exit the basement of the main building, stepped onto concrete slab, stepped off the left side of the slab onto the grass into an unseen hole. She twisted her left knee and falling forward. While the document is dated 6/23/16, the Petitioner notes that she didn't initially report the injury because she thought she could walk it off. (Px1). A "Critical Event Report", prepared on 6/24/16, provides the same history, and that the knee ended up swelling with tightness and pain. (Px2). The Petitioner saw a nurse and then Dr. Eck at the company clinic on 6/24/16. His report noted no history of a prior left knee injury "but has had arthroscopy for recurrent swelling." The diagnosis was a left knee sprain of deep knee ligament tear. (Px3 & 4). The reports submitted by Respondent are consistent with these reports as far as the history of how the injury occurred. (Rx1, 2 & 3).

The Petitioner presented multiple photos of the scene as Px15. Photo 99 depicts the blue door she exited from (she notes there was no caution tape or gravel present on the accident date). The blue door exits from the employee lounge, which is only accessible by employees, including those who work in other buildings as it is the only such lounge on the premises. This door is only an exit door from the lounge (see Photo 101), not an entrance from outside. Photo 100 shows the blue door from inside the employee lounge. She testified she typically exits through this door because it is the easiest route to the parking lot, which is about 10 feet away, noting other employees use the blue door as well. There is an "Exit" sign on the wall next to the door, and a small sign on the door which notes the door is not for entry. She was never told not to exit the blue door. She

does not use the tan door because, a) it requires you to walk all the way down to the end of the building or you have to step over the wall, and b) it is closer to the TV, vending area and pool tables in the lounge and she doesn't want to get in the way of other employees. Plus, again, the blue door has a more direct path to the parking lot. On the accident date, she stepped off the concrete to her left towards the sewer cap, which was closer to her car and away from the gravel area where she knew there were holes. She stepped directly into the hole with her first step. The grass must have been covering it at the time because she hadn't seen it. She had taken the same path before, and "I guess I had just missed the hole". She doesn't know if there were any work orders to fix this area. Petitioner has been part of the Respondent's health and safety committee since probably 2000, and meetings are monthly. The assistant chief engineer, Kevin Tucker, is also on the committee, and part of it does involve discussions about grounds safety. Tucker's boss is Chris Doctorman. When she returned to work after being injures, she was asked about the incident prior to the start of the meeting, and Tucker laughingly said, of course Petitioner would be the one to find the one hole. He indicated that it had been recorded and they filled the area with gravel and put up the caution tape. Nothing is indicated on the blue door about not using it to exit, but if someone did they would run into the caution tape.

Petitioner testified that there are no designated employee parking spots, but a recent change in parking policy means Petitioner has to tell new hires that they need a parking permit "and where to park and park out back behind the buildings that they work in.". The parking lot behind the main building is open to the public, but there would be no reason to park there because they could not enter the building. There are visitor lots on the other side of the building.

Photo 102 shows the rear of the main building, and the blue door is near where the depicted buildings corner with each other. The other "tan" colored door that is shown also exits from the employee lounge. Petitioner testified her car was parked where the orange car is shown in the photo. If she would exit the other tan door, she would have to walk all the way down the building because of the wall. She has always parked in the same location – "that's where staff park" that work in that building or the other building. You can enter the building via the tan door or another door on the end of the building. Petitioner testified she has seen employee smokers exit the blue door as well as housekeepers to shake dust mops over the railing: "Going out the other door, if they would shake it it would be on the sidewalk and parking lot area where people traverse."

Petitioner testified that the area where she stepped in the hole is depicted in photo 103, and that her understanding is that the gravel was placed there to fill it after she reported the incident. Photo 105 is the "before" phot, and photo 106 shows the area after the gravel was added. When she started wit Respondent there was no grass or concrete slab, just dirt, and there were holes out there then as well. She testified she once stepped into a hole in the snow and went in to her knee, and after she reported it that hole was then filled.

Photo 104 depicts the hole, and this photo was obtained by Respondent and security after Petitioner reported the incident. The leg in the hole is someone else's. She can't be sure it's the same hole she stepped in because she can't see its orientation versus the slab, but she was told it is the same hole.
Her foot went straight down into the hole, with toes pointed down, to about the ankle, and kind of caught her ankle. The grass looked about the same as in this photo, but some of the grass had been cut away so that they could photograph the hole.

Dr. Ribbing's 6/24/16 note states Petitioner injured her left knee the prior day at work when she stepped in a hole and twisted it. She was diagnosed with a sprain and held off work through 6/28/16. On that date she followed up and noted no improvement, so a left knee MRI was prescribed and Petitioner was continued off work. On 7/12/16, Petitioner was still awaiting MRI approval but wanted to continue to work light duty, which she was then continued on. She noted she was able to work but couldn't tolerate her usual ambulation and was

taking some days off. At the last visit of 7/26/16, Petitioner reported some minimal improvement, and Dr. Ribbing prescribed Norco while awaiting the MRI scheduling. (Px6). Petitioner testified that she returned to work on 7/6/16 because the Respondent was not paying her TTD, even though Ribbing wanted her to remain off work for two more weeks. She testified that he gave her restrictions on stair use and the need to sit and stand as needed, and when she went back to work a co-worker helped pick up her slack. She also used intermittent vacation and sick time.

8/19/16 left knee x-rays showed mild tricompartmental joint space narrowing with tiny osteophytes, but no acute findings. (Px6). The MRI was finally performed on 8/30/16 at Union County Hospital, and the reported impression was tricompartmental arthritis with multiple osteochondral loose bodies, as well as spurring in all compartments, but the menisci and ligaments were noted to be intact. (Px8).

Petitioner sought treatment with orthopedic surgeon Dr. Barr on 9/6/16 on referral from Dr. Ribbing. She noted 7/10 to 9/10 pain and swelling. Petitioner reported a prior arthroscopic surgery to the knee 15 years prior with a Dr. Davis. She reported having a synovial cartilage problem at that time, and doing very well after surgery with no symptoms until her recent injury. After examination and review of the x-ray and MRI, Dr. Barr diagnosed a left knee strain with intraarticular loose body and probable osteochondral fracture with persistent symptoms. Treatment options were discussed and Petitioner opted for surgery to remove the loose body or bodies. (Px10).

Surgery on 9/8/16 involved arthroscopy with chondroplasty of the patella and loose body removal. The report noted the loose body, grade 3 chondromalacia on the superior patella and intact ligaments and menisci. A separate loose body was initially noted in the posterior/superior knee, but it was fixed in place and so was not removed. Work restrictions were issued on 9/22/16, with Petitioner noting she was better but still having problems with stairs. She still had some soreness and swelling. She was advised to perform home exercises and to lose weight. (Px10). There is no indication in the medical records in evidence of further treatment.

On cross examination, Petitioner again indicated she was leaving work to go home when the incident occurred. She agreed that the tan door, depicted in photo 102, is also an exit, and that it has a completely paved path to the parking lot. However, she testified that it is not the "main" exit door versus the blue door, and that if she used the tan door she would have to walk all the way down the building and then come back around to her car. The blue door provided a more direct path. Petitioner agreed she testified that she knew there were holes in that area in the past, but that they were in front of the slab, not in the grassy area to the side of the slab. Petitioner and her daughter took photos 99, 105 and 106.

With regard to the documentation in Px16, Petitioner testified that she was actually on vacation from 8/8 to 8/12, and thus not claiming benefits for these dates. She also was on service connected leave from 6/27/12 to 7/1/12 and was paid, so did not include that in her claimed lost time either.

Petitioner had a prior arthroscopic left knee surgery in 2001 for a torn meniscus, but returned to work 5 days later and had no ongoing problems since that time. She is currently working full duty, as her restrictions were lifted on the 10/24/16. She has had no formal postsurgical therapy, just a home exercise program. She is not currently taking any medications. She occasionally wears a magnetic knee brace for swelling, but it is not prescribed. She testified she has been able to do her job satisfactorily "within the last week". She has been released from care but was told it would be 6 to 8 months before she would reach full improvement, and to follow up if needed.

Chris Doctorman, Respondent's chief engineer for the past 9 years, testified that he is familiar with the grounds around Petitioner's building, which is the main building. He testified that as to the tan door, "I consider it to be

the main entrance" and exit to the lounge, and that you cannot enter the building through the blue door. He testified that the blue door is mainly used as an exit from an area that is considered to be area occupied for. The blue door was used for vendors, and it was needed because the occupancy rules required a second means of egress. However, because they cannot get into the blue door, vendors don't use it. He testified that most employees use the tan door to exit from the lounge.

Mr. Doctorman testified that the area near the blue door is mowed weekly. In his position, he is made aware of any issues on the grounds, and he testified that he was not aware of any holes in the area prior to the Petitioner's injury.

On cross exam, Mr. Doctorman testified that he is in the main building almost every day. He is not typically there between 4 and 5 pm when employees are leaving. The area is mowed with a riding mower, not a push mower.

The blue door has an exit sign, and it doesn't say it is only an emergency exit. If Petitioner testified that half of the employees use the blue door to exit, Mr. Doctorman testified he would not be able to say if that was accurate or not. He is not aware of anyone with the Respondent telling employees not to use the blue door, but testified he did not realize people were using the blue door to exit the building. Had people been using that path, he testified that the grass would have been worn down in that area. You can tell by the grass which areas people commonly use.

CONCLUSIONS OF LAW

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

The key issue in this case is whether the Petitioner's injury arose out of her employment with the Respondent on 6/23/16. The *Dodson v. Industrial Comm'n* case clearly supports, in the view of the Arbitrator, that the Petitioner remained in the course of her employment with Respondent when the injury occurred. *Dodson v. Industrial Comm'n*, 308 Ill.App.3d 572, 720 N.E.2d 275, 241 Ill.Dec. 820 (1999).

The *Dodson* case involved a claimant who was leaving work for the day, exited the building on a designated path, went into cold and rainy weather and decided to cut across a grassy hill area instead of remaining on the sidewalk, where she slipped and fell and sustained injury. The Court determined that the case was not compensable. They noted that the claimant unnecessarily exposed herself to danger separate from her employment responsibilities for her own personal convenience of taking a short cut. Noting the claimant testified that she and other employees had taken the same path in the past, the Court also stated: "Employer acquiescence alone cannot convert a personal risk into an employment risk." Citing another case, *Hatfill v. Industrial Comm'n*, 202 Ill.App.3d 547, 560 N.E.2d 369, 148 Ill.Dec. 67 (1990), the Court stated: "The fact that some people may choose to leave the work place in an unsafe manner does not make such voluntary acts compensable, nor is Respondent required to police the exit routes to prevent all unsafe voluntary acts."

However, the Court also went on to note they were not implying that an injury cannot arise out of the employment simply because an employee chooses an alternative path to/from the work place, and that: "To be sure, employees are free to choose any safe route." Dodson at 577. The Court went on to note that the Commission's determination that the claimant exposed herself to an unnecessary personal risk was against the

manifest weight of the evidence. A dissenting justice, noting the *Hatfill* case involved a claimant who took a short cut that involved jumping over a ditch in violation of safety warnings, indicated that he would have decided the case differently because the claimant chose a route that was "customary, permitted and reasonable", particularly since there was evidence that the provided route may also have been unsafe due to the weather.

In *Litchfield Healthcare Center v. Industrial Comm'n*, 812 N.E.2d 401, 349 Ill.App.3d 486, 285 Ill.Dec. 581 (2004), a claimant was walking from her car back to the building when she tripped in some fashion on the sidewalk on the way back. The Court found in her favor, noting a defect in the sidewalk existed on the route, and the claimant was exposed to a greater risk based on having to traverse the defective area more often.

The Court also held that when an injury to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a specific risk or hazard, the hazard becomes part of the employment. *Id.* at 406. Special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act.

The Respondent cites *Dodson* in support of their defense of this case. On its face, the Arbitrator agrees that the fact pattern is similar to the one in the case at bar, in that the claimant chose a more convenient path to get to her car than what was generally provided by the employer. The Petitioner in this case admits that the reason she took the route she did instead of a route on a paved sidewalk to the parking lot is because it was more convenient because it was a more direct route.

However, the Arbitrator believes there are some key differences. First, the Court in *Dodson* notes that the path the claimant took involved an unnecessary risk. While in that case the claimant was traversing a wet and icy grass hill, in this case the Petitioner was attempting to cross a level grassy area with no indication that the weather made the path more treacherous. Secondly, this case involves a clear defective area with a deep hole that the Petitioner stepped in. There was no evidence of such a defect in *Dodson*. Additionally, it is arguable that the path the Petitioner took was really the general path all employees took who left by the blue door. It was not like there was a specified paved or concrete path leading out from the blue door exit. There was a concrete slab, and an employee would then traverse a dirt area if thy continued straight or the grassy area if they made a turn to where the Petitioner's car was parked. The blue door is marked with an "exit" sign inside the employee lounge, which would seem to the Arbitrator to indicate that this was a designated exit.

This does not appear to the Arbitrator to be a case of employer acquiescence in employees taking an odd and potentially unreasonable path as much as a case where the path was specifically provided as an exit and the employee took the closest route from that exit to the car. While another exit was provided, i.e. the tan door, there is no evidence which indicates that the employer directed employees to use that door versus the blue door. While Mr. Doctorman testified that most employees used the tan door, on cross examination he made it clear that he was not always present at the main building when employees would leave and would not be able to say which door was used more with any accuracy. Petitioner's testimony is that she has used the blue door for 17 years and other employees also used it to leave the building.

The Arbitrator finds that the preponderance of the evidence and current case law supports the finding that the Petitioner sustained accidental injuries arising out of and in the course of her employment with the Respondent on 6/23/16.

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 Respondent indicated prior to hearing that if the Petitioner were to succeed in proving a compensable accident, that there was no dispute on the issue of causation. The chain of events further supports this, as there is no evidence the Petitioner had prior left knee problems, credibly testified she twisted her left knee in the incident on 6/23/16, reported this promptly to the employer and thereafter had left knee symptoms. While she had a prior left knee surgery, this was 15 years prior to this accident, and the Petitioner credibly testified she had no ongoing left knee problems. The Arbitrator finds that the Petitioner's left knee injury was causally related to the 6/23/16 accident.

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

Based on the findings of the Arbitrator with regard to accident and causation, the Arbitrator finds Respondent is liable for medical services related to Petitioner's injuries. Respondent shall pay Petitioner's medical expenses set forth in Petitioner's Exhibits 5, 7, 9, 11, and 13 as provided in Sections 8(a) and 8.2 of the Act, and as itemized as follows:

Rural Health, Inc. (Px5)	$715.00
Union County Hospital (Px7)	$7,016.00
Orthopaedic Institute of Southern Illinois (Px9)	$5,401.00
Southern Illinois Orthopaedic Center (Px11)	$7,400.00
Brigham Anesthesia (Px13)	$950.00

As stipulated by the parties, the Respondent shall pay these expenses directly to the providers pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and shall have credit pursuant to these same Sections of the Act for any such awarded expenses that were paid prior to the hearing, so long as the Respondent holds the Petitioner harmless with regard to those bills.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator does not see any specific treatment recommendations that are currently pending for Petitioner. She was released from care by her orthopedic surgeon. As such, she is not entitled to an award of prospective medical treatment at this time.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted an itemization of her time off work related to her injuries, marked Petitioner's Exhibit 16. Petitioner took intermittent leaves of absences to received treatment related to her injuries. Petitioner's Exhibit 16 lists a number of days in which she was paid vacation or sick pay. Petitioner lists 5 days and 4 hours of time she was not able to work due to her injuries and for which she did not receive sick or vacation pay. Respondent shall pay a total of 5/7 weeks of temporary total disability.

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

Szymon Oleksy,

Petitioner,

vs.

NO: 15 WC 2473

18IWCC0760

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 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.

18IWCC0760

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: DEC 12 2018
TJT:yl
o 11/5/18
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I dissent. This case comes down to credibility, and I found it very difficult to believe the narrative manufactured by Wojtek Kowalczyk, the sole owner and operator of WK Heating, whose claim of having no employees working for him, only independent contractors, is patently absurd as far as I'm concerned. Indeed, it seems rather obvious to me that Mr. Kowalczyk is engaged in a form of corporate gamesmanship that, at the very least, contravenes the very purpose of the Act, which the Illinois Supreme Court has stated involves the basic premise that "... the burdens of caring for the casualties of industry should be borne by industry and not by the individuals whose misfortunes arise out of the industry, nor by the public." *Shell Oil Co. v. Industrial Commission*, 2 Ill.2d 590, 119 N.E.2d 224, 228 (1954).

Petitioner was just such an employee. And so was his co-worker Pawel Cembala, who corroborated Petitioner's testimony to the extent that (a) he was paid an hourly wage, and not per project as Mr. Kowalczyk claims; (b) Petitioner did not have previous experience in the HVAC business prior to his hiring by Respondent; (c) Respondent supplied all of the specialized tools and equipment, and even some of the more basic tools, and ordered and paid for the materials that Petitioner would often pick up; (d) Respondent, in the form of Mr. Kowalczyk, maintained and exercised a degree of control over the manner in which the work was performed and was in contact with his employees throughout the day, either in person or on the phone via calls or text messages; and (e) it was essentially a condition precedent to his employment with Respondent that he

incorporate and purchase his own workers' compensation insurance. Petitioner also produced a photograph of a t-shirt he noted Mr. Kowalczyk had printed up with the company name, address and phone number that they were to wear on the job. Or are we to believe that Petitioner printed up such a shirt for his own edification?

I also do not believe that Petitioner "opted" out of the Act by agreeing to exclude himself from the workers' compensation policy he purchased at the insistence of Mr. Kowalczyk. Indeed, I question whether Petitioner fully understood what he was doing, much less knowingly elected to exclude himself from the Act entirely, when all he wanted was a job and given his understanding that Respondent's insurance would cover him in the event of injury.

All of the above points to an employee/employer relationship, pure and simple, and it doesn't matter one bit that Petitioner had incorporated a company prior to working for Respondent or that no taxes were withheld from his paycheck. It likewise highlights, in sharp contrast, the inequitable bargaining positions of the respective parties in this case – namely, the experienced HVAC contractor and the Polish-emigre pool of workers he was able to exploit to operate his business under the radar.

In short, by affirming the Arbitrator's decision to deny compensation in this matter, the Commission is effectively allowing Respondent to avoid the expense and responsibility imposed on every other employer in the State, and in the process condones Respondent's efforts to circumvent the law.

And for that reason, I respectfully dissent.

Thomas J. Tyrrell

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

OLEKSY, SZYMON
Employee/Petitioner

Case# **15WC002473**

WK HEATING INC
Employer/Respondent

18IWCC0760

On 10/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2234 CHEPOV & SCOTT LLC
NATALIA OLEJARSKA
5440 N CUMBERLAND AVE STE 150
CHICAGO, IL 60656

0286 SMITH AMUNDSEN LLC
LESILE JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

S. Oleksy v. WK Heating, Inc., 15 WC 02473

18IWCC0760

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)

Szymon Oleksy
Employee/Petitioner
v.
WK Heating Inc.
Employer/Respondent

Case # 15 WC 02473

An *Application for Adjustment 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 **August 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 9, 2015, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did not* exist between Petitioner and Respondent.

On this date, Petitioner 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's average weekly wage was $713.29.

On the date of accident, Petitioner was 37 years of age, *married* with 3 dependent children.

Respondent *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

Claim for compensation denied. Petitioner failed to prove an employee-employer relationship existed between Respondent and him.

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

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

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

Signature of Arbitrator

October 26, 2017
Date

ICArbDec19(b)

OCT 26 2017

regarding a job from Wojtek over the phone or via text. Petitioner's Exhibit 18 documents several calls and texts from or to Respondent's phone number. Wojtek would tell Petitioner what time to report to a job site and what Petitioner was supposed to do.

Petitioner testified that Wojtek was often not on the job with him, but would stop by the job site, usually every day. Wojtek and Pawel would communicate regarding how the job should progress and Pawel would tell Petitioner what they were going to do and how to do it.

Petitioner testified that at some point in his relationship with Respondent he received T-shirts from Wojtek with Respondent's name and phone number on them. Petitioner testified that Wojtek gave him basic tools, like a screwdriver and scissors (tin snips?) because he had no tools when he started at WK. He then worked with these basic tools and WK furnished a welder, the leather, driller and hammer.

At various times, Petitioner would pick up materials and supplies from Munch Supply on behalf of Respondent. (PX 17)

When Respondent did not have work for him, Petitioner would work somewhere else. Petitioner testified that he worked with Pawel somewhere else during a slow period at WK.

On the date of accident, January 9, 2015, Petitioner was working at a job site on Campbell Street. He had been told by Wojtek to go with Marek (the General Foreman on the Campbell job) to Munch Supply and pick up a furnace. The job was to install the whole system in the building. Petitioner and Marek carried the furnace (weighing 140 to 150 pounds) up some stairs. Petitioner was on top, climbing backwards. He missed a step with his left foot and his foot slipped on the step. He felt pain in his low back. Petitioner and Marek put the furnace down. Marek was leading the job and he showed Petitioner how the system was supposed to look like. Petitioner picked up the furnace by himself and worked on the installation. When asked if he worked until the end of the shift that day, Petitioner replied that he worked till the end of the job, so it is assumed that Petitioner completed the installation. Midway through the job, the pain became more intense and Petitioner had to take a break and lay down. He had pain in his low back on the left side and down his left leg. Wojtek came by the job site and Petitioner told him that he could not walk. "My leg is hurting, I can't walk." Petitioner did not tell Wojtek how the injury occurred. He did not tell Marek that he was feeling pain. Neither Party called Marek to testify. Marek was not employed by Respondent; he appears to have been the General Foreman on the job.

January 9, 2015 was a Friday. Petitioner did not work for Respondent after this date. He was not scheduled to work on Saturday and Sunday. He did not work on Monday, January 12, 2015, because his back hurt. Petitioner testified that he first sought medical treatment from Dr. Sabrina Indyk, on January 13, 2015. The history charted by Dr. Indyk was of a back injury on Friday. The pain started a few days ago - he thinks that he might have injured it at work because he was lifting something heavy and going up/down stairs - he is a contractor. He had seen another doctor before and received Saleto 600 mg, but has had no improvement. The pills helped initially, but wore off. The diagnosis was: sciatica, left; muscukloskeletal pain; gait abnormality; and back pain. Petitioner was given a Medrol dose pak and a shot of Toradol. Naproxyn and Flexerill were prescribed, along with Ativan for relaxation. The patient refused PT. An MRI was recommended if there was no improvement. Petitioner was instructed to go to the ER if the pain worsened. (PX 1) No evidence was adduced regarding the identity of the doctor who allegedly saw Petitioner first and who had prescribed the Saleto.

Petitioner testified that he had not injured his back prior to this event and was in good health on January 9, 2015.

INTRODUCTION

This matter was tried as a §§19(b)/8(a) proceeding with the disputed issues being: Act/Employer-employee; Accident; Notice; Causal connection; Wages; Incurred and prospective medical expenses; TTD; and Whether Petitioner opted out of coverage under §1(a)3 of the Act.

Petitioner and a colleague of his, Pawel Cembala, testified on behalf of Petitioner. Wojtek Kowalczyk, the owner of the Respondent corporation, testified on behalf of Respondent. All witnesses testified via a Polish/English interpreter.

FINDINGS OF FACT

Petitioner is originally from Poland. He has lived in the United States for approximately 10 years. He attended high school and a technical school in Poland. When Petitioner first came to the U.S., he worked at Belmont Sausage Company in a shop in Elk Grove Village. He was employed as "a contractor and maintenance". He worked at Belmont for 6 or 7 years and then began a relationship with Respondent, WK Heating, Inc. ("Respondent" or "WK").

Petitioner began receiving checks from Respondent in May or June of 2014. The checks were made out to a business that Petitioner owned, "SO System, Inc." (PX 20; RX 5) SO System, Inc. (SO) was incorporated on September 11, 2013. (RX 5) Petitioner was the president of SO. (RX 1, RX 3) According to Petitioner, Respondent's business was "the same as I did, heating and cooling." According to the workers' compensation insurance policy issued by Liberty Mutual for SO System, Inc., on May 21, 2014, SO's business was: "Heating, ventilation, air conditioning and refrigeration systems-installation, service and repair." (RX 1)

The owner of Respondent was Wojtek Kowalczyk (Wojtek) Petitioner testified that he heard about work at Respondent through Wojtek's mother, who worked at Belmont. Petitioner contacted Wojtek and met with him at a job site. Wojtek said that he had a lot of jobs and needed a worker. Respondent's other workers, Pawel and Mercin, would show Petitioner what to do. Wojtek required Petitioner to form his own business and get workers' compensation insurance in order to work with WK. Petitioner already owned SO. Petitioner obtained workers' compensation insurance for SO System, Inc., for the policy period of 5/21/2014 to 5/21//2015. (RX 1) Petitioner elected to decline coverage for himself, as an officer of SO. (RX 1; RX 3) Petitioner first testified that Wojtek told him to buy his own insurance "and in case I have my own insurance, that it would cover any kind of accidents." "If I have my own worker he –he pays with checks. And on that base, and in case of accident, he has his own insurance to cover for it." Pawel and Mercin would do the main system and Petitioner would finish it. There was no written contract regarding the relationship between Petitioner, SO, and Respondent. Petitioner said that he started as a helper, and later did the same work that the other guys were doing. He would install the whole system, including duct work and vents.

Petitioner was paid by check, every week or two weeks. He first testified that he was paid "either way", weekly or per hour. Petitioner testified on cross-examination that he was not paid on a per job basis; he thinks that he was paid on an hourly basis. He started at $14.00 per hour and made $20.00 per hour at the highest. His standard work week was 50 hours, working 7:00am to 5:00pm. The payment checks were made out to SO System, Inc. (PX 20) He received an IRS Form 1099 from Respondent at the end of the year. No taxes or social security was deducted from Petitioner's pay. (RX 4) Petitioner informed Wojtek regarding the hours that he worked via little pieces of paper and then in a notebook that Wojtek gave him. Neither Party submitted any copies of these documents. Petitioner thought that Wojtek was his employer. He would receive instructions

Petitioner testified that within a week after the accident Wojtek came to his house and dropped off a check. At that time, Petitioner advised Wojtek that he had injured his back carrying a furnace. It looks like the last check to SO System from Respondent was dated January 20, 2015. (PX 20) The Arbitrator finds that the date of this conversation was January 20, 2015.

On January 17, 2015, Petitioner was taken from his house by ambulance to Northwest Community Hospital (NWCH) due to excruciating low back pain. The records of the paramedics reveal severe low back pain with sciatica for 1 week. There was no history of an injury, although it was charted that the patient was released from the hospital on 1/13/2015 with a diagnosis of sciatica. Petitioner was given fentanyl by the paramedics for pain management. The paramedics noted that the patient did not speak English and the history was given through a translator. (PX 2)

At NWCH, the patient presented with a history of sciatica. He had increasing pain over the last week. The NWCH records state that there was no language barrier for the patient, but then state that a translator was used. He was seen at Resurrection Hospital last week and was discharged with a rx for Naprosyn and Flexeril, which has not helped. Petitioner improved at NWCH and was discharged home to follow up with his PCP for an MRI. He was to continue with Naprosyn and take Valium as well. (PX 3) No records from Resurrection were submitted.

Petitioner followed up with Dr. Indyk on January 22, 2015. He had low back pain and left leg pain. Petitioner was given a script for PT, a script for an MRI and was excused from work for a month. (PX 1)

Petitioner began PT at Global Rehabilitation on January 19, 2015. He had therapy at Global from January 19, 2015 to April 2, 2015. The therapy consisted of therapeutic strengthening, stretching exercises, modalities, taping and manual therapy. Petitioner also had post-surgery therapy at Global from February 24, 2016 through May 6, 2016, utilizing e-stim, core strengthening, ultrasound, HEP and other modalities. (PX 6)

Petitioner began treatment with Dr. Mark Sokolowski, an orthopedic surgeon, on January 29, 2015. This was on a referral from Dr. Indyk. Petitioner gave a history of injuring his low back carrying a furnace at work. He has left sided low back pain, down the buttock and down the left leg. The physical exam was consistent with a herniated lumbar disc. Dr. Sokolowski reviewed a lumbar MRI of January 22, 2015 and thought that it showed a large annular tear at L4-5 and a very large disc herniation at L5-S1 with complete displacement of the thecal sac to the right. The Assessment/Plan was: 1.) L4-5 annular tear; 2.) Left L5-S1 very large disc herniation. The recommendation was to continue PT and undergo lumbar injections. Petitioner was excused off work. If therapy and injections were not successful, lumbar decompression from L4-S1 would be appropriate. Dr. Sokolowski communicated with the patient in Polish. (PX 7)

Petitioner had injections performed by Dr. Hussain at Global Rehab on February 2, 2015 and May 11, 2015. (PX 6) Petitioner followed up with Dr. Sokolowski on several occasions. On June 19, 2015, Petitioner was seen by Dr. Sokolowski and was released to modified work duty, with restrictions of 20 pounds lifting and frequent position changes. A home TENS unit and dendracin lotion was recommended. Full duty work was contemplated in 2 weeks. (PX 7)

Petitioner testified that he began doing carpentry work for "David" about six months after the accident. He installed baseboards on windows and floors. He had helpers to carry heavy materials. Petitioner then worked for "Vydas" doing painting and patching. Petitioner had helpers to carry heavy items. Petitioner had no injuries working for David or Vydas.

Petitioner had an urgent visit with Dr. Sokolowski on September 8, 2015, due to intolerable back pain. Dr. Sokolowski recommended surgery. Petitioner underwent a L4-S1 decompressive laminectomy, foraminotomy, discectomy and facetectomy, by Dr. Sokolowski with the assistance of Dr. Ivankovich, at Westlake Hospital on February 2, 2016. (PX 11)

Petitioner was released by Dr. Sokolowski to modified duty work, on April 15, 2016. He was released to full duty work, as of May 13, 2016. Petitioner returned to Dr. Sokolowski on May 31, 2016 with increased back pain after returning to full duty work. Modified duty work was recommended. Another MRI was done on June 18, 2016 and Dr. Sokolowski thought that it showed desiccatory changes. The study was said to show satisfactory resection of the herniated discs. Continued modified duty, with the possibility of L4-S1 fusion was recommended. Petitioner's last visit with Dr. Sokolowski was on November 14, 2016. He complained of 2/10 pain at rest, but unbearable pain with activity. Dr. Sokolowski recommended HEP and modified duty work. If the back pain became intolerable, fusion surgery would be necessary. A provocative discogram should be performed before fusion surgery. If the symptoms continue, PRN. If there was a regression, Dr. Sokolowski would be happy to see the patient. (PX 7)

Petitioner denied any back injuries occurring after January 9, 2015.

Petitioner is awaiting approval for the proposed fusion surgery. He can't drive for a long distance. He doesn't play soccer or ride a bike. He can't jump. He doesn't go for long walks with his kids. He has to be careful when going down stairs. He has to change positions a lot. He has trouble sleeping. He does continue to work at modified duty. He has pain. He has numbness in his left leg and spasms. He would like to have the proposed surgery, but he cannot afford it.

Pawel Cembala (Cembala) testified at the request of Petitioner. He knows Petitioner from HVC work. Cembala thinks that he was employed by Respondent. When he worked at Respondent, Cembala was paid hourly on a weekly basis. Cembala would provide Respondent with little slips of paper to substantiate his claimed wages. He was paid by check or cash. He did not have a definite starting time, as that was coordinated with the other trades and the general contractor. The GC would contact Wojtek to schedule jobs. Cembala used some of his own tools and used Respondent's tools for specialized tasks. At the time of the accident, Cembala had not worked for Respondent for 2 to 3 months. Cembala did show Petitioner how to do the heating and cooling trade. Cembala also owned his own company.

Magdalana Bilski testified at the request of Respondent. She is the insurance agent who sold Petitioner the workers' compensation insurance policy for SO System, Inc. She explained the documents to Petitioner in Polish. Petitioner chose to exclude himself from coverage. He understood the effects of being excluded from coverage.

Wojtek Kowalczyk (Wojtek) testified at the request of Respondent. He is the sole owner of Respondent and has been so since 2008. WK's business is to install whole new systems, the furnaces, new construction. WK has no employees other than Wojtek. Basically, general contractors contract with WK and then WK hires subcontractors to do the work. Wojtek does not recall how he became involved with Petitioner. Typically, WK has written contracts with its subcontractors. Some agreements are verbal, not in writing. There was no written contract with Petitioner or SO. Everybody has to have insurance. Respondent is not responsible for them. WK does not withhold taxes from its payments to the subs. WK did not provide any benefits, such as paid time off, vacation, holiday pay or health insurance. Wojtek did not give ant T-shirts to sub-contractors. He did not require subs to wear WK T-shirts. WK required Petitioner to get insurance. Wojtek would advise Petitioner of

the job site location and meet Petitioner at the site and he should show Petitioner what to do. He would show Petitioner the plans. Wojtek would not stay at the job and watch Petitioner work. WK provided materials. Wojtek would tell the subs the way to install the HVAC, based on the blueprints. Wojtek testified that Petitioner had back pain before the accident date. Wojtek did not tell Petitioner that WK's wc insurance would pay for Petitioner. WK did not give Petitioner any tools. Petitioner's job was to install furnaces. He was not paid hourly. He was paid per unit. Petitioner's actions at the Campbell project were part of the regular course of business for Respondent. Petitioner's actions benefitted WK. Wojtek did not bring a copy of WK's IC agreement with him to the hearing. Wojtek believes that Petitioner had prior HVAC experience before working with WK. Wojtek does not recall Petitioner using Respondent's tools. Wojtek would tell Petitioner what to do on the job. He would show Petitioner where to install the furnace and then Petitioner was left to do it. Wojtek would rely on Petitioner to see to the details of the installation.

Petitioner testified in rebuttal that his prior experience in HVAC was watching others do it in the maintenance shop (at Belmont ?). He never had tools that could be used to install heating and cooling systems. Wojtek got them for Petitioner, even the basic ones. Wojtek brought the ladders and the concrete drills. Petitioner got 10 shirts from Respondent. He was paid hourly, not $500.00 per job.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set for the below.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the 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)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

The Arbitrator was not impressed with the credibility of the testimony of both Petitioner and Wojtek Kowalczyk. They both knew the consequences of the subcontractor/contractor relationship that they entered into. They both were trying to avoid the expenses of payroll taxes, unemployment taxes and wage and hour laws, along with workers' compensation insurance premiums in structuring their relationship as they did. Petitioner and Kowalczyk do have a level of sophistication regarding construction business relationships and that persuades the Arbitrator that neither took advantage of the other in their relationship. Shame on them both for not defining the relationship in a written agreement.

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

Respondent's business was to install and work on HVAC systems. Thus, coverage under the Act is "Automatic", pursuant to §3(2) of the Act.

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

According to the Supreme Court, an employment relationship is a prerequisite for an award of benefits under the Act. A fact specific inquiry is required to determine whether an employment relationship exists. The Parties designation of their relationship is not controlling, but may be considered, along with the following other factors: 1.) Respondent's right to control the manner in which Petitioner performs the work; 2.) Does Respondent dictate Petitioner's schedule? ; 3.) Is Petitioner paid hourly, or on a per job basis? ; 4.) Are taxes and social security withheld from the payments to Petitioner? ; 5.) Does Respondent's business encompass Petitioner's work? 6.) Can Petitioner be discharged at will? . Roberson v. The Industrial Commission, 225 Ill. 2d 159 (2007)

After considering all of the evidence adduced and the above factors, the Arbitrator finds that Petitioner failed to prove that he had an employee/employer relationship with Respondent.

First, Petitioner's testimony regarding his novice status in the HVAC industry prior to working with WK is not believable. Petitioner formed SO System, Inc. before a relationship with Respondent was even contemplated. The primary business of SO was said to be HVAC and refrigeration systems – installation, service and repair. Petitioner formed SO to get subcontractor jobs in the HVAC field. He would not have incorporated a business if he did not know the trade. Further, Petitioner's testimony that he had no tools when he started with WK is not believable. He had incorporated a business in a trade and he had no tools? Wojtek gave him a screwdriver and scissors and he used WK's tools for the rest of a furnace installation? Would other tradesmen freely let Petitioner use their tools? – No. Common sense and experience lead the Arbitrator to conclude that Petitioner did not show up at a job site with no tools. The Arbitrator finds that Petitioner had HVAC experience before he became involved with WK. He used some of his own tools on the job. He would not have been hired if he did not demonstrate knowledge in the trade.

Regarding the issue of control of the manner of the work, Wojtek told Petitioner where to place a furnace, based on the blueprints or the contractor's plans. The proofs do not show that Wojtek dictated or controlled the manner in which Petitioner installed a furnace – he did not direct that Petitioner use a certain fitting on a certain pipe, for example. While Respondent supplied job materials, this is more a function of complying with Codes and the requirements specified by the General Contractor. Wojtek was clearly not monitoring Petitioner's work in a detailed manner. Respondent's level of control over Petitioner's work does not persuade the Arbitrator that Petitioner was an employee of Respondent.

Petitioner's schedule is dictated by when the General Contractor has the job site open and when the other trades are on site. This factor does not support an employment relationship.

Petitioner and Wojtek disagreed on whether Petitioner was paid hourly, or per job. Even considering Cembala's testimony that he was paid hourly (sometimes in cash, albeit at a time prior to the accident), the Arbitrator cannot conclude that Petitioner was paid on an hourly basis, given the evidence adduced.

Petitioner and Wojtek agreed that SO System received a Form 1099 from Respondent at the end of the year and that no taxes or Social security was deducted from payments to it. Petitioner received no employee benefits such as paid time off, vacation or health insurance from Respondent. The checks were made out to SO System, Inc. This factor implies that there was no employment relationship.

Respondent's business certainly encompasses Petitioner's work, but SO's business was said to include HVAC work as well. This factor is not persuasive on the issue of employee/employer, given the remainder of the evidence.

There was no evidence on the issue of whether Petitioner could be discharged at will. This should have been addressed in a written agreement. Given the lack of evidence, this factor is given no weight on the issue of employment relationship.

Petitioner was able to work elsewhere when there was no work from WK. This weighs against the existance of an employee/employer relationship.

Petitioner testified that he believed that he was an employee of Respondent. Wojtek's testimony was that Petitioner was a subcontractor. Of course, these conflicting opinions are regarding a legal conclusion and do not provide persuasive weight on the ultimate issue of employment. Further, SO System, Inc. obtained workers' compensation insurance and appears to have had a bank account (as evidenced by the endorsements on the checks in PX 20, albeit six of the checks having been signed by Petitioner's wife), thus implying that it was a distinct entity from Petitioner and actually negating any employee/employer relationship with Respondent.

Petitioner has the burden of proof on the issue of employee/employer relationship and the Arbitrator finds that the preponderance of the evidence does not support a finding that such a relationship existed.

The claim for compensation is, therefore, denied.

REMAINING ISSUES

As the Arbitrator has found that Petitioner failed to prove that an employee/employer relationship existed between him and Respondent, the Arbitrator needs not decide the remaining issues of: Accident; Notice; Causal Connection; Wages; Incurred and prospective medical expenses; and TTD.

Regarding the issue of Average Weekly Wage, the Arbitrator calculated the AWW based upon Petitioner's Exhibit 20. Petitioner's testimony regarding the AWW is deficient, in that he testified that he started with Respondent making $14.00 per hour and was making $20.00 per hour at the time of the accident, working 50 hours a week. This does not explain what the actual earnings of the Petitioner were in the employment during the 52 weeks preceding the date of accident. Therefore, the Arbitrator calculated that the checks in PX 20 total $12,228.00 and the covered time period was 8/27/2014 to 1/8/2015 (17-1/7 weeks), yielding an AWW of $713.29.

As to the issue of whether Petitioner elected out of coverage for himself under the Act, the Arbitrator finds that Petitioner voluntarily and knowingly excluded himself from coverage under SO System, Inc.'s workers' compensation insurance policy, based upon the unrebutted and credible testimony of Bilski and Respondent's Exhibit 3. This finding, of course, has no effect on the other disputed issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

☒ Affirm and adopt with clerical corrections	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with correction	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Audelia Miranda,

Petitioner,

vs.

NO: 12 WC 29935

Flanders Precisionaire,

Respondent.

18IWCC0761

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the issues of causal relationship, temporary total disability benefits, medical expenses both incurred and prospective and being advised of the facts and law, corrects clerical errors in the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission corrects the clerical error on Page 2, sixth paragraph of the Arbitrator's Decision. Dr. Coats performed bilateral endoscopic carpal tunnel release surgery on May 28, 2013, not May 29, 2013. PX6, PX7. The Commission also corrects the clerical error on Page 3, second paragraph, under Provena St. Mary's Hospital (PX2), from August 15, 2017 to August 15, 2012. The Commission further corrects the clerical error on Page 3, second paragraph under Nueva Vida Medical Center Records and Bills (PX3 & PX4), from October 9, 2017 to October 9, 2012. The Commission affirms and adopts the Arbitrator's Decision with these corrections.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017 is corrected for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $19,260.00 for reasonable, necessary and related medical expenses pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act. This award consists of medical bills from New Life Medical for $15,035.00 and Dr. Thurston for $4,225.00 and Respondent shall receive credit for any payments made.

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 is entitled to a credit of $6,006.00 for TTD benefits paid and this will be credited against a further amount of temporary total compensation or of compensation for permanent disability, if any, to be determined on remand to the Arbitrator for further proceedings.

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 the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,400.00. 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: DEC 12 2018
LEC/maw
o11/14/18
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

MIRANDA, AUDELIA
Employee/Petitioner

Case# **12WC029935**

FLANDERS PRECISIONAIRE
Employer/Respondent

18IWCC0761

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUSA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
) SS
COUNTY OF KANKAKEE)

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

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

Audelia Miranda
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 12 WC 29935

18IWCC0761

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Kankakee**, on **January 18, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. 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 **August 7, 2012** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,021.00**; the average weekly wage was **$404.25**.

On the date of accident, Petitioner was **45** years of age, **married** with **1** dependent child.

Respondent ***owes, in part, as stated below for*** all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$6,006.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,0006.00.**

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

ORDER

Medical Benefits

Respondent shall pay the $15,035.00 to New Life Medical and $4,225.00 to Dr. Gregory Thurston, subject to the fee schedule and pursuant to §8 and §8.2 of the Act and subject to credit for any payments made by respondent directly or pursuant to §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.

Christine McCarthy

Signature of Arbitrator

08/28/2017

Date

IC ArbDec19(b) p. 2

AUG 29 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Audelia Miranda, **Petitioner,**	)	
vs.	)	**No. 12 WC 29935**
Flanders Precisionaire, **Respondent.**	)	**18IWCC0761**

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard in Kankakee on January 18, 2017. The parties agree that on August 7, 2012, petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act. The parties agree petitioner gave notice of the claimed accident within the provisions of the Act and that in the year predating the claimed accident, petitioner earned $21,0210.00 and her average weekly wage, as calculated pursuant to §10 of the Act, was $404.25.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for the unpaid medical bills totaling $89,555.92.
4. Whether petitioner is entitled to temporary total disability benefits.
5. Whether respondent is liable to pay for prospective medical treatment.

STATEMENT OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Carmen Kelly, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Kenny served as an interpreter for the Petitioner.

Petitioner testified she began working for respondent in February, 2012, in the line grabbing filters. Petitioner [grabbed the filters], placed them in a box and packed them. She testified she did this very fast. She then placed the box in a pallet. She testified the boxes to her were very heavy. In doing her job, she had to move everything from one side to the other.

Petitioner was required to grabbed the filters to put in the moving boxes. She put the filters together with tape. She also made boxes. She was standing straight with her head bent down. She performed this job constantly for ten hours a day.

On August 7, 2012, petitioner testified her right wrist began to hurt and the pain went up her right arm into her shoulder and neck. She reported the pain to the person operating the machine.

She continued to do the same work, but on a different line, until September 6, 2012. On that day her pain was very strong in her neck and back and then started in her other hand.

Petitioner was initially seen at St. Mary's Occupational Health from August 9, 2012 to August 28, 2012. She testified she had told the doctors at St. Mary's Occupational Health all the areas she was having pain.

On September 6, 2012, petitioner sought treatment at New Life Medical Center. She received therapy from September 7, 2012 through November 16, 2012 at New Life Medical Center. Treatment at New Life was mainly to her right wrist and shoulder. She had an MRI done of her right wrist on October 9, 2012 and an NCV test on October 10, 2012.

Petitioner had no treatment at New Life from November 16, 2012 through February 26, 2013. She was not working during that time. She did not have any new accidents. She was feeling very bad; the pain was very strong in both hands and neck. She also felt numbness in both hands; it felt like someone was pinching them.

She went on her own to the Specialty Physicians of Illinois and saw Dr. Coats as she could not take the pain. Dr. Coats gave her injections, splints and therapy. Dr. Coats also referred petitioner to his associate, Dr. Payne, for treatment of her neck and back. She continues to receive treatment from Dr. Payne. The treatment includes an injection in her neck.

She was also sent for an EMG on March 22, 2013. She was sent to a neurologist, Dr. Young, whom she saw on March 29, 2013. She had an injection in her hands on April 9, 2013 by Dr. Coats. Dr. Payne sent petitioner for epidural injections in her neck which were done in June and September, 2013. An MRI were done of her neck and back in March, 2013.

Dr. Coats performed carpal tunnel surgeries on both hands on May 29, 2013. Petitioner saw Dr. Coats through July, 2013.

She continues to see Dr. Payne ever month or two. Dr. Payne sent petitioner for a repeat cervical MRI in August, 2013. She also saw Dr. Payne for right shoulder pain for which he sent her for an MRI on May 29, 2015. Dr. Payne sent petitioner for a discogram which was done on November 5, 2015. Dr. Payne performed a cervical fusion on January 11, 2016. Petitioner testified she last saw Dr. Payne on January 5, [2017]. She has an appointment scheduled for February, 2017. She remained in physical therapy, which was being done at St. James facility in Chicago Heights.

The medical treatment was being paid by her husband's health insurance. Petitioner has not worked since September 6, 2012. She denied having any new injuries. She continues to have neck pain although the surgery and the therapy has helped. She also continues to have "pinching" in her hands; numbness; some pain and weakness. The hands surgeries had helped. She cannot do a lot of housework or heavy lifting as her neck and hands get numb. She takes medication prescribed by Dr. Payne which helps.

On cross-examination, petitioner identified Respondent's Exhibit Number 5 as a report she signed on August 8, 2012 reporting a wrist injury. She agreed she was seen at Provena St. Mary's on August 9, 2012 for a right wrist injury. She was seen again on August 15, 2012 with complaints of right wrist and arm pain. She received physical therapy on August 20, 2012.

She identified Respondent Exhibit Number 4 as the Application for Adjustment of Claim she signed on August 24, 2012 claiming injury only to her right arm and right wrist. Petitioner received therapy in August, 2012 for only right wrist and arm pain without complaints of neck, back or left hand pain. On Respondent's Exhibit Number 8, that was signed by petitioner on September 7, 2012, petitioner had circled pain and numbness in her arm only.

Petitioner confirmed she was told by Dr. Scott Heller that the EMG he performed on January 9, 2013 was normal. She also confirmed she underwent a cervical MRI on March 21, 2013 and she had another EMG and NCV done at St. James Hospital on March 22, 2013. She also confirmed she underwent a lumbar MRI on June 12, 2013. She confirmed she saw Dr. Ro, a neurologist, on November 19, 2013, who advised her all the EMG testing was negative, as well as the MRIs of the cervical, thoracic and lumbar spine.

Petitioner confirmed she underwent a brain MRI on December 18, 2013, another EMG/NCV on February 10, 2015, and another cervical MRI on August 15, 2015.

Petitioner confirmed she and her husband completed Respondent Exhibit Number 5. She also confirmed the medical providers at St. Mary's Clinic spoke Spanish to her and they seemed to understand her.

Laborers' Health and Welfare Fund Subrogation Claim (PX.1)

The Union claims $18,643.65 paid in behalf of petitioner for her work injuries.

Provena St. Mary's Hospital (PX.2)

Petitioner was initial seen at Provena St. Mary's Hospital Occupational Health on August 9, 2012 for a right wrist injury on August 7, 2012. She reported she was stacking boxes on pallets and felt twisting in her wrist. She reported pain at 10 out of 10. The diagnosis was strained right wrist. She was put on modified work, prescribed a splint and Naprosyn. The right wrist X-rays were negative.

At her August 15, 2017 petitioner returned to Occupational Health with complaints of the right wrist and arm, with pain increasing. Diagnosis was now strained right wrist and arm. She was to continue with the splint; prescribed Ultracet, Naprosyn and occupational therapy. On August 28, 2012, after receiving physical therapy, petitioner's range of right arm motion was restricted.

Nueva Vida Medical Center Records and Bills (PX.3 & PX.4)

Petitioner was first seen by Dr. Manish Padya, DC on September 7, 2012. As for the mechanism of the injury, petitioner reported she was moving boxes at work and injured her right wrist. Petitioner's complaints and treatment through November, 2012, was to the right wrist. Dr. Padya, DC reported on November 16, 2012 that petitioner's condition was at a permanent state.

The right wrist October 9, 2017 MRI was negative for any objective findings. The October 10, 2012 EMG/NCV, performed by Dr. Gregory Thurston, chiropractic neurologist, showed mild-moderate C6, C7 radiculopathy without axonopathy and without evidence of the denervation.

Bills claimed for services rendered total $15,035.00; with a balance of $890.00.

Dr. Gregory Thurston's bill from October 10, 2012 for the EMG is $4225.00

Franciscan St. Joseph Health Bills (PX. 5)

These bills total $65,979.27 for the period from February 27, 2013 through June 2, 2016.

Specialty Physicians of Illinois (PX.6)

Petitioner was first seen on February 26, 2013 by Dr. Robert Coats with complaints of bilateral hand pain with numbness and tingling that is worse at night. Dr. Coats reported petitioner's Tinel's and flexion testing was positive. The diagnosis was bilateral carpal tunnel syndrome.

On March 12, 2013, Dr. Coats reported petitioner had not worked since September and had undergone carpal tunnel injections, oral steroids and occupational therapy. Petitioner was to continue with therapy and night splints. Petitioner reported her bilateral carpal tunnel pain was much less.

On March 14, 2013, petitioner was seen by Dr. William Payne for complaints of neck and back pain since August, 2012. Petitioner reported she initially was treated for bilateral carpal tunnel syndrome but that the pain has been getting worse in her back and especially in her neck. She also complained of feeling weak in both arms and weak in the feet with tingling and numbness in both feet. Dr. Payne's assessment was cervicalgia, myofascial pain and tripper point of upper back. The cervical X-ray was unremarkable.

The March 21, 2013 cervical MRI reported as mild predominantly degenerative facet and uncovertebral joint disease, more conspicuous on the left.

The March 22, 2013 EMG for the neck and low back pain was normal.

On March 28, 2013, Dr. Payne reported there was no orthopedic cause for petitioner's pain after a normal EMG and MRI. She was referred for pain management and was being sent to rule out MS, rheumatologic disease and fibromyalgia.

She was seen by Dr. Young-IL Ro on March 29, 2013, as a referral by Dr. Payne. Dr. Ro's diagnosis was multiple pain syndrome.

Petitioner was seen again by Dr. Coats on April 9, 2013. Petitioner reported the carpal tunnel syndrome injections helped, but the pain had returned.

On May 9, 2013, Dr. Payne assessment was possible carpal tunnel syndrome.

Petitioner was next seen by Dr. Coats for her bilateral carpal tunnel syndrome on May 20, 2013 at which time bilateral carpal tunnel surgery was discussed.

Petitioner followed up post-operatively with Dr. Coats on June 11, 2013, after undergoing bilateral carpal tunnel release on May 28, 2013.

The June 12, 2013 thoracic MRI was normal and lumbar MRI was basically normal, except for mild endplate degenerative changes at the L2 level.

On June 13, 2013, petitioner was seen by Dr. Payne and reported no pain after receiving cervical epidural steroid injection and bilateral carpal tunnel surgery.

On July 18, 2013, petitioner was seen by Dr. Payne requesting a home TENS unit for left and right upper back pain.

Petitioner was see again on July 19, 2013 by Dr. Coats with ongoing hand pain despite the carpal tunnel release.

Petitioner was seen by Dr. Payne for neck and back pain on August 15, 2013.

On August 16, 2013, petitioner was seen by Dr. Coats withongoing bilateral hand pain.

Petitioner was seen by Dr. Payne on September 26, 2013 for back and neck pain reporting the ESI had helped.

On November 11, 2013, Dr. Payne reported continued to have back and neck pain.

On November 19, 2013, Dr. Ro reported petitioner had pain all over her body and also dizziness and headaches. She was sent for an MRI. The December 8, 2013 brain MRI was normal.

Petitioner was seen by Dr. Payne on January 23, 2014 with back and neck pain. Dr. Payne made no diagnosis.

On March 25, 2014, petitioner was seen by Dr. Payne after Dr. Adlaka performed neck injections. Dr. Payne's assessment was cervical spondylosis.

Petitioner was seen by Dr. Payne on June 5, 2014 following undergoing radiofrequency neurectomy of the left side third occipital nerve C4 by Dr. Adlaka on May 21, 2014.

On December 8, 2014, petitioner was seen by Dr. Coates with bilateral hand pain for one month.

She was seen by Dr. Payne on December 18, 2014 for neck and low back pain. The diagnosis was cervical degenerative disc disease, cervical spondylosis and low back pain. The lumbar MRI was negative.

Dr. Ro performed another EMG on December 10, 2015, which was normal.

On May 26, 2015 petitioner was seen by Dr. Payne for back pain. Diagnosis was cervical degenerative disc disease, cervical spondylosis, low back pain and golfer elbow. She was seen again by Dr. Payne on August 11, 2015 for right-sided neck pain. The diagnosis was cervical pain with radiculopathy.

A May 29, 2015 right shoulder MRI showed moderate AC joint degenerative changes with some fluid in the bursa or possible mild bursitis.

The August 11, 2015 cervical X-rays were negative.

On September 3, 2015, she was again seen by Dr. Payne for right sided neck pain and pain in both arms. Dr. Payne assessment was cervical pain. A discogram at C3-4, C5-6, C6-7 and shoulder scope for right shoulder subacromial impingement was recommended. On November 5, 2015, Dr. Payne recommended a cervical fusion at C5-6 for an annular tear at C5-6 and right hand weakness. On November 19, 2015, petitioner was seen by Dr. Payne to discuss the neck surgery.

Petitioner was seen by Robin Major, NP on January 26, 2016, February 9, 2016, March 8, 2016, April 12, 2016 in follow up to the C5-C6 fusion. On May 12, 2016, petitioner was seen by Dr. Payne status post C5-6 fusion of January 11, 2016 with a non-union. On June 30, 2016 Dr. Payne reported slight progressive fusion mass.

The EMG done by Dr. Ro on August 8, 2016 was reported as normal.

On August 18, 2016, Dr. Payne's assessment was neck pain status post January 11, 2016 cervical fusion, and bilateral carpal tunnel. Petitioner reported ongoing neck pain when seen by Dr. Payne on September 22, 2016. On October 27, 2016 was seen by Dr. Payne with continued neck pain.

The January 26, 2016 cervical X-ray showed hardware in place. The February 9, 2016 cervical X-ray showed no change from the previous study, as was the March 8, 2016, April 12, 2016, May 12, 2016, June 30, 2016, August 18, 2016, September 22, 2016, October 27, 2016 and December 1, 2016 cervical X-rays.

Franciscan St. James Health Records (PX. 7)

Petitioner underwent bilateral endoscopic carpal tunnel release by Dr. Coats for carpal tunnel syndrome on May 28, 2013.

Petitioner underwent cervical epidural steroid injection was performed by Dr. Adlaka on September 12, 2013.

The February 10, 2015 EMG of petitioner's upper extremities was normal.

Petitioner underwent a provocative cervical discogram at C5-C6 and C4-C5 level failed to reproduce her pain. The CT cervical spine showed a central annular tear at C5-6.

Dr. Babak Lami October 29, 2015 Deposition (RX.1)

Dr. Lami, a board certified orthopaedic surgeon, testified via deposition in behalf of respondent from his report. Dr. Lami examined petitioner on April 4, 2014 and reviewed medical records and diagnostic studies. Dr. Lami's examination was completely negative for disability. Dr. Lami did not find any objective evidence of injury or disability upon his review of the medical

records and diagnostic studies. Dr. Lami concluded petitioner had sustained no injury to her cervical, thoracic and lumbar spine.

Dr. Prasant Atluri November 19, 2014 Deposition (RX.2)

Dr. Atluri, a board certified orthopedic hand surgeon, testified via deposition in behalf of respondent. Dr. Atluri examined petitioner on January 24, 2013. Petitioner advised Dr. Atluri that she began having pain and swelling in her right hand in August, 2012, but was uncertain as to why the pain began.

Dr. Atluri limited his examination to petitioner's right hand and wrist. Dr. Atluri noted petitioner's right wrist was positive Tinel's sign and compression test which is indicative of carpal tunnel syndrome. Dr. Atluri also noted grinding in the carpal metacarpal joint which he attributed to symptomatic arthritis. Dr. Atluri did not believe any of the objective findings of petitioner's right hand was related to the claimed work accident of August 7, 2012.

Provena St. Mary's Hospital Records (RX.3)

These records are duplicate of Petitioner's Exhibit Number 2, but also includes the physical therapy records received to the right wrist and arm from August 20, 2012 to September 5, 2012.

Application for Adjustment of Claim Filed August 29, 2012 (RX.4)

The Application indicates petitioner suffered right arm, right wrist (see meds) from repetitive overuse of upper extremities on August 7, 2012.

Flanders Corporation Incident Report (RX.5)

Petitioner completed the incident report describing the August 7, 2012 accident as: "stacking boxes, onto pallet. My wrist then folded and I felt pain." The form was signed by petitioner on August 8, 2012. The form also indicated petitioner wanted to wait to see a doctor.

EMG January 9, 2013 Report by Dr. Scott Heller of Lakeshore Neurology (RX.6).

Dr. Heller conducted an EMG of the petitioner on January 9, 2013, at the request of Dr. Atluri, which was reported as negative.

Specialty Physicians of Illinois (RX.7)

The records are duplicate of Petitioner Exhibit Number 6.

Patient Information from Nueva Vida Medical Center (RX.8)

Petitioner identified this form as the form she completed for Dr. Pandya, D. C. on September 7, 2012. On the form she indicated her pain began suddenly on August 7, 2012. On the form she indicated pain and numbness of her arm only. She also indicated she had no other symptoms. This form was signed by the petitioner on September 7, 2012.

Respondent's Medical and Temporary Total Disability Payments (RX.9)

The list includes payments totaling $19,571.00 for medical treatment and $6,006.00 in temporary total disability payments.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. In regard to the issue of whether an accident occurred which arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator makes the following conclusions of law:

Based upon the testimony of petitioner and Respondent's Incident Report (RX.5), which was completed by petitioner on August 8, 2012, the Arbitrator finds petitioner sustained a strain to her right wrist and right arm pain in a specific accident which arose out of and in the course of her employment with respondent on August 7, 2012 when she was packing boxes of filters.

F. In regard to the issue of whether petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator finds petitioner sustained a right wrist sprain and arm pain that was resolved as of November 16, 2012. No other claimed condition, included but not limited to petitioner's left hand/wrist, neck or lumbar strain is causally related to petitioner's work accident of August 7, 2012. The Arbitrator notes none of the treating physicians related the problems with any other body part, other than her right hand, wrist and arm, were caused by the work accident of August 7, 2012. Respondent's examining physician, Dr. Lami, affirmed the petitioner's condition involving her left upper extremity, neck or back were not related to the claimed work accident.

In addition, the Arbitrator finds petitioner failed to prove that her bilateral carpal tunnel condition was caused by her work accident of August 7, 2012, or any other date. The Arbitrator makes this determination based upon the fact that petitioner claimed a specific accident occurring on August 7, 2012. Furthermore, no treating physician related her carpal tunnel condition, of either hand, to her employment with respondent. To the contrary, Dr. Atluri, respondent's examining physician, did not believe petitioner's right hand's carpal tunnel condition was caused by the claimed work accident.

J. In regard to the issue of medical bills incurred, the Arbitrator makes the following conclusions of law:

The Arbitrator finds all treatment rendered to petitioner up to November 16, 2012 was reasonable and necessary to treat petitioner of her work injuries and awards medical bills from New Life Medical in the sum of $15,035.00 and Dr. Gregory Thurston in the amount of $4,225.00, to be paid in accordance with §8 and §8.2 of the Act, with credit to be given to respondent for any payments made.

In addition, the Arbitrator finds that any treatment after March 28, 2013, whether related to the work accident or not, was not reasonable or necessary based upon the opinion of Dr. Payne, who reported there was no orthopedic cause for petitioner's pain after a normal EMG and MRI. Despite this opinion, Dr. Payne saw fit to continue providing treatment.

K. In regard to the issue of whether petitioner is entitled to prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator, having determined petitioner had reached maximum medical improvement as of November 16, 2012, denies petitioner's claim for any medical treatment after that date.

L. In regard to the issue of whether petitioner is entitled to temporary total disability benefits, the Arbitrator makes the following conclusions of law:

There is no statement in the medical records of New Life Medical as to whether petitioner should be off work due to the injury involving her right wrist and arm during the period she received treatment there from September 7, 2012 through November 16, 2012. Also, the petitioner failed to prove that her claimed ongoing condition after November 16, 2012 was the result of the work accident of August 7, 2012. Therefore, the Arbitrator denies petitioner's claim for temporary total disability.

N. In regard to the issue of whether respondent is due any credit, the Arbitrator makes the following conclusions of law:

Respondent is entitled to credit in the amount of $6,006.00 for temporary total disability and $19,571.00 for medical bills paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kristin Roeing,

Petitioner,

vs. NO: 13 WC 2673

Mannheim School District #83,

Respondent.

18IWCC0762

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent and Petitioner herein and notice provided to all parties, the Commission, after considering the issues of causal relationship, medical expenses and permanent disability and being advised of the facts and the law, affirms and adopts the Decision of the Arbitrator as modified below, which is attached hereto and made a part hereof.

The Arbitrator concluded Petitioner sustained a 4% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. The Commission agrees with the permanence determination but believes a more detailed explanation of the relevance and weight placed upon factors is necessary to satisfy the requirements of Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101.

Section 8.1b(b)(i) – level of impairment

Dr. Lami provided a 0% impairment rating based upon the 6th Edition AMA Guidelines. RX3. The level of impairment is not solely determinative of an award of permanent partial

18IWCC0762

disability and must be weighed with the other four factors. Such factor is relevant in assessing Petitioner's ongoing disability. The Commission finds this weighs in favor of a decreased permanence.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner sustained injury while performing her duties as an early childhood autism teacher. Following her injury, Petitioner returned to work in her full capacity as an early childhood autism teacher. Her job duties require her to physical interact with students who may become combative at times. The Commission finds this weighs in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 28 years old on the date of accident. The Commission observes Petitioner is still relatively young, has many work-years ahead of her, and will therefore have to deal with the effects of her injury for a longer period of time. The Commission finds this weighs in favor of an increased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner returned to work in her pre-injury occupation. No evidence was presented that Petitioner's wages or her earning capacity was affected by the injury she sustained. The Commission finds this weighs in favor of a decreased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Following her injury, Petitioner underwent a course of physical therapy as well chiropractic treatments. PX1. Despite such treatments, Petitioner continued to experience pain requiring her to undergo facet joint injections. Following the injections, Petitioner's pain decreased significantly and was manageable. PX3. Petitioner testified she continues to experience periodic flare-ups of pain. T. 18-19. The Commission finds this weighs in favor of an increased permanence.

The Commission finds Petitioner sustained a 4% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 2, 2017 decision, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable, necessary and related chiropractic expenses to Dukane Chiropractic Rehab for treatment of Petitioner's low back from October 19, 2012 through November 18, 2012 pursuant to

18IWCC0762

§8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act. Respondent shall receive credit for payments of $5,917.28 made to Dukane Chiropractic Rehab. Respondent shall also pay the reasonable, necessary and related medical expenses to the following providers: $1,700.00 to American Diagnostic MRI; $20,260.00 to Aiden Center for Day Surgery; $875.00 to Oak Brook Anesthesiologists, Ltd.; $372.00 to Pain Care Specialists; pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $647.18 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 4%.

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

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

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 12 2018
LEC/maw
o10/24/18
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROEING, KRISTIN
Employee/Petitioner

Case# **13WC002673**

MANNHEIM SCHOOL DISTRICT#83
Employer/Respondent

18IWCC0762

On 10/2/2017, 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 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4103 GRAVLIN, MICHAEL J LLC
JAKUB BANASZAK
134 N LASALLE ST SUITE 2020
CHICAGO, IL 60602

0863 ANCEL GLINK
ERIN BAKER PELL
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

Kristin Roeing
Employee/Petitioner

v.

Mannheim School District #83
Employer/Respondent

Case # 13 WC 02673

Consolidated cases:

18IWCC0762

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Chicago**, on **7/26/17**. 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 9/25/12, 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.

In the year preceding the injury, Petitioner earned $56,089.36 the average weekly wage was $1,078.64

On the date of accident, Petitioner was 28 years of age, *single* with 0 dependent children.

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

Respondent ***has 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 $5,917.28 for other benefits (payments to Dukane Chiropractic Rehab, Ltd), for a total credit of $5,917.28.

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

ORDER

Respondent is responsible and shall pay the necessary medical services, pursuant to the medical fee schedule, for the petitioner's chiropractic treatment from October 19, 2012 through November 18, 2012 (after a credit of $5,917.28 for prior payments is applied) to Dukane Chiropractic Rehab, Ltd. Respondent is responsible and shall pay the necessary medical services of the following medical providers pursuant to the Illinois Medical fee Schedule at costs not to exceed: $1,700.00 to American Diagnostic MRI; $20,260.00 to Aiden Center for Day Surgery; $875.00 to Oak Brook Anesthesiologists, Ltd.; and $372.00 to Pain Care Specialists, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $647.18/week for 20 weeks ($12,943.60), because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 3(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

October 2, 2017
Date

OCT 2 - 2017

FINDINGS OF FACT

The issues in dispute in this matter are: 1) causal connection; 2) medical bills; and 3) the nature and extent of Petitioner's injury.

Accident and Treatment

Petitioner Kristin Roeing (hereinafter "Petitioner") is employed by Respondent Mannheim School District #83 (hereinafter "Respondent"), and has been for about eight years, including the date of the accident, September 25, 2012. The parties stipulated to an average weekly wage of $1,078.64. At the time of the accident, Petitioner was a 28 year old single female with no dependent children under the age of 18.

Petitioner testified that on September 25, 2012 she was working as an early childhood autism teacher for Respondent. She was a newer teacher at the time, having worked less than two years at this school. Her duties involved various tasks associated with teaching, helping, and caring for autistic students throughout the school day.

Petitioner testified that on September 25, 2012 she was outside on the blacktop with some students for recess. As recess was ending, Petitioner attempted to bring one of the students back inside to the classroom. The aide who was usually assigned to this student was not present on this day. As Petitioner was holding the student's hand, the student began resisting and threw himself to the ground, yanking Petitioner's arm and body down in the process. Petitioner testified that she immediately felt pain in her lower back. Petitioner also testified that she had never felt pain in her back like this prior to this incident.

Petitioner sought treatment with her primary care physician, Dr. Steven Rittman, on October 18, 2012 and complained of low back pain which had persisted for three weeks (since September 25, 2012, the date of the accident) (Rx. 4).

Physical Therapy and Chiropractic Treatments – DuKane Chiropractic

At the advice of her primary care physician, Petitioner sought chiropractic treatment at Dukane Chiropractic with Dr. Allan Kirchner-Gomez. (Px 1). Her initial evaluation was on October 19, 2012. (Px 1). Dr. Gomez noted that Petitioner presented with the following symptoms "due to a work related injury: constant pain in low back, sharp pain localized in right lumbar and left lumbar, shooting pain into lower right lumbar area, right posteriolateral upper thigh, right posterolateral thigh, right popliteal region, right calf, right gluteal area, and right coccyx region." (Px 1). On examination, Dr. Gomez noted "vertebral fixation and restricted joint function at C4, C6-C7, T3-T5, T9-T10, L3-L5, increased intensity of pain at C4, C6 to C7, T3 to T5, T9 to T10, L3 to L5, and the right ilium bilaterally was elicited on examination of the spine". (Px 1). Dr. Gomez recommended that Petitioner come in for physical therapy and chiropractic treatments four times a week. (Px 1). Petitioner began regularly treating with Dr. Gomez for the

next few months to treat her low back pain. (Px 1). Treatments which Petitioner underwent at Dukane Chiropractic included: interferential current therapy, placement of refrigerated gel packs on Petitioner's back (cryotherapy), various spinal manipulations and adjustments and manual therapies. (Px 1). Petitioner was also given a back brace and a TENS unit to use at home. (Px 1)

Dr. Gomez recommended that Petitioner attain an MRI of her lumbar spine, which she did on October 22, 2012. (Px 2). The MRI as read by the radiologist showed "central protrusion, L5-S1 with disc bulging, L4-L5". (Px 2).

Petitioner continued to treat with Dr. Gomez at Dukane Chiropractic; however her response to treatment was slower than Dr. Gomez expected. (Px 1; p53). A month into the treatment, Petitioner rated her low back pain as a 4 out of 10. (Px 1; p19). Two months into the conservative treatment, Petitioner's low back pain was still constant and described as "stiffness with dull-and-achy pain generalized in the right lumbar, left lumbar, right sacroiliac area, left sacroiliac area, right lower lumbar area, and right sciatic region". (Px 1; p31). Petitioner's back pain actually began to get worse in January of 2013, and she elected to undergo lumbar facet joint injections. (Px 5; Px 1).

Petitioner testified that she continued to receive physical therapy and chiropractic treatments with Dr. Gomez for a few weeks following the injection, and that the treatments were beneficial). Petitioner last treated with Dr. Gomez on April 29, 2013, at which point she was discharged from care. (Px 2).

Pain Management – Dr. Morgan and Dr. Jain

Petitioner sought treatment with pain care specialist Dr. Christopher Morgan on October 24, 2012, about a month after the injury she sustained at work. (Px 5). Petitioner relayed her work accident history to Dr. Morgan, and explained that her low back pain had not subsided over the previous month. (Px 5). Her low back pain was severe at times, caused her to lose sleep, and increased with any prolonged walking, sitting, and bending. (Px 5). Petitioner was experiencing low back pain traveling to the right and left buttocks area, and she denied any prior history of similar type of symptoms. (Px. 5). At this time, Petitioner was working modified duty, avoiding any lifting more than ten pounds and avoiding bending. (Px 5). On physical examination, lumbar range of motion was moderately to severely limited in flexion and extension in both the right and left. (Px 5). Straight leg raising on both the right and the left were positive for low back and buttocks pain ipsilaterally. (Px 5). Dr. Morgan discussed treatment options including lumbar epidural steroid injections; however Petitioner did not want to consider any injections at this time. (Px 5). Dr. Morgan recommended that Petitioner continue treating with Dr. Gomez, and reevaluate in a few weeks. (Px 5).

Petitioner followed up with Dr. Morgan on January 1, 2013 after the pain in her low back had not subsided. (Px 5). Petitioner relayed that she continued to experience low back pain with part of her pain extending up to her mid back, and no recent leg pain or paresthesias. (Px 5). She reported increased pain especially with sitting and bending, and that she recently sneezed which caused an increase in her pain. (Px 5). On physical examination, lumbar extension was limited

both forward flexion and extension causing axial low back pain without leg pain. (Px 5). Dr. Morgan recommended that Petitioner undergo lumbar facet joint injections (Px 5).

Petitioner testified that the pain reached a point in January, that she could not sleep at night, had to stay with her parents, and had to miss a few days of work due to the severity of the pain. Petitioner testified that she did undergo the facet joint injections as recommended by Dr. Morgan. (Px 3). Petitioner underwent bilateral L3-L4, L4-L5, L5-S1 facet joint injections administered by Dr. Neeraj Jain on January 30, 2013. (Px 3).

Petitioner followed up with Dr. Morgan on March 14, 2013 and relayed that she was doing much better with regards to her low back pain. (Px 5). Petitioner was able to function better and able to dress herself now without much difficulty. (Px 5). Her pain was rated as a 1 of 10 on this visit. (Px 5). Petitioner testified that the injection greatly helped improve her pain symptoms.

Petitioner testified that although her back feels better today, she still has flare ups from time to time which require the use of the back brace and TENS unit.

IME - Dr. Klaud Miller

Petitioner testified that she was seen for an Independent Medical Examination by Dr. Klaud Miller on January 2, 2013. (Rx 1). Petitioner testified that she explained her incident at work on September 25, 2012 to Dr. Miller. Dr. Miller authored a report with his findings and opinions regarding Petitioner's work related injury. (Rx 1). He also authored an addendum to his report. (Rx 2). Petitioner denied any previous back trauma, pain, or treatment before the work related injury on September 25, 2012, and relayed her injury wherein she "was escorting a student with autism who dropped suddenly to the floor pulling her arm". (Rx 1). Petitioner relayed that she had missed a couple days of work, that her pain is constant, and that she occasionally has pain at night that wakes her up. (Rx 1). Petitioner relayed that she has pain with essentially all activities and takes Naproxen and Ultram for the pain. (Rx 1). Dr. Miller reviewed Petitioner's medical records as well as an accident report dated October 22, 2012 – relaying the same incident occurring on September 25, 2012. (Rx 1). Dr. Miller opined that Petitioner had undergone reasonable treatment to date, that it was minimally aggressive and marginally successful. (Rx 1). Dr. Miller recommended an "exercise program" to help with Petitioner's back pain. (Rx 1).

In conjunction with his addendum report, Dr. Miller reviewed medical records from Petitioner's primary care physician dating back to 2006. (Rx 2). All of the medical records reviewed were for unrelated medical issues, and there was no mention of any prior back pain or injury. (Rx 2). Dr. Miller opined that Petitioner's back pain may have been caused by a sneeze, and any connection to the work accident in question is "completely speculative". Dr. Miller stated in his report that petitioner told him on January 2, 2013 that she was unimproved. Dr. Miller believed that chiropractic care was appropriate for up to one month on a trial basis. Dr. Miller also believed that as petitioner was not benefiting from the chiropractic therapy, it was not appropriate on a continuing basis. (Rx 2). He also stated that "MMI is not applicable since no injury can be related to the accident". (Rx 2).

AMA Rating - Dr.Babak Lami

Petitioner underwent another independent medical examination for the purpose of obtaining an AMA rating with Dr. Babak Lami on July 22, 2016. (Rx 3). Dr. Lami reviewed medical records and summarized them in his report in chronological order. (Rx 3). Dr. Lami only reviewed the IME reports and chiropractic records. (Rx 3). Dr. Lami did not review the MRI films or any records from Dr. Jain and Dr. Morgan. (Rx 3). He notes that Petitioner presented with "chronic recurring" back symptoms and relays that she has "degenerative changes" seen on MRI. Petitioner relayed to Dr. Lami that she continues to have intermittent low back pain. (Rx 3). Her back pain episodes "can sometimes be significant and they last for several days to weeks". (Rx 3). Dr. Lami opined that Petitioner fell under Class 0 and was given 0 percent impairment. (Rx 3).

Dr. Jain Narrative Report

Dr. Neeraj Jain authored a narrative report regarding Petitioner's treatment and it's relation to her work accident. (Pet. Ex. 6). Dr. Jain reviewed all of Petitioner's medical treatment and records, including his injection records from January 30, 2013. (Pet. Ex. 6). Dr. Jain opined that all of Petitioner's treatment was completely appropriate, reasonable and of necessary frequency and duration. (Pet. Ex. 6). Dr. Jain also noted that Petitioner's low back pain and symptoms were all directly related to the incident at work on September 25, 2012. Dr. Jain's opinions were based on Petitioner's history, physical examination, imaging studies, and medical records which were provided to him for review. (Pet. Ex. 6).

CONCLUSIONS OF LAW

(F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Based upon the testimony of the Petitioner and based upon the medical records, the Arbitrator finds that the petitioner's low back condition is causally related to her accidental injuries of Septemebr 25, 2012. The Arbitrator adopts the medical opinion of Dr. Jain on this issue. (Px 6). Petitioner testified that she had never had previous back pain or any of the symptoms which she experienced following the incident on September 25, 2012. Petitioner testified to the accident at work, and the respondent stipulated to the claimed accident of September 25, 2012. Respondent argues that the chiropractic records make a reference that petitioner had a chronic medical condition that had been exacerbated. However, the respondent offered no medical records that pre-date the accident which contain any mention of back pain or any treatments for back injuries. In fact, the respondent's expert, Dr. Miller reviewed the medical records of the petitioner's primary care provider, AMITA Health which date back to 2006 and states in his narrative report that those records contain no reference to any complaints or treatment for low back pain.

The respondent also argues that petitioner sustained an intervening accident when she sneezed on January 7, 2013 and when she slipped in the shower on January 23, 2103. However, the

Arbitrator notes that the petitioner was receiving active medical care at that time. The petitioner therefore had not reached maximum medical improvement prior to these incidents. There was no evidence presented to show that the intervening incidents changed the nature of the petitioner's underlying low back condition. At best, these incidents could have only exacerbated or contributed to the petitioner's underlying condition and symptoms related to her employment injury of September 25, 2012. *ABF Freight Systems v Illinois Workers' Compensation Commission, 396 Ill. App. 3d 1122, 6 N.E.3d 446, 379 Ill. Dec. 369.*

Based upon all of the above, the Arbitrator concludes that Petitioner's condition of ill-being is causally related to the injury which occurred in the course of Petitioner's employment for Respondent on September 25, 2012.

(J) REASONABLE AND NECESSARY MEDICAL SERVICES AND RESPONDENT'S PAYMENT OF ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES

Dr. Miller opines in his initial narrative report that chiropractic care can be appropriate empiric therapy. Dr. Miller also opines that if a patient does not improve after one month of care, the chiropractic therapy should be stooped (Rx 1). Dr. Miller states in his second narrative report that chiropractic care can be appropriate for up to one month on a trial basis. Dr. Miller notes that the petitioner reported to him that she was unimproved at the time of his examination o fher on January 2, 2013. Therefore, Dr. Miller stated that it was his medical opinion that there was insufficient evidence to substantiate continued chiropractic care. (Rx 2).

Based on the above, the Arbitrator finds chiropractic care from October 19, 2012 through November 18, 2012 was necessary and that the respondent is responsible to pay the charges for those dates of treatment (after a credit of $5,917.28 for prior payments is applied) to Dukane Chiropractic Rehab, Ltd pursuant to the medical fee schedule.

The Arbitrator finds that Petitioner's treatment at American Diagnostic MRI was necessary medical care. Petitioner's low back pain had not subsided for weeks, and Dr. Gomez recommended Petitioner attain an MRI. Petitioner did so on October 22, 2012, less than a month after the accident at work. The MRI revealed a central protrusion at L5-S1 with disc bulging L4-L5. The Arbitrator finds that Respondent is responsible for the $1,700.00 charges owed to American Diagnostic MRI to be paid pursuant to the medical fee schedule.

The Arbitrator finds that Petitioner's treatment at Pain Care Specialists with Dr. Morgan and Dr. Jain was reasonable and necessary, and the $372.00 charges associated with the treatment were reasonable and necessary. Petitioner was referred to a pain care specialist by Dr. Gomez for evaluation and possible pain care management. Dr. Morgan ended up recommending the lumbar facet joint injection which eventually greatly improved Petitioner's low back pain. The Arbitrator finds that Respondent is responsible for the $372.00 charges owed to Pain Care Specialists to be paid pursuant to the medical fee schedule.

The Arbitrator finds that Petitioner's treatment at Aiden Center for Day Surgery where she received the lumbar facet joint injection administered by Dr. Jain and the $20,260.00 charges

associated with the treatment was necessary medical care. Further, the Arbitrator finds that the anesthesia services provided by Oak Brook Anesthesiologists, Ltd were reasonable and necessary and the $875.00 charges associated with the anesthesia treatment was necessary medical care. After conservative treatment had failed to alleviate Petitioner's low back pain, Dr. Morgan recommended that Petitioner undergo a lumbar facet joint injection. Petitioner followed through on the recommendation, and the injection greatly helped improve her low back pain and placed her on track to pain relief and attaining MMI. The Arbitrator finds that Respondent is responsible for the $20,260.00 charges owed to Aiden Center for Day Surgery and $875.00 owed to Oak Brook Anesthesiologists, Ltd to be paid pursuant to the medical fee schedule.

(L) NATURE AND EXTENT OF THE INJURY

Based upon the medical records and the credible and unrebutted testimony of the Petitioner, the Arbitrator finds that Petitioner has sustained a loss pursuant to section 8(d)(2) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 0% of use of man as a whole as determined by Dr. Lami, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Res. Ex. 3). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The Arbitrator gives the appropriate weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an early childhood autism teacher at the time of the accident and that she was able to return to employment in her prior capacity after the injuries she sustained. The Arbitrator notes that Petitioner's injury arose out of and in the course of her employment as an early childhood autism teacher. Her employment does not require much heavy lifting or prolonged physical labor, and she is able to perform her duties proficiently. Because of the foregoing, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was twenty eight years old at the time of the accident. Due to the fact that Petitioner was relatively young, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner can continue to perform her employment related duties, and her future earnings will not be impacted by this accident and injury. Because of the foregoing, 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's testimony regarding her low back pain and accident are corroborated by the treating medical records. Petitioner was injured in late September, sought treatment several weeks later, and when conservative treatment failed, received a lumbar facet joint injection in January. Petitioner and was released from care in late April 2013, seven months after her accident. Petitioner testified that her lower back feels better

today, however she continues to have episodes and flare ups of pain in her lower back. Petitioner underwent an MRI on October 22, 2017 which was interpreted by the radiologist to reveal a central protrusion at L5-S1 and a bulge at L4-5.

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 4% loss of use of man as a whole pursuant to §8(d)(2) of the Act, equivalent to 20 weeks of benefits, as a result of the injury she sustained while working for Respondent.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janet A. Droege,
Petitioner,

vs. No. 14 WC 11405

Dynegy Midwest Generation,
Respondent.

18IWCC0764

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 underlying facts of this claim were laid out in the Arbitrator's Decision, which is incorporated herein. The Commission affirms the Arbitrator's determination as to occurrence of the accident, the causal connection between the original accident and the injuries sustained, as well as liability for medical treatment and temporary total disability benefits, and the 8(j) credit available to the respondent regarding same.

With regards to the assessment of the nature and extent of the injury, the Commission does arrive at somewhat different conclusions than did the Arbitrator. The Arbitrator properly reviewed the five factors enumerated in Section 8.1b of the Act in arriving at the conclusion that the claimant had established disability to the extent of 12.5% of the whole body pursuant to Section 8(d)2 of the Act. However, the Commission weighs the evidence somewhat differently than did the Arbitrator.

18IWCC0764

The Arbitrator noted no AMA rating was submitted and properly gave no weight to that factor. The Arbitrator also noted the claimant's employment as a lab technician, in which capacity she continues to be employed. The Arbitrator gave no weight to the petitioner's age (53 at the time of injury) as there was no evidence of how the claimant's age would impact the extent of the disability or her recovery. The Arbitrator further noted that the claimant had received a raise since the accident and concluded there was nothing to suggest any negative impact on the claimant's future earning capacity. Lastly, the Arbitrator noted a "relatively extended recovery time" and noted that the last note of Dr. Lenarz had stated that the claimant had needed to decrease the level of her exertion at work in order to relieve her residual symptoms.

The Commission notes that the Arbitrator's findings correctly relate the evidence presented, but the Commission weighs such evidence differently. However, the Commission does further note, regarding the ongoing disability faced by the claimant and factor (v) of Section 8.1b in particular, that Dr. Paletta noted only minimal loss of range of motion and very mild subjective complaints post-operatively. While his causation assessment was ultimately less persuasive than that of Dr. Lenarz, his clinical examination and physical findings are notable and persuasive in this context. The Commission further notes that at the time of trial the claimant pursued her pre-injury occupation for several years after last seeing Dr. Lenarz without ill effect and secured a pay increase since, which suggest that permanent partial disability would be of a more limited valuation.

In light of the totality of the evidence adduced and a review of the Section 8.1 factors, the Commission finds that permanent partial disability would be appropriately assessed at 7.5% loss to the whole person under Section 8(d)2, and modifies the Arbitrator's award accordingly. All other findings are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 37.5 weeks, as provided in §8(d2) of the Act, for the reason that the injuries sustained caused 7.5% 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 is entitled to a credit of $14,422.90 under Section 8(j) of the Act, but shall hold the claimant harmless, pursuant to Sections 8(j), from any provider's recoupment efforts regarding these benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit for any amounts previously paid regarding this matter.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,800.00. 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: DEC 12 2018

o-11/27/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DROEGE, JANET
Employee/Petitioner

Case# **14WC011405**

DYNEGY MIDWEST GENERATION
Employer/Respondent

18IWCC0764

On 7/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

18IWCC0764

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

JANET DROEGE
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION
Employer/Respondent

Case # **14** WC **11405**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$74,880.00**; the average weekly wage was **$1,440.00**.

On the date of accident, Petitioner was **53** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$14,422.90** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment on June 24, 2013. The Arbitrator further finds that the Petitioner's left shoulder condition is causally related to the June 24, 2013 accident.

The Arbitrator finds that the Petitioner is entitled to the medical treatment expenses contained in Petitioner's Exhibit 7 pursuant to Sections 8(a) and 8.2 of the Act, including the Petitioner's out of pocket expenses. The Respondent is entitled to credit for the medical expenses previously paid pursuant to Sections 8(a), 8(j) and 8.2

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55 per week**, the maximum allowable statutory rate, for **62.5 weeks**, because the injuries sustained caused the **12.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

The parties stipulated that the Respondent has paid the full amount of lost time benefits due and owing via non-occupational disability benefits, and thus no TTD was requested at the hearing.

Respondent shall pay Petitioner compensation that has accrued from **November 18, 2014** through **October 26, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

July 7, 2017
Date

JUL 10 2017

STATEMENT OF FACTS

A 23 year plus employee of the Respondent, the Petitioner testified that she works for Respondent as a lab technician, and was also working in this position on 6/24/13. On that date, she testified that a unit was down, and her job involves making sure the chemicals in the unit have a proper pH balance, and so she had to add a caustic soda to avoid having the unit go off line.

Using the photos contained in Rx5, the Petitioner described how she was on all fours, reaching her left arm to the side between two white supports, in order to operate a valve that appeared to be a foot or slightly more above the floor level. She testified that she had to use her thumb to push up a locking mechanism before she could operate the valve itself. She testified: "My arm was outstretched as far as I could reach to get the valve, gripped and then turned it." She then further testified: "And when I reached between the supports I was so outstretched there's no way that my arm could have been bent so I'm reaching here and then trying to grasp the valve lifting up the lock trying to get the valve open while outstretched while ducking underneath of a valve here with the oil line -- drain line in my hand."

Petitioner testified that the valve was not easily pulled and would not budge because the line was clogged, and so she had to jerk it hard to the left twice. She felt immediate pain after she tried to jerk it the second time and reported it to her supervisor. She didn't seek immediate treatment.

The Petitioner acknowledged that she reported two additional incidents to Nurse Practitioner Brown at Wood River Clinic/Midwest Occupational Medicine on 7/17/13. She described one incident where she was turning off of a roadway suddenly on 7/7/13 and felt a pain in her arm when her muscle tightened, and the other incident on 7/12/13 where she felt pain in her arm and when she was sitting in a chair and showing her husband what happened, where the muscle in her arm again tightened and it hurt.

As to NP Brown's records indicating her symptoms resolved and returned, the Petitioner testified she continued to have pain the whole time, it just depended on what she was doing. There were certain things at the job that also would cause pain, such as having to pull and yank a hose trailing behind her with her left arm while at waist level, and she reported that to Brown as well even though this is not indicated in her records.

Petitioner testified that she saw Dr. Lenarz on 9/30/13 and did not believe that she told him that her symptoms resolved after 6/24/13. She had surgery and agreed this resulted in improvement. She returned to unrestricted work duties in her regular job, and while she testified that she still has residual pain, it does not prevent her from working.

On cross examination, Petitioner testified that she was honest with NP Brown and with Dr. Paletta. She has returned to her regular job and testified that she earns more now than she did before. She agreed that her injury involved a single event at work.

Petitioner first sought left shoulder treatment on 7/17/13 at Midwest Occupational Medicine and saw NP Brown. She reported being on her hands and knees at work on 6/24/13, reaching out to turn a valve to the left when she felt left shoulder pain. The valve was stuck and she had to jerk and turn it, and she felt a pull in the shoulder. It "hurt initially and resolved", she completed her shift and just rested for a short time. On 7/7/13, she reported she was attempting to reproduce the motion to her husband and it hurt her again, with pain that lasted for approximately 15 minutes. Then, on 7/12/13, she reported that she was driving and had to make a sudden left turn, and she felt the pain in the left shoulder again, and this time the pain lasted into the next workday of 7/15/13, when she requested a medical evaluation from the Respondent. Petitioner denied any previous shoulder injuries. She pointed to "approximately" the AC joint when she indicated where the pain occurred. Exam was essentially normal. She was diagnosed with sporadic left AC joint pain and advised to work as tolerated, avoiding activities that elicited pain, and x-ray was prescribed. The Arbitrator notes that a pain diagram completed by Petitioner noted no pain "right now", and severe pain "when having pain." (Px1).

At her 7/24/13 follow up, Petitioner indicated she had no episodes of pain over the prior week. X-rays showed mild to moderate glenohumeral and AC degenerative change, with some widening of the glenohumeral joint space with slight inferior subluxation of the humeral head with possible underlying joint effusion or ligamentous injury. NP Brown indicated that degenerative AC joint changes noted on x-ray may account for the sporadic flare-ups. She was advised to continue working as tolerated, and if symptoms persisted an MRI may be needed. (Px1). Petitioner had to "make a quick sudden left turn" and her shoulder pain did not resolve and she sought medical treatment. (Px1 at 11) It was noted that she was "pain free in between these episodes." (Px1 at 11

On 8/7/13, the Petitioner noted she had been working light duty and noticed pain that was increasing in frequency and severity: "Any time she is bringing her arm over in front of her or when she was driving the forklift and hitting a bumpy area, she noticed increasing pain at the left anterior shoulder." The pain previously ad been occurring with sudden movements, but now was happening with everyday motion. MRI was prescribed. (Px1).

9/13/13 left shoulder MRI reportedly reflected moderately advanced AC joint arthritis, tendinopathy of the supraspinatus and, less prominently, the infraspinatus and subscapularis tendons. Labral tears were also noted by the radiologist, including a complex SLAP tear that extended into the labral biceps anchor. (Px6).

Petitioner initially saw Dr. Lenarz on 9/30/13. Petitioner reported left shoulder pain since 6/24/13, when she was at work twisting a valve forcefully with her left hand while she was on the ground. The pain was anterior, and she has had constant pain since, worse with any shoulder rotation. He indicated the MRI was consistent with the report. His diagnosis was bicipital labral complex injury. He noted that while there was no way to tell by MRI whether the left shoulder condition was preexisting, the mechanism as described could have caused or exacerbated or aggravated the condition. An injection was provided and Petitioner was referred to physical therapy. (Px2). Dr. Lenarz testified that he changed offices around this time. On 12/3/13 he prescribed arthroscopic left shoulder surgery. (Px3).

The 12/20/13 operative report notes postoperative diagnoses of subacromial bursitis and impingement, biceps tendonitis, and a full thickness rotator cuff tear of the anterosuperior cuff. Surgery involved diagnostic arthroscopy, biceps tenodesis, rotator cuff repair and extensive debridement and subacromial decompression. Dr. Lenarz noted on examination there was a full thickness tear of the superior border of the subscapularis

tendon, subluxation of the biceps tendon, a minor anterior border supraspinatus PASTA type tear, and a moderate amount of subacromial bursitis and small type II acromion spur. (Px4).

At the last visit with Dr. Lenarz on 11/18/14, the doctor noted Petitioner had some ongoing symptoms, but had decreased her level of exertion at work and that significantly improved her symptoms. She had minimal pain and was occasionally taking over-the-counter medications.

Board certified orthopedic surgeon Dr. Lenarz testified via deposition on 2/25/16. 90% of his practice involves the shoulder. The Petitioner's stated history was that she was holding a container under a spout while opening the valve with her left hand in a counter-clockwise fashion on 6/24/13. (Px5).

Examination indicated a probable bicep and SLAP tear issue. However, Dr. Lenarz initial review of the left shoulder MRI indicated no tears and some AC joint degeneration. He thus recommended injection and physical therapy. Petitioner did have some improvement. He reported on 12/3/13 that he re-reviewed the MRI films and this time noted a subscapularis tear, noting he had a radiologist review it, and the radiologist also saw the tear. Dr. Lenarz provided two MRI plane views where he identified the tear. He testified that it is relatively common for both radiologists and surgeons to miss these types of subscapularis tears on MRI. (Px5).

Dr. Lenarz testificd that this type of tear is consistent with the mechanism of injury, as the mechanism involved supinating the forearm and wrist while rotating the shoulder. He thus recommended surgery. He agreed that the need for surgery, given Petitioner had 80% intact, is based on symptomatic complaints, as he would not recommend surgical insult if someone feels they can live with their symptoms. He noted the 12/20/13 surgery noted a full thickness tear, as well as a subsurface tear which Dr. Lenarz opined did not require repair. He noted it normally would take 4 to 6 months to regain full function following this type of surgery. He believed Petitioner had a successful result and released her to full duty on 11/18/14. (Px5).

The two post-accident reports of pain noted in Petitioner's records, i.e. the event where she demonstrated her original mechanism of injury to her husband and where she suddenly jerked her steering wheel, were discussed. Dr. Lenarz did review the records of Wood River and Dr. Paletta. On direct exam, Dr. Lenarz testified that showing the husband what happened could reproduce symptoms. Turning a steering wheel suddenly would depend, but if turning it counter-clockwise, that would be basically the same motion Petitioner described in the work accident. He testified that while Petitioner may have reported waxing and waning symptoms after the accident, this would not be surprising to occur depending on the activity. He did not recall the Petitioner ever indicating to him that her symptoms completely resolved after the accident, or that she had any new accidents. (Px5).

On cross examination, Dr. Lenarz agreed he didn't know the height of the valve, but indicated it didn't matter to his opinion unless it required her to use the left arm overhead. He testified that the risk of injury was greater the further away from the valve she was. He did not know the size of the valve of the force required to turn it, but it doesn't matter to his opinion as it is based on Petitioner's stated history if injury. He did agree that the motion involved is something people do routinely, but don't suffer rotator cuff tears. (Px5).

Dr. Lenarz did not review any of the records of Wood River or Dr. Paletta before the deposition. He agreed he first saw Petitioner about 100 days after the accident date. He agreed that the more contemporaneous the history, the more likely it was accurate. There was no way to date the actual pathology other than symptoms onset, and agreed the symptoms of that tear can wax and wane. Tears like Petitioner's can be acute or cumulative, but she did describe an acute event. Subsequent incidents can aggravate or exacerbate a condition, but his focus is on when the symptoms started. It was unlikely to him that the steering wheel incident caused the entire injury, as

the Petitioner's type of pain was similar to what she had before, but he agreed it could have aggravated her condition. He agreed Petitioner did not indicate a "pop" at the time of the accident, and a SLAP tear was not seen during surgery. While she did not have weakness, Dr. Lenarz indicated that the type of injury Petitioner had would not cause weakness. (Px5).

Respondent obtained a records review from Dr. George Paletta dated 10/16/14, and in that review Dr. Paletta noted the initial reports of nurse practitioner (NP) Lynn Brown and the three events as recounted by Petitioner as well as a review of the MRI, which he felt showed extensive degenerative changes in the shoulder. Dr. Paletta issued an addendum report on 11/3/14 and then subsequently examined the Petitioner on 8/31/15. (Rx3)

Dr. Paletta testified that he did not think Petitioner's shoulder condition was work related because of several factors. This included the fact that the mechanism of injury as documented would not cause a rotator cuff tear, the fact that the contemporaneous medical records showed that the symptoms fully resolved after the event at work, which would not be consistent with a rotator cuff tear, and she then had the event with the steering wheel after which she initially sought treatment. Dr. Paletta opined that the MRI did not show evidence of the rotator cuff tear that Dr. Lenarz noted at the time of surgery. (Rx2).

Dr. Paletta's 11/3/14 report diagnosed Petitioner as status post rotator cuff repair with AC joint arthritis in the left shoulder. She had not yet reached MMI at that point. He agreed that, based on Lenarz's findings, surgery was warranted. (Rx2).

When Dr. Paletta examined the Petitioner on 8/31/15, she did not report anything about turning a valve: "What she told me is that she was trying to get some chemicals out of a tank, that she was down on her hands and knees holding a collection bottle in her right hand. And as she was trying to get the chemical out of the tank she felt, quote, a little pain in the shoulder." She didn't initially report the injury because she thought it would get better. Petitioner disputed NP Brown's statement that her symptoms had fully resolved. Dr. Paletta testified that from his understanding of the alleged event of 6/24/13, as documented by NP Brown, Petitioner would not have be in a position to put force on the rotator cuff that would result in a tear. (Rx2).

Post-surgically, Dr. Paletta's examination indicated minimal loss of range of motion and mild subjective complaints, and he felt Petitioner had reached MMI and needed no further treatment or work restrictions. Dr. Paletta testified that Dr. Lenarz initially did not see either a subscapularis tear or bicep displacement in the MRI, which is identical to Paletta's findings. He said he later saw these things in surgery, and then went back to the MRI and saw them. Dr. Paletta's re-review of the MRI shows no evidence of this, noting there is a very low likelihood an MRI would not pick up such tearing had it been there when the test was performed. He opined that the pathology found by Dr. Lenarz during surgery was inconsistent with reaching out in front, but instead was a result of attritional wear and tear. Turning a steering wheel suddenly to the left could have caused the pathology in Petitioner's shoulder if it was "pretty aggressive." Given Petitioner's symptoms never resolved after that event and that it precipitated her seeking medical treatment, it was the more likely cause than the work event. He agreed that the more contemporaneous a stated history is, the more likely it is accurate. He did agree that the work incident could have involved a temporary exacerbation. (Rx2).

On cross examination, Dr. Paletta agreed that Petitioner's initial accident description to NP Brown was not contradictory to what she reported to him, but it was more detailed. He did not know how much force was involved in the incident. He agreed that the records he reviewed did not indicate any left shoulder injuries prior to 6/24/13. Dr. Paletta did not believe that an arthrogram with contrast would not help to evaluate a cuff injury. Dr. Paletta acknowledged that Dr. Lenarz noted a tear in the MRI prior to performing surgery, and agreed it is possible that such a finding could be missed when reviewing an MRI. Dr. Paletta agreed that Petitioner's stated

history to him was that her shoulder pain never resolved after the initial 6/24/13 accident. He agreed he had no reason to doubt Dr. Lenarz surgical findings. While to a reasonable degree of medical certainty he did not believe the mechanism of injury would have torn the rotator cuff, it would not be impossible. (Rx2).

Dr. Paletta testified that if the third factor which supports his causation opinion, that Petitioner's symptoms fully resolved after the 6/24/13 accident, was not correct, it would not change his opinion as to the mechanism of injury or what was seen on MRI, but it could change his opinion with regard to whether there could have been an aggravation. He agreed symptoms could wax and wane with Petitioner's shoulder condition, but not resolve. He agreed that his post-surgical diagnoses sometimes add things to the original MRI diagnosis. (Rx2).

CONCLUSIONS OF LAW

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

The Arbitrator states that, based on a viewing of the Petitioner demonstrating the 6/24/13 incident, she was in a very awkward position, reaching as far as she could with her left arm, having minimal room to move the arm itself, while trying to use her thumb to open the valve lock and then turn the valve. Petitioner also testified that turning the valve itself involved some difficulty, requiring her to jerk it twice, with immediate pain the second time. The Arbitrator found the Petitioner's testimony credible in this regard. The photographs really show just how awkward this position had to be given the location of the valve and her description of how she had to access it.

The Arbitrator believes that the mechanism of injury, as described by the Petitioner verbally and with the assistance of photographs, involved an increased risk of injury to the left upper extremity. As such, the Arbitrator finds that the Petitioner sustained an accidental injury which arose out of and in the course of her employment with the Respondent on 6/24/13.

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

There was much dispute and focus in this case on the exact mechanism of injury that occurred and whether such a mechanism could cause the tears that Dr. Lenarz found during surgery on the Petitioner's shoulder.

The Arbitrator acknowledges the testimony of both Dr. Lenarz and Dr. Paletta with regard to the mechanism of injury. The Arbitrator believes the Petitioner's description of the incident comports with the opinions of Dr. Lenarz, which supports that the injury of 6/24/13 was causally related to the Petitioner's left shoulder condition. To some degree, the Arbitrator is being asked to split hairs in terms of the exact mechanism that occurred on 6/24/13 and how it may have produced forces within the left shoulder. The Arbitrator's review of the evidence in this case indicates that the Petitioner was in an extremely awkward position, on her hands and knees, while reaching as far as she could to her side, while trying to open a valve lock and open a difficult to turn valve lever. It is clear that there was very limited ability for her to bend her arm or maneuver it while in that position. Plus, she indicated she had to yank the valve mechanism because it was tight, and testified that she had immediate pain and promptly reported an injury even though she did not immediately seek treatment. Thus, in the Arbitrator's view, the mechanism of injury could have transmitted force to the Petitioner's shoulder when she was trying to turn the valve while in this position. Dr. Paletta is a respected physician and his opinion is valid,

however it is not clear to the Arbitrator that he had a full understanding of exactly what the Petitioner was doing at the time. The dispute with the MRI would appear to be moot based on the findings of Dr. Lenarz during surgery. The Arbitrator believes the preponderance of the evidence does not support a finding that the Petitioner's structural condition worsened after the MRI was obtained. Plus, the MRI findings noted structural abnormalities. While an MR arthrogram would have been instructive, the Arbitrator found the testimony of Dr. Lenarz in this regard to be credible. The preponderance of the evidence supports a causal connection between the Petitioner's described activity on 6/24/13 and her left shoulder injury.

The Respondent also sought to defend this case on the basis of intervening injury or injuries. This would include the Petitioner demonstrating to her husband what occurred on 6/24/13, as well as a subsequent incident where she had to suddenly turn her steering wheel to the left, with pain subsequent to both events. The defense also relies on the report of NP Brown that her symptoms resolved after the 6/24/13 incident and before these two additional events.

While the defense is fair, the Arbitrator believes the preponderance of the evidence again supports the Petitioner in this case. There is no evidence this claimant had any left shoulder problems prior to 6/24/13. The Arbitrator believes that, based on a review of the 7/17/13 report, that Petitioner's indication that her pain resolved related to the time after the injury on the date of accident. These additional events both took place within three weeks of the 6/24/13 incident. The Arbitrator also notes with significant interest the Petitioner's 7/17/13 pain drawing for NP Brown, which basically indicated that at times she had no pain at all, and at other points severe pain. This would support the fact that when she did not have significant pain unless she was putting the shoulder in a position that caused pain, such as the demonstration and steering wheel incidents. These subsequent incidents appear to have simply involved a recurrence of symptoms due to the activities she was performing, and that the Petitioner was credible in her indication that the condition never completely resolved after 6/24/13.

The Petitioner did indicate that after the 7/12/13 incident with the steering wheel, her symptoms continued and on 7/15/13 when she returned to work she requested medical attention. However, Petitioner noted on 7/24/13 that she had not had any episodes of pain, even after this incident. This, again, leads the Arbitrator to conclude that her pain was significantly activity-activated, and that it depended on exactly what activity she was performing as to whether she had pain or not, and thus a lack of pain at any particular point in time did not mean her condition of pathology actually resolved.

The Arbitrator would also state that current case law in Illinois would not appear to support the idea that such alleged intervening incidents would have broken the causal relationship between the 6/24/13 accident and the left shoulder condition. Both of these subsequent events appear to the Arbitrator to involve significantly less force and awkwardness than the original 6/24/13 incident. Even if these events possibly worsened her condition, this would not indicate to the Arbitrator that the 6/24/13 accident was not still a causative factor in the need for treatment that included surgery.

It is certainly possible that the Petitioner's left shoulder condition was preexisting and that each of the described incidents, including the 6/24/13 incident, simply were temporary symptomatic aggravations of that preexisting condition. However, the fact that the Petitioner denied any prior left shoulder problems, and the fact that there is no evidence which would indicate any prior problems, the preponderance of the evidence supports that the initial insult and injury occurred on 6/24/13. Dr. Lenarz's causation opinion is significantly based on this determination as well. As such, the Arbitrator finds that the Petitioner has proven that her left shoulder condition was caused by the 6/24/13 accident.

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

The Arbitrator finds that the Petitioner is entitled to payment of the medical expenses contained in Petitioner's Exhibit 7, including any out of pocket expenses. The Respondent is entitled to credit for payments made towards these expenses prior to trial, and the Arbitrator notes that the parties have stipulated to the Respondent being entitled to a credit of $14,422.90 pursuant to Section 8(j) of the Act. Ultimately, the Petitioner is not entitled to double payment of medical expenses, and the Respondent is entitled to credit for all awarded bills which were paid prior to the hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act, and shall hold the Petitioner harmless with regard to same.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that the parties did not indicate an issue at hearing with regard to TTD. However, the Arbitrator notes that while no TTD was claimed, the parties stipulated that Petitioner received full lost time benefits via Respondent's payment of non-occupational disability benefits.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating and/or opinion was submitted into evidence. As such, this factor carries no weight in the permanency determination.

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 lab technician at the time of the accident, and she testified she has returned to work in this prior capacity following her medical release. There is no evidence of an inability to do her job. The Arbitrator finds that this factor tends to show a lower level of permanent disability.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. Neither party has presented evidence which would support how the Petitioner's age would impact her permanent disability, and the Arbitrator does not find anything in the presented evidence which would indicate the impact of her age. As such, this factor carries no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented which indicates that the Petitioner has any anticipated loss of future earnings as a result of her accident and injury. She testified that, in fact, she is earning more now than she was at the time of the 6/24/13 accident. The Arbitrator finds that this factor also tends to show a lower level of permanent disability versus someone who as suffered such a loss of future earnings.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner underwent repair of a full thickness cuff tear and bicep tenodesis. She had a relatively extended recovery time. She was released to full duty, and testified she works full duty today, but the last note of Dr. Lenarz states that she had decreased her level of exertion at work, and that ended up relieving her symptoms.

Based on the above factors, the record taken as a whole and a review of Commission awards involving similar injuries and similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mahoutin Avocetien,
Petitioner,

vs. NO: 15 WC 18604

Tyson Foods, Inc.,
Respondent.

18IWCC0765

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of prospective medical expenses and being advised of the facts and law, modifies the Decision of the Arbitrator as noted below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission generally affirms the Arbitrator's award of benefits, inasmuch as the respondent did not challenge causal relationship as to the orthopedic diagnosis and treatment for same. However, the Commission clarifies the Arbitrator's award and finds that, given Dr. Gordon's discharge of the claimant at Maximum Medical Improvement on June 1, 2015 and the lack of objective findings on MRI, that only an initial evaluation by the pain management physician should be deemed reasonable and necessary at this juncture. What, if any, diagnosis is made by that physician, and whether or not any medical treatment is recommended by that physician, and whether such treatment is causally related to the original accident as well as being medically appropriate and reasonable, are all speculative at this time. As such, any such findings or treatment would, if disputed, be properly determined only at a future §8(a) hearing.

18IWCC0765

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 2017, is hereby modified as noted above but otherwise affirmed and adopted.

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

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

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

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: DEC 12 2018

Joshua D. Luskin

o-11/27/18
jdl-mcp
68

Charles J. DeVriendt

Elizabeth Coppoletti

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

AVOCETIEN, MAHOUTIN
Employee/Petitioner

Case# **15WC018604**

TYSON FOODS INC
Employer/Respondent

18IWCC0765

On 6/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0568 WINSTEIN KAVENSKY & CUNNINGHAM
CRAIG L KAVENSKY
PO BOX 4298
ROCK ISLAND, IL 61204-4298

2593 GANAN & SHAPIRO PC
PAUL DYKSTRA
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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)/8(a)

MAHOUTIN AVOCETIEN,
Employee/Petitioner

v.

TYSON FOODS, INC.,
Employer/Respondent

Case # **15** WC **18604**

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 **6/6/17**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **6/6/14**, 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 **$28,839.08**; the average weekly wage was **$554.60**.

On the date of accident, Petitioner was **29** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

The respondent shall pay reasonable and necessary medical services for a pain management evaluation and treatment with Dr. Sundar, or another pain management specialist, as recommended by Dr. Wynn and Dr. Coe, 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

6/27/17
Date

ICArbDec19(b)

JUN 30 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 29 year old spinal cord vacuum operator, sustained an accidental injury to his neck and right shoulder that arose out of and in the course of his employment by respondent on 6/6/14. As a spinal cord vacuum operator his duties included cutting the spinal cord out of the cow. He would cut the cord in half and remove the spinal cord of the cow.

On 6/6/14 the machine the petitioner was working on was not working properly. He reported the problem with the machine to his supervisor, who called maintenance to come fix it. Although maintenance allegedly fixed it, petitioner testified that the machine continued to not work properly. Nonetheless, the petitioner continued to work until he developed pain in his right shoulder and neck.

Petitioner testified that his job involved standing on a platform and grabbing a machine overhead and pulling it down to cut the cow in half. He testified that the machine was higher than him, and in order to operate the machine he had to raise his right arm above his head. He would bring his arm overhead and then down to cut one side of the cow, and then would bring his right arm overhead again and bring it down to cut the other side of the cow. He testified that the machine he used had big pointy spikes attached to a tube and when he cut through the cow the spinal cord went into the tube. Petitioner testified that the machine was harder to move because it was broken. Petitioner performs this activity for respondent 8 hours a day. Petitioner performed this job for 2 years and 10 months.

Petitioner first saw the company nurse. Eventually he was referred to MOHA On-Site Physician Services and saw Dr. Candler on 7/11/14. He presented with right trapezius/neck pain after working at the spinal vac station. Petitioner was assessed with right trapezius pain. Petitioner was instructed to use over the counter Aleve and ice as needed with the nurses. He was also prescribed physical therapy for a week for range of motion and modalities. He was then instructed to progress through work hardening over the next two weeks. On 7/25/14 petitioner reported that his pain was not any better. Dr. Candler assessed complaints of right shoulder/neck and trapezius pain with no physical findings and with inconsistencies between observation and examination. Petitioner was told to progress to full duty in two weeks.

On 3/27/15 petitioner returned to Dr. Candler. He reported that his pain had been ongoing since he was last seen. He stated ibuprofen had been helping the pain, but was no longer working. Dr. Candler noted that petitioner had complaints of right shoulder pain, but refused to cooperate with the examination. Petitioner was restricted to light duty with no work above chest level and only occasional lifting up to 10

pounds with the right arm. An x-ray and physical therapy was ordered. He was prescribed Naproxen. He was also told he could go to the nurses' station for use or heat up to 2 times a shift.

On 4/13/15 petitioner presented to Dr. Gordon at MOHA. The x-ray revealed no acute findings, but did reveal mild to moderate acromioclavicular degenerative changes. Petitioner denied any prior problems to his right shoulder. Dr. Gordon examined petitioner and assessed right shoulder girdle pain. He recommended Relafen, Flexeril, continued physical therapy, alternate duty, a review of his job video.

On 4/25/15 petitioner returned to Dr. Candler. He continued to complain of right shoulder and neck pain. He stated that he felt cold most of the time, and had numbness and pain in his right arm. Dr. Candler was of the opinion that petitioner had rheumatic heart disease (RHD) that needed to be considered in his differential diagnosis. He noted that shoulder pain secondary to arthritis from RHD can occur. He also assessed possible vasoconstriction/Raynaud's phenomenon in the right hand and right arm, and cervical and right upper shoulder pain with no clear etiology. Dr. Candler ordered a C-spine, chest, and right shoulder xrays. Petitioner's restrictions were continued.

On 5/11/15 Dr. Gordon noted that the x-rays were negative, but the right shoulder x-ray showed an element of AC joint arthrosis. Petitioner still complained of pain in his cervical region/right shoulder girdle region. Petitioner reported that physical therapy had not been of any benefit. Dr. Gordon assessed cervical/right shoulder girdle region pain. He recommended an MRI of the cervical spine, right shoulder, and right scapula. He was instructed to continue on alternate duty. Therapy was discontinued.

On 6/1/15 petitioner returned to Dr. Gordon. He complained of pain in his right paracervical region along with right shoulder girdle region including his right parascapular region diffusely. He reported that none of the treatment to date had really helped. The MRI of the cervical spine was unremarkable. The MRI of the right shoulder revealed mild degenerative changes of the right acromioclavicular joint. The MRI of the right scapular revealed degenerative changes at the right acromioclavicular joint. Petitioner was examined and his diagnosis was cervical/right shoulder girdle region pain. His examination was nonphysiological. His MRIs did not reveal any notable pathological findings that would explain his diffuse complaints from a primary musculoskeletal standpoint. He released petitioner to full duty. He also instructed him to perform home exercises. He recommended work progression. Dr. Gordon discharged petitioner from his care at maximum medical improvement.

On 7/7/15 petitioner presented to Dr. Wynn at ORA Orthopedics. He provided a consistent history of the accident and his complaints to date. His chief complaint was right sided neck and right sided

shoulder and arm pain. He described his pain as locking, along with numbness, tingling, swelling, and weakness. He rated his pain at 7/10. He reported that it was constant and radiated on the right from his neck to his arm. He reported that nothing has made his symptoms better. Following an examination and review of the x-rays and MRIs, Dr. Wynn's impression was right sided cervical spine pain, right upper extremity pain and decreased range of motion and strength fairly globally in the right upper extremity. He did not think petitioner's physical exam findings fit his radiographic or MRI findings. He saw no real significant pathology on the x-rays or MRIs. He was of the opinion that petitioner's effort on exam was limited. He recommended a referral to a pain specialist, Dr. Sundar. He was okay with petitioner continuing on light duty. He did not think there was anything he could do for him from an orthopedic perspective.

On 10/1/15 petitioner was terminated. He testified that he was working on the floor and was called to the office. He was told he returned to the floor late and because of that he was fired. Petitioner testified that did not return to the floor late.

On 5/13/16 petitioner underwent a Section 12 examination performed by Dr. Jeffrey Coe at the request of his attorney. Dr. Coe performed an examination and a record review. Petitioner provide a consistent history of his work activities and the accident. Petitioner reported that he has not seen Dr. Sundar because it has not been approved by respondent. He continues to perform home therapies with over the counter anti-inflammatory and analgesic medication, ice, heat and liniment. Petitioner complained of pain in his right shoulder radiating into the right side of his neck, right upper back and down his right arm. He also reported that he sometimes experiences numbness and tingling in his fingers of his right hand. He complained of right arm weakness in association with pain. He also complained of neck and right shoulder stiffness. He complained of episodic "coolness" of his right hand with increased sweating. Following an examination, Dr. Coe opined a causal connection between petitioner's now chronic right shoulder girdle and arm myofascial and neurogenic pain and his work activities at Tyson Foods on 6/4/14 (sic). Dr. Coe was of the opinion that petitioner was in need of additional medical treatment that would include an evaluation by a pain management specialist as prescribed by Dr. Wynn on 7/7/15. He was of the opinion that petitioner had elements of chronic myofascial pain and chronic right upper extremity CRPS, with appropriate treatment for this condition to be determined by a pain management specialist, and may include medication and a trial of diagnostic and therapeutic nerve blocks. Dr. Coe was of the opinion that petitioner was unable to use his right arm for any work activities requiring forceful lifting, pulling or pushing or use of his right arm above shoulder height.

On 9/16/16 Dr. Junaid Makda, American Board of Orthopedic Surgery, drafted a peer review with respect to the request for pain management for petitioner. Medical documentation reviewed was the visit to Dr. Wynn on 7/7/15, the report of Dr. Gordon on 6/1/15, the MRIs of the right shoulder, right scapula and cervical spine on 5/21/15. Based on review of these records, Dr. Makda determined that the requested pain management referral was not medically necessary and appropriate. Dr. Makda did not examine petitioner or talk with him. Dr. Makda's opinions were based on the fact that there is no identified pathology and complaints are not supported by objective exam findings.

Petitioner testified that currently he has pain in the right side of his neck, right shoulder and right arm. He testified that he cannot lift anything heavy. He stated that his right arm is always cold. He reported difficulty lifting, movement and sleeping on right arm. He testified that he cannot keep up with the work environment without the pain becoming bad. Petitioner cannot lift overhead without pain. He reported pain when turning his neck.

Petitioner has not worked since 10/1/15. He testified that his condition has remained the same.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

It is unrebutted that petitioner sustained an accidental injury to his right shoulder/neck area on 6/6/14 while removing spinal cords from cows with a machine that was not working properly, and that his current condition of ill-being is casually related to the injury he sustained on 6/6/14. Immediately after experiencing pain petitioner reported the accident and sought treatment. Petitioner first sought treatment with the company nurse and at MOHA. Petitioner treated with Dr. Candler and Dr. Gordon at MOHA.

Dr. Candler first assessed petitioner with trapezius pain. He was prescribed physical therapy without any improvement. On 7/25/14 Dr. Candler believed petitioner's complaints of right shoulder/neck and trapezius pain did not match any physical findings. He also noted inconsistencies between observation and examination. Petitioner's pain continued and Dr. Candler put petitioner on light duty. Dr. Gordon also treated petitioner and assessed right shoulder girdle pain.

By 4/25/15 petitioner's complaints were that he felt cold most of the time and had numbness and pain in his right arm. Dr. Candler was of the opinion petitioner had rheumatic heart disease. He believed shoulder pain secondary to arthritis from RHD can occur. However, the arbitrator finds it significant that petitioner's shoulder pain did not occur until after working for an extensive period of time on a defective machine. Dr. Candler assessed cervical and right upper shoulder pain with no clear etiology. Additional diagnostic testing was ordered. The neck x-rays were negative, but the right shoulder x-ray showed an

element of AC joint arthrosis. Dr. Gordon assessed cervical/right shoulder girdle region pain. An MRI of the right shoulder and right scapular revealed mild degenerative changes of the right acromioclavicular joint. Dr. Gordon was of the opinion that the MRIs did not reveal any notable pathological findings that would explain his diffuse complaints from a primary musculoskeletal standpoint.

Petitioner next presented to Dr. Wynn, an orthopedic specialist. His complaints remained the same. Dr. Wynn's impression was right sided cervical spine pain, right upper extremity pain and decreased range of motion and strength fairly globally in the right upper extremity. He did not think petitioner's physical findings fit the radiographs or MRI findings. He recommended a referral to pain specialist, Dr. Sundar, since he did not think there was anything he could do for him from an orthopedic perspective.

Respondent did not authorize the pain management referral, and petitioner's attorney had petitioner examined by Dr. Jeffrey Coe. Dr. Coe opined a causal connection between petitioner's now chronic right shoulder girdle and arm myofasial and neurogenic pain and his work activities at Tyson Foods on 6/4/14 (sic). Dr. Coe was of the opinion that petitioner was in need of additional medical treatment that would include an evaluation and treatment by a pain management specialist, as prescribed by Dr. Wynn. He was further of the opinion that petitioner had elements of chronic myofascial pain and chronic right upper extremity CRPS.

Respondent had a peer review performed by Dr. Makda. Dr. Makda determined that the requested pain management referral was not medically necessary and appropriate. Dr. Makda did not examine petitioner and only reviewed the report of Dr. Wynn on 7/7/15, the report of Dr. Gordon on 6/1/15 and the MRIs. The arbitrator finds it significant that Dr. Makda did not review any medical records between the date of accident and 6/1/15, or any reports or records after 7/7/15. Based on this, the arbitrator gives little weight to the opinions of Dr. Makda, because these opinions and findings are based on an incomplete review of petitioner's medical treatment from the date of accident. Additionally, the arbitrator finds it significant that Dr. Makda did not examine petitioner or even talk to him.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's request for future medical services as they relate to a pain management evaluation and treatment by Dr. Sundar, or another pain specialist, to be reasonable and necessary. The arbitrator finds the petitioner had no prior complaints of any right shoulder, right neck or right arm complaints prior to the injury; that petitioner's complaints continued from the date of injury without any improvement; that petitioner had no significant findings on diagnostic tests; that petitioner's condition has not improved since the injury; and that both Dr. Wynn and Dr. Coe, the last two doctors to examine petitioner, agreed that petitioner was in need of a

pain management referral and possible treatment for his complaints, and Dr. Coe's diagnosis of chronic myofascial pain and chronic right upper extremity CRPS.

The arbitrator finds the respondent shall pay reasonable and necessary medical services for a pain management evaluation and treatment with Dr. Sundar, or another pain management specialist, as recommended by Dr. Wynn and Dr. Coe, 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.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fabian Munoz-Bautista,

Petitioner,

vs.

NO: 16 WC 16977

18IWCC0766

Buckeye Diamond Logistics,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

18IWCC0766

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

DATED: DEC 13 2018
TJT:yl
o 12/11/18
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

MUNOZ-BAUTISTA, FABIAN
Employee/Petitioner

Case# **16WC016977**

BUCKEYE DIAMOND LOGISTICS
Employer/Respondent

18IWCC0766

On 11/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.43% 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:

2234 CHEPOV & SCOTT LLC
NICHOLAS CLIFFORD
5440 N CUMBERLAND AVE STE 150
CHICAGO, IL 60656

0560 WIEDNER & McAULIFFE LTD
JASON STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS
COUNTY OF DuPage)

18IWCC0766

☐ 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)

Fabian Munoz-Bautista
Employee/Petitioner

v.

Buckeye Diamond Logistics
Employer/Respondent

Case # **16** WC **16977**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 27, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 20, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,208.91**; the average weekly wage was **$426.09**.

On the date of accident, Petitioner was **20** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT ON MAY 20, 2016 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HIS CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO ANY ACCIDENTAL INJURY OCCURRING ON MAY 20, 2016, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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

Signature of Arbitrator

November 17, 2017
Date

NOV 28 2017

ICArbDec19(b)

Statement of Facts

Petitioner Fabian Munoz-Bautista testified though an interpreter. He testified that on May 20, 2016, he was working for Respondent, Buckeye Diamond Logistics. He had worked there for about 10 months. He worked preparing pallets. The job was replacing wood on damaged pallets. It required frequent pushing, pulling and lifting of the pallets. Petitioner estimated that the pallets weighed between 25 and 40 pounds. Felix Bonilla testified that they weigh between 60 and 70 pounds. Petitioner testified he would fix 200 pallets per day. Petitioner testified that before May 20, 2016, he had no problems performing his job duties. RX 2 documents that Petitioner had been disciplined for failing to meet this minimum number of pallets on 2/17/2016, 3/31/2016 and 5/12/2016. He had also been disciplined for poor quality work and a "no call-no show."

Petitioner denied any prior injuries to his low back or right shoulder. He testified he had a prior injury to his right wrist in April, 2016. Petitioner was seen at Community First Medical Center on April 15, 2016, giving a history that an empty pallet fell on his right forearm yesterday after noon. He complained of pain to the wrist and fingers. The examination noted right wrist decreased range of motion and tenderness. X-rays of the right wrist, forearm and hand were unremarkable. Petitioner was diagnosed with a right wrist injury. He was prescribed Tylenol and Advil and advised to follow up with his doctor (PX 2, p 1-16).

Petitioner testified that at 9:00 A.M. on May 20, 2016, he was reaching up above his head to grab a pallet on top of a stack of fifteen pallets. While trying to pull the pallet down, it started falling on him. He fell and tried to support himself with his right arm on a table. He was unable to grab the table and he fell with the pallet on top of him. He testified that he landed on his back. He testified that the pallet landed on his right wrist and shoulder. He testified that he experienced immediate severe pain in his right shoulder, right wrist and lower back. Petitioner testified that he was able to get the pallet off of his body. He reported the accident to his supervisor Felix Bonilla immediately that day. He reported it in Spanish. Mr. Bonilla speaks both English and Spanish.

Petitioner testified he prepared an accident report with Mr. Bonilla. He testified he read the report and it was accurate. He later testified that he cannot read English and is not familiar with the document. RX 1 is the document Mr. Bonilla showed him when he was filling out the accident report. He testified Mr. Bonilla did not read the document to him. Petitioner testified that he then showed Mr. Bonilla where the accident occurred. Petitioner testified that Felix Bonilla took him to the hospital.

Felix Bonilla testified that he works for Respondent as the first shift supervisor. Petitioner was a repairman on his shift. He would interact with Petitioner daily. They would communicate in Spanish. Mr. Bonilla speaks Spanish and never had difficulty communicating with Petitioner. Mr. Bonilla testified that he had a conversation with Petitioner on May 20, 2016. Jim Gudeman, the plant manager informed him that Petitioner might have had an injury and they walked together to Petitioner's work station. He testified that when he arrived, he asked Petitioner what had happened. Petitioner told him that as he was pulling a pallet off the stack, it fell and hit him on the wrist. He did not describe injuring any other part of his body. After the conversation, they went back to Mr. Bonilla's office and he wrote up the accident report. He identified RX 1 as the report he prepared on May 20, 2016. He typed it up as Petitioner was telling him what happened. Petitioner had an opportunity to review it. Mr. Bonilla testified that he read what he wrote to Petitioner in Spanish both as he was typing it and after the document was completed.

Mr. Bonilla testified that he then asked Petitioner to step outside. He then went into Mr. Gudeman's office to pull surveillance video. He pulled the camera feed for Petitioner's workstation to review the video from the beginning of the shift until he saw himself and Mr. Gudeman arrive. He is familiar with the surveillance system in the plant. It stores the material for 21 days and then rewrites over itself. He obtained the specific time period by using the computer search engine. He testified it is not possible he pulled up a different date because the system defaults to the current date and he is in the video so he knew it was the current day. He viewed it with Mr. Gudeman multiple times that morning. RX 3 was identified as the video he reviewed of May 20, 2016. He identified Petitioner in the video. He testified that he saw Petitioner grab his wrist and walk off camera. He did not see a pallet strike his wrist. He did not see Petitioner fall to the ground. Mr. Bonilla testified he then brought Petitioner into the office and showed him the video so that he could point out exactly the pallet that fell on his wrist. He testified Petitioner had a deer in the headlights look once he saw the video. Then someone took Petitioner to the hospital.

James Gudeman testified that he is employed by Respondent as the plant manager since March, 2016. He is familiar with Petitioner. He recalls learning of Petitioner reporting an injury on May 20, 2016. He saw Petitioner with Jose Acosta, the first shift lead come into the front office. Jose indicated that Petitioner had injured himself. He testified that he went and found Felix Bonilla, told him what happened, and went to the work station to have Petitioner explain what happened to cause the injury. He testified that he and Mr. Bonilla viewed the surveillance video. Then Mr. Bonilla brought Petitioner in to view the video. Mr. Gudeman viewed RX 3. He identified the video as from May 20, 2016. He identified Petitioner in the video. He identified himself and Mr. Bonilla entering the scene. Petitioner was instructed to seek medical attention after he viewed the video. There is no date or time stamp on the video. Mr. Gudeman testified the accident report was filled out in the outer office in his presence, where Petitioner explained what happened to Felix Bonilla. Mr. Bonilla showed the report to Petitioner. He believed that Mr. Bonilla read the report to Petitioner.

RX 1 is the accident report prepared May 20, 2016. The report states that while flipping pallets onto his table, a second pallet fell from the stack and hit Petitioner in the wrist. The injury was a swollen right wrist.

The Arbitrator has viewed RX 3. The Arbitrator agrees with the description of the video contained in Dr. Atluri's January 13, 2017 report and the testimony concerning the video by Mr. Bonilla and Mr. Gudeman. The Arbitrator notes that the Petitioner is initially working without any apparent difficulty with his right hand or arm. He empties the pile of pallets and a new stack is delivered by forklift at about 5 minutes into the video. Petitioner begins exhibiting pain with moving the top pallet, but no pallets ever fall. Petitioner is never struck on the shoulder and never falls to the ground. The Arbitrator notes that at no time do either of the other workers in the video show any concern for Petitioner or any awareness of any accident. The Arbitrator also notes the entrance of Mr. Bonilla and Mr. Gudeman and finds their identification of the video as May 20, 2016 persuasive based upon watching Petitioner describe the alleged falling of the pallet.

Petitioner testified on rebuttal that he has never seen the video in RX 3 before today; the only time was when he was feeling discomfort in his arm. He then testified he did not see it with Felix Bonilla after the accident. He testified he is in the video. He testified he was wearing different cloths on May 20, 2016. He remembers he was wearing a red shirt and black pants on May 20, 2016. He is wearing a green shirt and brown pants in the video. He testified that the video does not show the events of May 20, 2016. He testified the video is from March 23, 2016, right after Mr. Gudeman began working for Respondent. He remembers he was having discomfort in his hand on that day.

Petitioner was evaluated at Rush Copley Hospital on May 20, 2016 (PX 1). Petitioner testified that he complained of right wrist, shoulder and back pain. He testified that the failure of the medical record to note complaints other than to the right wrist is wrong. A Spanish interpreter was available on the phone. The Rush Copley Hospital record was placed into evidence as Petitioner's Exhibit 1. The record was prepared on May 20, 2016 at 11:30 A.M. Petitioner reported that a pallet had fallen from a stack at a height of two to three feet and landed on his right wrist. The incident occurred at 10:00 a.m. Petitioner denied any previous injury or trauma to the right wrist. He reported a pain level of 10/10. X-rays of the right hand and right wrist revealed no acute fracture or dislocation. Petitioner was diagnosed with a right hand contusion and a right wrist contusion (PX 1). Petitioner testified that he worked the next day, but he did not work thereafter because of the pain in his wrist and shoulder. When he was informed that the next day was a Saturday, Petitioner testified he worked the next regularly scheduled workday.

Petitioner was seen at Community First Medical Center on May 24, 2016 (PX 2, p 24-42). Petitioner testified that he complained of pain in his wrist, shoulder and back and was examined for all these body parts. The records note that he complained of right arm pain following an injury at work on Friday. Petitioner reported that that it was thought he had an occult fracture but x-ray of the right wrist/forearm revealed no overt fracture. The examination noted the right wrist was tender with minimal swelling and decreased range of motion. The diagnosis was a snuff box injury with possible scaphoid fracture. Petitioner was given a prescription for Hydrocodone and Ibuprofen.

Petitioner treated with Dr. Gabriel Levi of Orthopedic and Rehabilitation Centers on May 27, 2016. Petitioner testified that he had found Dr. Levi online. Dr. Levi's records were admitted as Petitioner's Exhibit 3. Petitioner's history was that he was injured on May 20, 2016 at work. He was going to pick up pallets and one of the pallets fell on him. He then fell onto his right upper extremity and injured the right wrist, right shoulder and low back. Petitioner complained of right forearm, right shoulder, and back pain, all of which he rated a pain level of 10/10. He did not report the April, 2016 right wrist injury. Dr. Levi records that x-rays of the wrist, shoulder and lumbar spine were negative for fracture. He diagnosed a right shoulder contusion, a lumbar strain, and a right wrist scaphoid fracture. Petitioner was given a cock-up splint for the right wrist, and a cortisone injection to the right shoulder. Petitioner was referred to physical therapy, and was taken off all work (PX 3, p 1-4). Petitioner was also given a prescription for a home CPM for the right shoulder and back (PX 8). Petitioner attended physical therapy at Universal Healthcare, P.C. beginning May 31, 2016 through August 11, 2016 (PX 4).

Petitioner followed up with Orthopedic and Rehabilitation Centers (PX 3). A June 4, 2016 MRI of the right wrist showed a very small cyst suspected to be ganglion in nature, and was otherwise unremarkable (PX 5, p 1-2). On June 14, 2016, Petitioner again reported a pain level of 10/10 as it related to the right shoulder, right wrist and back. Dr. Levi diagnosed a right shoulder contusion, a right wrist contusion, and a lumbar sprain. He ordered a TENS Unit for the back and shoulder and a back brace. Petitioner was to remain off work (PX 3, p 7-11). On July 12, 2016, Petitioner again reported a pain level of 10/10 in relation to the right wrist and pain with all motions of the right shoulder. Petitioner reported that the right shoulder injection had not provided much relief. He was to remain off work and was referred to Dr. Roberto Levi (PX 3, p 12-14).

Respondent admitted a surveillance report and video as Respondent's Exhibit 4 and 5. Mr. Wicks testified that he performed the surveillance. The Arbitrator viewed the video. Petitioner is seen performing routine activities from July 19, 2016 through July 21, 2016. Petitioner also does not appear to be in any discomfort. Petitioner does not appear to be favoring one arm over the other. Petitioner is seen wearing a black brace on his right

wrist. Petitioner is shown lifting a suitcase with his right hand/arm and carrying the suitcase 15 to 20 feet into a residence. Petitioner does not appear to be in any pain when lifting or carrying the suitcase (RX 4, RX 5). Petitioner testified that the suitcase was nearly empty and weighed less than 15 pounds.

On July 27, 2016, Petitioner was seen by Dr. Roberto Levi. He records a history that on May 20, 2016, a pallet weighing approximately 50 pounds fell upon Petitioner's right hand and upper extremity, throwing him to the floor, causing him to strike his back. Petitioner reported some pain in the right shoulder but good strength and right wrist pain. His back pain is gone. Dr. Roberto Levi recommended that Petitioner discontinue physical therapy and return in one month, at which time it was anticipated Petitioner would be able to return to work and regular activities (PX 3, p 16). Petitioner was released to work with a 20 pound lifting restriction (PX 3, p 18). During the visit on August 17, 2016, Physician's Assistant, Shari Newman, recommended that Petitioner reinstate physical therapy to strengthen his wrist and obtain an MRI of the right shoulder (PX 3, p 21). An August 27, 2016 MRI of the right shoulder showed mild rotator cuff tendinitis and/or bursitis, with no obvious tears (PX 5, p 3).

On September 14, 2016, Petitioner reported minimal pain in the right wrist. He has no back pain. He reported shoulder pain with across-the-chest maneuver and a little bit with abduction and external rotation. Petitioner reported performing light-duty work. Dr. Roberto Levi continued his 20 pound lifting restriction and recommended additional physical therapy (PX 3, p 25). Petitioner testified that he obtained employment at Creative Services, which involved cleaning pallets. The job is similar his job with Buckeye Diamond Logistics but the material was not as heavy. Petitioner returned on October 6, 2016, complaining of ongoing right shoulder and right wrist pain. Dr. Levi noted impingement. Petitioner recommended a right shoulder arthroscopy (PX 3, p 28).

Petitioner returned to Universal Healthcare, P.C. on November 1, 2016, but was not authorized for further therapy (PX 4). On November 23, 2016, Dr. Levi notes that therapy was denied. He requested authorization for arthroscopy of the right shoulder (PX 3, p 30). On January 13, 2017, Dr. Levi notes the right wrist is doing well with no pain and good range of motion. He continues to recommend the arthroscopy for the right shoulder. He continues Petitioner on restrictions and medications (PX 3, p 36). On February 24, 2017, Petitioner had full range of motion, no pain or swelling in the right wrist. Dr. Levi stated it seems to be recovered. Petitioner continues to report pain in the right shoulder. Dr. Levi is waiting for surgical approval (PX 3, p 40). On May 5, 2017 and July 17, 2017, Petitioner still advances complaints in the right shoulder. Dr. Levi continues to recommend arthroscopy for impingement (PX 3, p 44-49). A September 15, 2017 arthrogram of the right shoulder was read as showing impingement. MRI performed on September 15, 2017 showed subtle irregularity of the posterior lateral aspect of the humeral head, with no obvious labral tears, and an intact rotator cuff (PX 3, p 50-51). Petitioner remains under restrictions.

Dr. Prasant Atluri of Hand to Shoulder Associates prepared a record review report dated January 13, 2017 (RX 6). He notes that he reviewed listed medical records and the video labeled May 20, 2016. Dr. Atluri noted that in his review of the video he did not see any obvious injury or the accident as described by Petitioner. Dr. Atluri noted that although Petitioner did demonstrate some pain behavior involving the right upper extremity, he was seen using his right upper extremity to handle pallets both before and after the onset of that pain behavior without any clear traumatic injury. He noted that the history provided to the treating doctors is not consistent with the events depicted on the video. He also notes the treatment one month prior to May 20, 2016. Dr. Atluri concluded that although additional medical treatment may be appropriate, said treatment was not necessitated by a work injury from May 20, 2016 (RX 6).

Dr. Atluri performed a Section 12 medical evaluation on February 7, 2017 and prepared a report dated February 8, 2017 (RX 7). Petitioner reported that on May 20, 2016, a pallet fell from a stack of 14, striking his right shoulder and arm. Petitioner categorically denied any prior evaluation for the right upper extremity prior to May 20, 2016. Petitioner reported a lot of pain at the posterior aspect of the right shoulder, right elbow, forearm, and wrist. Dr. Atluri performed a physical examination, and found no objective findings which correlated with Petitioner's subjective complaints. Dr. Atluri noted no findings indicative of any mechanical pathology in his right upper extremity. Petitioner's responses on examination were inconsistent, and did not make physiological sense. Dr. Atluri noted clear symptom magnification. Dr. Atluri opined that the provided materials did not support the occurrence of any accident such as the one Petitioner described having occurred on May 20, 2016. Based upon the available information, Dr. Atluri found that no work injury had occurred involving Petitioner's right upper extremity. Even if an injury had occurred, there were no findings suggestive of any ongoing traumatic problem involving the right upper extremity. Dr. Atluri felt that Petitioner was capable of using his right upper extremity without restrictions (RX 7).

Petitioner testified he continues to have pain in the right shoulder. He has difficulty with reaching to the right side outward or straight up. Petitioner continues to work for Creative Services full time. He does similar duties to those he performed at Respondent, but the job is lighter. He can work at his own pace. He does not have to reach overhead. He testified he has difficulty lifting a chair. He continues to take medication. Petitioner testified that he wishes to proceed with the surgery recommended by Dr. Levi.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. Petitioner testified that he suffered a specific accident on May 20, 2016 while working for Respondent. Petitioner testified that at 9:00 A.M. on May 20, 2016, he was reaching up above his head to grab a pallet on top of a stack of fifteen pallets. While trying to pull the pallet down, it started falling on him. He fell and tried to support himself with his right arm on a table. He was unable to grab the table and he fell with the pallet on top of him. He testified that he landed on his back. He testified that the pallet landed on his right wrist and shoulder. He testified that he experienced immediate severe pain in his right shoulder, right wrist and lower back.

Petitioner's testimony is contradicted by the testimony of Respondent's witnesses, the Accident Report prepared as RX 1, the video submitted as RX 3, and the initial medical histories provided on May 20, 2016 and May 24, 2016.

Petitioner has testified to an incident with the pallet falling from heights, driving him to the ground. The Arbitrator initially notes that Petitioner works in relatively close proximity to other pallet repair workers, yet this dramatic incident did not result in any coworkers coming to his aid or even witnessing the event. The testimony of Mr. Bonilla and Mr. Gudeman is that Petitioner reported only that a pallet fell on his right wrist. His only injury claimed was a swollen wrist. The Arbitrator notes that Petitioner had a clear prior condition of ill being in the wrist documented by the April 15, 2016 medical records. The testimony of Respondent's witnesses is completely consistent with the medical records of Rush Copley Hospital on May 20, 2016 and Community First

Medical Center on May 24, 2016. These records document complaints, examination and treatment only for the right wrist. The enhanced version of the accident and expanded complaints into the shoulder and back only appear beginning May 27, 2016. The Arbitrator notes that this change in treating providers occurred after the filing of the Application for Adjustment of Claim in this matter. This initial office visit notes Petitioner's attorney information.

The Arbitrator has also viewed the video and finds the testimony of Mr. Bonilla and Mr. Gudeman identifying it as the May 20, 2016 surveillance persuasive. The fact that they can identify themselves coupled with the timing of its review is compelling. Petitioner's explanation is internally inconsistent. His alleged memory of his outfit is not persuasive and his supposition that the video is from late March, 2016 is totally incredible given that the unrebutted testimony is that the system is overwritten every 21 days. His claim of right arm pain in March is contradicted by every medical record and his own testimony. The video contradicts both Petitioner's testimony as to how the accident occurred and his initial report of the pallet falling and striking his right wrist. Neither event is shown on the video.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence. The Arbitrator viewed Petitioner's testimony and noted his repeated contradiction of his own statements as to the viewing of the accident report, the viewing of the video, and the details of the accident. Petitioner is contradicted on every item by the consistent and credible testimony of Respondent's witnesses and the surveillance video documenting his work activities before the reporting of the injury. Petitioner provided inconsistent and contradictory medical evidence. He disputes his own treating doctors as to his initial history, complaints and treatment. The records contain specific denial of any prior injury despite the documented April, 2016 wrist treatment and Petitioner's incredible rebuttal testimony that he had right arm problems in March. The Arbitrator also notes the July surveillance which, while it does not demonstrate any significant activity, shows Petitioner without any pain behavior, which is inconsistent with his 10/10 pain reporting to Dr. Levi during the same timeframe.

Based upon the numerous inconsistencies in Petitioner's testimony and medical records, the video evidence submitted and the credible testimony of Respondent's witnesses, the Arbitrator finds that Petitioner's entire testimony is not credible including that any accident occurred on May 20, 2016.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on May 20, 2016.

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

The undisputed evidence presented was that Petitioner reported the alleged accident on May 20, 2016 to Respondent on that date and an accident report was prepared. The accident report indicates that Petitioner alleged a pallet fell on his right wrist and that Petitioner had a swollen right wrist at that time. Although the Arbitrator has found that no accident occurred on that date, the Petitioner has proven that he did provide notice of the alleged accident within the time limits stated in the Act.

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. As more fully discussed above in the Arbitrator's finding with respect to Accident, the Arbitrator finds that Petitioner was not credible. The Arbitrator has found that no accident occurred on May 20, 2016. Additionally, the Arbitrator finds that Petitioner failed to prove any condition on ill being causally related to his employment with Respondent on May 20, 2016.

Petitioner initially reported complaints in the right wrist to Mr. Bonilla and had initial treatment for that condition at Rush Copley Hospital on May 20, 2016 and Community First Medical Center on May 24, 2016. Petitioner did not report the documented treatment to the same wrist on April 15, 2016, allegedly caused by the same mechanism of injury, a pallet falling and hitting his wrist. Thereafter, Petitioner expanded his complaints to include the low back and right shoulder. Dr. Levi records a history that on May 20, 2016, a pallet weighing approximately 50 pounds fell upon petitioner's right hand and upper extremity, throwing him to the floor, causing him to strike his back. As discussed more fully in the Arbitrator's finding with respect to accident, that history is not credible and the Arbitrator finds that the incident as describe did not happen.

Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. None of the treating doctors in this matter were provided and accurate and complete history in this matter. Only Dr. Atluri was provided with all medical records and the video of the May 20, 2016 events. He opined that Petitioner has no condition of ill being related to an accident on May 20, 2016. This opinion is persuasive to the Arbitrator.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained any condition of ill being causally related to his employment with Respondent on May 20, 2016.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Prospective Medical, and (L) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the further issues of Medical, Prospective Medical, and Temporary Compensation are moot.

Petitioner's claim for compensation is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stacy Kundinger,

Petitioner,

vs. NO: 14 WC 39038

Village of Northbrook,

18IWCC0767

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, and nature and extent, and being advised of the facts and law, modifies the applicable legal analysis as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's conclusions relating to the disputed issues of accident, causal connection, medical expenses, temporary total disability, and nature and extent. However, while the Arbitrator correctly concluded that Petitioner suffered an accident arising out of her employment, the Commission disagrees with the Arbitrator's legal analysis. After carefully reviewing the facts and relevant law, the Commission finds Petitioner was a traveling employee at the time of her work accident; thus, a general risk analysis is inappropriate.

Petitioner is a firefighter and paramedic. Her job duties include responding to emergency calls, transporting injured people to the hospital, running Advanced Life Support rigs, and responding to fires. On the date of accident, Petitioner's fire engine responded to a vehicle fire on an expressway. She injured her right foot as she stepped off the fire engine and onto uneven pavement on the expressway. Petitioner was rushing to respond to the fire and was carrying and wearing her required gear.

The Arbitrator analyzed the facts surrounding Petitioner's work accident using a neutral risk analysis. Although the Arbitrator arrived at the correct conclusion that Petitioner's injury is the result of an accident arising out of and in the course of her employment, the Commission notes that Petitioner is a traveling employee and a neutral risk analysis is inappropriate. A traveling employee is an employee whose duties require them to travel away from their employer's

18IWCC0767

premises. *Venture-Newberg-Perini v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728, ¶ 17. Illinois courts have found that injuries sustained by a traveling employee arising from the following 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 the employer; and 3) acts which the employee might be reasonably expected to perform incident to his assigned duties. *Id.* at ¶ 18. Generally, if the employee is engaged in conduct that is reasonable and foreseeable, any resulting injury arises out of and occurs in the course of employment.

Petitioner's position as a firefighter and EMT requires her to leave her assigned station and respond to emergencies. Petitioner injured her foot during one such call. The injury occurred while she was wearing her full firefighting uniform, carrying the necessary equipment including her helmet and air pack, stepping down from the higher than average rung on the engine ladder, and rushing to contain an active car fire. After analyzing the pertinent facts, it is unquestionable that Petitioner's injury occurred while she performed acts that she would reasonably be expected to perform as part of her job duties as a firefighter. Thus, Petitioner sustained a compensable injury to her right foot on the date of accident.

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 April 25, 2016, is modified as stated herein.

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

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

DATED: DEC 13 2018

o: 10/23/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KUNDINGER, STACY
Employee/Petitioner

Case# **14WC039038**

VILLAGE OF NORTHBROOK
Employer/Respondent

18IWCC0767

On 4/25/2016, 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 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4788 HETHERINGTON KARPEL BOBBER
ALAN KARPEL
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
EDWARD JORDAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

18IWCC0767

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

STACY KUNDINGER
Employee/Petitioner

v.

VILLAGE OF NORTHBROOK
Employer/Respondent

Case # 14 WC 39038

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 Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **February 17, 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 _____

18IWCC0767

FINDINGS

On **09/16/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$92,401.40**; the average weekly wage was **$1,776.95**.

On the date of accident, Petitioner was **42** 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 **$18,669.26** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,184.63**/week for **14-4/7**th weeks, commencing **10/24/2014** through **10/29/2014** and **10/31/2014** through **02/03/2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$34,436.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$18,669.26** for medical benefits that have been paid by its group carrier and Respondent shall hold Petitioner harmless from any claims by its group carrier and by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall be given a credit of **$1,019.43** for medical benefits that have been paid by its workers' compensation insurance carrier and Respondent shall hold Petitioner harmless from any claims by its group carrier and by any providers of the services for which Respondent is receiving this credit.

Respondent shall pay Petitioner permanent partial disability benefits of **$735.37/week** for **50.1 weeks**, because the injuries sustained caused the **30%** loss of the right foot as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

4-21-2016
Date

APR 25 2016

FINDINGS OF FACT

Stacy Kundinger ("Petitioner") testified she is a 42-year-old firefighter and EMS technician and has been so employed in that capacity for the Village of Northbrook ("Respondent") since 2001.

On September 16, 2014 Petitioner worked for Respondent and was dispatched to a car fire on the expressway. She put on her "bunker" gear (fire pants and jacket) and rode the fire engine to the location of the car fire. The car was on the inside shoulder of the expressway. The fire engine was positioned at an angle between the shoulder of the expressway and the adjacent traffic lane to protect the firefighters from vehicular traffic. Petitioner grabbed her air pack and helmet and began to disembark from the fire engine. She testified that she was moving fast because she was responding to an emergency. She placed her left foot on a metal bar that was about 15 inches above the ground and grabbed a handrail for balance as she descended from the fire engine. When she planted her right foot on the ground, she heard "a pop or a crack" and experienced immediate pain on the top of her right foot. She believes the ground was uneven, explaining that her right foot was between the road pavement and the shoulder of the expressway and the pavement was about an inch or two higher than the shoulder. She said she felt a pop or crack.

Petitioner admitted to prior injuries and problems to the right foot. She first injured it on September 20, 2004 when she was descending from a fire engine with heavy equipment and her right foot gave out. She reported hearing it crack. She was diagnosed with a stress fracture and spent two months in a boot. She returned to normal work and recreational activities afterward, but noticed that she had a little bone or knot on the top of her foot. If she stepped wrong or "tweaked it" she would experience pain that could last a couple days. Petitioner completed an Incident Investigation Report for this. Rx9. A Supervisor's Report of Accident was also completed. Rx10. On cross, she said the crack she heard in 2004 was very different than the sound she heard when she injured her foot on September 16, 2014.

Respondent also admitted into evidence an Incident Report noting that on August 2, 2007, Petitioner twisted her right ankle while exercising. No injury to the foot is documented.

The next incident occurred on February 14, 2010. Petitioner slipped on an icy curb while responding to a fire alarm. She reported feeling a painful "snap" on the top of her right foot. She received a cortisone injection which resolved her symptoms. She did not lose time from work. She was able to resume her normal activities. Petitioner completed an Employee's Statement of Incident and an Illinois Form 45. Rx8, Rx11.

On September 6, 2012, Petitioner saw Dr. Webber of Aurora Health Care for the right foot. Px2:23. She reported pain over the area the prior stress fracture. On exam, she has tenderness over the TMT joint and pain with motion at the TMT joint. The area was injected with Depo- Medrol, Marcaine and Lidocaine. Petitioner was referred to foot and ankle specialist, Dr. Malicky. The doctor noted Petitioner's work and that she was on her feet most of the day. Exam showed mass at the dorsum of the right mid-foot at the base of the first and second metatarsal cuneiform joints. Radiographs showed ossicle at the dorsum of the mid-foot at the level of the first metatarsal medial cuneiform joint in the junction just between the first and second metatarsals. Dr. Malicky diagnosed an exostosis right dorsal mid-foot at the junction of the first and second metatarsal at the level of the first metatarsal medial cuneiform joint. He recommended right dorsal exostectomy. Px2:31. He advised her that the condition would be a long term problem unless she had the exostosis surgically removed. She declined because her symptoms had resolved with the cortisone injection.

Petitioner testified that she did not have a recurrence of symptoms until her accident on September 16, 2014. During this two year period she performed the strenuous duties required by her job as a firefighter/paramedic

including responding to emergencies, carrying heavy equipment, getting in and out of the fire engine, transporting patients, and fighting fires. She also maintained her physical conditioning program at work which involved running, biking and using the Stair Master as well as weight training. Outside of work she engaged in recreational activities including playing in a basketball league with ex-college players, playing in a flag football league, running and playing sports with her son. Shortly before her accident, Petitioner registered to run in a marathon in Los Angeles which was going to take place in the Spring of 2015.

Petitioner testified that she reported the September 16, 2014 accident by filling out a "Page One" after she returned to the fire house on the day of the accident. An employee statement of incident report was also completed for the date of injury. Rx5. It was noted that petitioner injured her right foot stepping on uneven pavement while responding to a car fire. She reported pain on the right foot on the top of the foot. When asked what she was doing at the time of the injury, the response written noted that she was grabbing gear and heading to the car fire, she stepped and planted foot, twisting wrong. Petitioner admitted to a prior injury to the same foot in the same location.

On September 16, 2014, Petitioner called Dr. Malicky's office noting that she felt she may have re-injured her foot. Px2:37. She explained she stepped wrong on a graveled area and requested and appointment. She was told that the earliest available appointment was not until October 16, 2014. She explained that she could not wait that long and would attempt to see a work doctor. On September 17, 2014, Petitioner again contacted Dr. Malicky's office stating that she was having trouble with her job because of her foot pain and that she felt she had re-aggravated her foot. She felt it was the same issue as when she last saw the doctor. She was interested in surgery. She was waitlisted.

On October 2, 2014, Petitioner saw Dr. Malicky. Px2:41. She said she injured her foot when she planted her foot on uneven ground. *Id.* The doctor noted that she had complaints of a "new onset of pain" in the foot related to a work injury. He wrote she was walking around on uneven ground while fighting a car fire when she "twisted her right foot and experienced exquisite pain and hypersensitivity to the dorsum of the right mid-foot." *Id.* at 43. Exam revealed a palpable exostosis of the dorsum of the right mid-foot reproducing chief complaint of pain along with positive Tinel's with percussion along the deep peroneal nerve in the right mid-foot. Petitioner also had pain with manipulation of the first and second metatarsal cuneiform joint of the right foot. Radiographs of the right foot showed osteophyte/exostosis dorsum of the right metatarsal joints at the junction of the first and second metatarsal, which the doctor felt correlated directly to the radiodense marker placed on the skin. Assessment was right dorsal mid-foot exostosis with impingement of the deep peroneal nerve contributing to the anterior tarsal tunnel syndrome and left ankle instability and peroneal tendon subluxation with dorsal talar neck exostosis. The plan was for excising of the right dorsal mid-foot exostosis with exploration of the deep peroneal nerve and anterior tarsal tunnel release. Regarding the left foot the plan was for open repair of the peroneal tendon subluxation, open at cystectomy to law and back and stress of the left ankle and suspected repair of the ankle ligaments.

Petitioner went to OMEGA on October 2, 2014. Px3. She described the accident and her persistent pain. The doctor at OMEGA noted that she was going to see her own physician. The mechanism noted was that Petitioner stepped out of the fire truck onto uneven pavement and that her right foot slightly everted. She developed pain in the anterior mid-foot which had persisted. Assessment was right foot strain versus stress fracture versus ligamentous injury.

Dr. Malicky performed surgery on Petitioner's right foot on November 4, 2014. Px2:8-10. Pre and post operative diagnosis was right anterior tarsal tunnel syndrome with dorsal mid foot exostosis. A right dorsal mid foot exostectomy and right anterior tarsal tunnel release was performed. Intraoperatively, he found an obvious

area of incarceration of the deep peroneal nerve along the anterior tarsal canal which correlated directly with Petitioner's pain. He surgically released the nerve at the area of impingement. A well circumscribed, firm, mobile, exostosis was found to be directly compressing along the deep peroneal nerve.

On November 25, 2014 Petitioner returned to see Dr. Malicky. She was having difficulty with weight bearing. The plan was for physical therapy, hydrotherapy, wean from crutches and off work. She was instructed to avoid lowering her foot for more than 20 to 30 minutes at a time.

On January 6, 2015, Dr. Malicky noted Petitioner was still experiencing pain, swelling and she felt unsteady with vigorous activity. Dr. Malicky recommended therapy and a transition to full duty work. Petitioner was excused from her marathon.

On January 21, 2015, petitioner was evaluated by Dr. Vora of Illinois Bone and Joint Institute. Rx3. The doctor summarized medical records from Dr. Malicky dating back to October 2014, Omega Health records, an operative report and follow-up care. He noted that Petitioner related that she was responding to a call and that her foot was planted on a crack, she rolled her right foot and felt a pop with pain and discomfort in the right foot. The doctor noted that in the initial radiographs there was evidence of an unchanged injury to the dorsum of the mid-foot from the x-ray report he had received from Aurora Medical Center. He did not review the actual images but stated that the report clearly stated that there was evidence of an old injury of the dorsum of the mid-foot. The doctor felt that although the surgical procedure was reasonable it would have no work-related basis. Explaining that the diagnosis of the right foot as it relates to September 16, 2014 injury was difficult to say since the claimant had already undergone surgery but it would be most likely a foot sprain. The doctor noted that in comparing radiographs from 2012 to 2014, there was no interval change and thus there was clearly a pre-existing condition with regard to the dorsal exostosis of the mid-foot. Regarding the diagnosis of anterior tarsal tunnel release, Dr. Vora felt that this was not an anatomic area of the tarsal tunnel. He noted that deep peroneal neuritis could occur along that region as it relates to the dorsal osteophyte and would have no relationship to a work-related condition. Dr. Vora opined that it would be considered pre-existing, related to the anatomic body deformity exostosis, which was present and pre-existing. The doctor felt that surgery was appropriate although he found no relationship between the surgery and the mechanism of injury. The doctor stated that there would be no restrictions as it related to light-duty or full duty related to work-related injury as there was no indication for surgery was work-related.

On February 26, 2015, Petitioner followed up with Dr. Malicky. Px2:3. She told him that her attorney was requesting an explanation of his opinion that her right foot condition was "directly related" to the accident. In his progress note he laid out the history leading up to the surgery and stated he felt the acute injury likely displaced or fractured the exostosis, which was pre-existing. He thought the acute event caused dislodging of the dorsal exostosis (from the twisting injury mis-stepping on the uneven ground) which also caused compression on the adjacent deep peroneal nerve (along the anterior tarsal canal).

On May 18, 2015, petitioner returned to Dr. Vora for an AMA impairment rating. Rx4. Petitioner reported that she was still having pain in her foot, worse when getting up from a seated position and worse with strenuous activity. She said she could not run normally. Regarding the AMA impairment rating, the doctor diagnosed a right foot contusion and said that it would have been anticipated to resolve without sequelae and that there would have been no radiographic abnormalities associated with this as directly related to the contusion. Thus, he concluded a likely 0% lower extremity impairment rating. He found her foot was normal, functional, without objective pathology and with subjective neuritis complaints. He noted she was able to run but with some symptoms afterwards. The doctor also used the diagnosis of superficial peroneal nerve as a potential applicable diagnostic criteria key factor. Using the net formula key adjustment factor, the doctor concluded it would result

in severity great of a resulting in a 1% lower extremity impairment rating. That translated to 1% whole body impairment rating.

Dr. Malicky testified on November 11, 2015 in an evidence deposition. He is a board certified orthopedic surgeon who limits his practice to treatment of the foot and ankle. Dr. Malicky acknowledged he diagnosed a right dorsal mid-foot exostosis. He offered surgical treatment but Petitioner declined because she had responded to a cortisone injection previously administered by Dr. Weber. He next saw Petitioner on October 2, 2014. She provided a history of the accident including her sensation of a "pop" followed by exquisite pain and hypersensitivity to the dorsum of her right foot. He examined her foot and noted differences from his exam in 2012. Unlike her exam in 2012, she now had exquisite pain and hypersensitivity and could not tolerate any pressure on the dorsum of her right foot. She also now had a positive Tinel's which suggested that her deep peroneal nerve was bothering her. In 2012 her Tinel's was negative. He diagnosed a right dorsal mid-foot exostosis with impingement of the deep peroneal nerve contributing to anterior tarsal tunnel syndrome. He recommended surgery to excise the exostosis and explore the deep peroneal nerve in the anterior tarsal tunnel. Dr. Malicky concluded that Petitioner's problem was directly related to her accident. He explained that Petitioner had not sought treatment for her right foot for two years before the accident. She felt a "pop" at the time of the accident which he opined represented a change in the bone on the top of her foot, whether the nerve was then compressed against the bone, or if the bone, through the twisting of her foot, moved into the nerve, but some change occurred at the top of her foot from the work injury. He opined that the accident was a competent cause of the change in the exostosis based on her walking on uneven ground and twisting her right foot. Dr. Malicky disagreed with Dr. Vora's statement that the deep peroneal nerve is not in the anterior tarsal tunnel. He thought that Dr. Vora was describing the posterior tarsal canal which is located on the inner aspect of the ankle. The anterior tarsal tunnel, according to Dr. Malicky, is located on the top of the foot where he had operated.

Dr. Vora's evidence deposition was taken on November 23, 2015. Rx2. Dr. Vora is also a board certified orthopedic surgeon who limits his practice to treatment of the foot and ankle. Dr. Vora testified that there is no work related injury but agreed the surgery performed by Dr. Malicky was reasonable. He testified consistent with his two reports on direct examination. Regarding his statement that the deep peroneal nerve is not in the anterior tarsal tunnel he responded that the tarsal tunnel is on the medial aspect of the ankle but also agreed that anterior tarsal tunnel syndrome most commonly presents in part with pain upon palpation of the deep peroneal nerve in the entrapped area and a vague burning sensation in the distribution of the deep peroneal nerve. Dr. Vora also agreed that trauma can aggravate or exacerbate an underlying condition. He also agreed that trauma can change the course of the condition, and necessitate treatment that was previously unnecessary.

Petitioner testified that she has a four inch long and half centimeter wide scar on the top of her right foot at the site of the surgical incision. It is bright pink and purple, raised and sensitive. She also still has a black stitch in the area of the incision. The scar and the surrounding area are numb. She experiences the numbness daily, particularly when she touches it. The top of her right foot is tender to touch. She has pain in the area where the exostosis was removed if she moves her foot in certain directions, such as when she plants her foot and pushes off. The pain is activity dependent, but she notices it on a daily basis. She gave examples such as when she carries something on a call or when she picks up her six year old son. She no longer plays basketball or football because it hurts when she plants her right foot, and she does not want to risk a re-injury. She cannot run like she did before the accident. Before the accident she had registered to run in a marathon. Now she can no longer train. Although she is working full duty for Respondent, she has to be "very careful and extra cautious" to avoid re-injury. She is conscious of her foot while working. She mentioned climbing the "tower ladder" as an example. She is careful of how she places her right foot on the ladder rungs. At trial, Petitioner submitted various bills she claimed were unpaid. Px5, Px6.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only person to testify at the hearing. The Arbitrator finds her testimony to be candid, forthright and otherwise credible.

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. The Arbitrator finds that Petitioner suffered an accidental injury arising out of and in the course of her employment with Respondent on September 16, 2014. Here, there is no doubt Petitioner's injuries were sustained in the course of her employment. The dispute between the parties is essentially over whether Petitioner's injuries arose out of her employment.

Arising out of the employment refers to the origin or cause of the claimant's injury. For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. 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. *Litchfield Healthcare Ctr. v. Indus. Comm'n*, 349 Ill. App. 3d 486, 812 N.E.2d 401 (5th Dist. 2004). There are three categories of risk to which an employee may be exposed; namely: (1) risks distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics.

In this case, Petitioner testified she was stepping down from the fire engine steps/stairs and did so onto uneven ground, causing her to twist her foot. This history is repeated in her medical records. The risk of such an event is not distinctly associated with her employment, nor is it personal to her. The risk of stepping on uneven ground is a neutral one. As such, the Arbitrator considers whether the risk of stepping down onto uneven ground is one to which Petitioner was exposed to a greater extent than that to which the general public was exposed.

Evidence established that Petitioner's duties included responding to emergency calls, riding in a firetruck, using various equipment and loading and unloading equipment while responding to emergencies. Petitioner described the fire truck ladder as higher off of the ground than a normal steps or stairs. She said the last step or stair is twice the height of a normal step or stair. Petitioner testified that when she stepped with the right foot she stepped onto uneven ground. She explained the level between the shoulder of the highway and the actual highway was not even. Petitioner's statement that the ground was uneven is reiterated in her medical record. She also testified that because of the uneven ground, she twisted her foot. This too is corroborated by her medical record. While the act of stepping onto the ground is an everyday activity to which it may be said the general public is exposed, the Arbitrator notes Petitioner described a higher than normal distance between the fire engine's last step and ground level, described an uneven surface between the curb and the highway, stated her job duties required her to respond to emergencies away from her normal fire station or location, to carry her bunker gear and to step off fire engines with that gear. She was engaged in these activities when she stepped off the fire engine stairs/steps and onto the uneven ground. The Arbitrator finds Petitioner's activity of stepping off the abnormal height of the stair and onto the uneven ground exposed her to a risk greater than that to which the

general public is exposed. *Blackburn v. Waste Mgmt. of Ill.*, 11 IWCC 1123 (claimant was exposed to the defective street and the risk of stepping thereon more frequently than the general public).

The evidence also supports a conclusion that Petitioner's act of stepping down a ladder and onto uneven ground were acts she might reasonably be expected to perform incident to her assigned duties as a firefighter responding to an emergency call. Here, the evidence showed that Petitioner would have been reasonably be expected to disembark the fire engine down the stairs and onto the uneven pavement in order to carry out her duties of attending to the emergency described. Such actions would thus be incidental to those duties. *Kram v. SOI/Vienna Correctional Ctr.*, 15 IWCC 0286 (Apr. 23, 2015) (stepping down to take corrective action was incidental); *Young v. IWCC*, 2014 IL App (4th) 130392WC (act of reaching was distinctly associated with his employment duties). Based on the foregoing, the Arbitrator concludes Petitioner's accident 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 findings of fact and conclusions of law as though fully set forth herein.

At trial, Respondent disputed that Petitioner's right foot condition was causally related to her work injury. Ax1. In support thereof, evidence was introduced showing that Petitioner had injured her right ankle on prior occasions and was previously diagnosed with exostosis for which a prior surgical recommendation was made. Therefore, Respondent argues, the condition is not causally related. Respondent's doctor, Dr. Vora opined both in his medical opinion report at during his deposition that the exostosis was pre-existing and bore no relationship to the work accident. He compared x-ray reports and felt they demonstrated no interval change. The doctor also believed that the anterior tarsal tunnel, for which Dr. Malicky performed a nerve decompression, was not an anatomical location but that deep peroneal neuritis could develop along that area.

Petitioner, on the other hand, acknowledges that the exostosis was preexisting but contends that the accident aggravated the condition and accelerated the need for treatment. In support thereof, Petitioner testified that although her doctor had recommended surgical removal of the exostosis approximately two years prior to the work accident, she testified she felt relief with a pre-accident cortisone injection and was able to function for two years before the accident. Petitioner relies on the opinions of Dr. Malicky in support of her position. Dr. Malicky opined that Petitioner's accident which resulted in a pop, aggravated her condition but also caused the anterior tarsal tunnel syndrome, which was not present before the work accident.

The Arbitrator finds the medical opinions of Dr. Malicky more persuasive and credible than those of Dr. Vora. Regarding the exostosis, Dr. Malicky explained that Petitioner was able to function for nearly two years before the accident without the need for treatment or surgical intervention. Dr. Malicky noted that following the work accident, Petitioner developed a popping sensation in the foot which to him indicated that the exostosis had become aggravated, possibly loosened, resulting in increased pain. He also felt the aggravation of the exostosis contributed to the acute tarsal tunnel syndrome. The doctor's diagnosis was confirmed intraoperatively when he noted the exostosis was mobile and compressing on the peroneal nerve. Dr. Vora, on the other hand, did not actually review any radiographs and instead only looked at reports in concluding that he appreciated no interval change. He also did not consider the operative report for interval change. If he had, he would have noticed the exostosis compressing the peroneal nerve. Finally, he also dismissed Petitioner's lack of treatment for two years before the accident and onset of symptoms following the work accident. He nonetheless concluded the surgery was reasonable and necessary.

Regarding the anterior tarsal tunnel syndrome, Dr. Malicky's records show an absence of the syndrome before the work accident and an onset of symptoms consistent with anterior tarsal tunnel syndrome. For example, Dr. Malicky documented positive Tinel's sign and found the impingement of the nerve to be contributing to the syndrome. His clinical findings were ultimately correlated intra-operatively. Dr. Malicky noted that the syndrome was absent before the accident and he felt the popping sensation felt by Petitioner at the time of the accident were indications to him that Petitioner's exostosis was aggravated and that the syndrome was caused by the accident. Dr. Vora, on the other hand, stated that the anterior tarsal tunnel syndrome was not an anatomical location. In this regard, Dr. Vora does not offer any persuasive explanation for the tarsal tunnel release. Further, Dr. Vora's opinion is lacking in that he did saw Petitioner one time and did not actively manage or treat Petitioner's right foot. Based on the foregoing the Arbitrator finds that Petitioner's traumatic tarsal tunnel syndrome is causally related to her work accident and that the work accident further aggravated Petitioner's pre-existing exostosis.

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. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes Petitioner's treatment was reasonable and necessary. The Arbitrator relies on the opinions of Drs. Malicky who stated Petitioner's right foot treatment was necessary to treat her. The Arbitrator notes Dr. Vora took no real dispute with the reasonableness of Petitioner's treatment or her surgery.

At trial petitioner submitted the following unpaid medical bills: Aurora Medical Group $1,088.00 (Px6) and Aurora (Advanced) Healthcare in the amount of $33,348.29, which included various accounts and dates of service (Px5). Respondent shall pay reasonable and necessary medical services of **$34,436.29**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of **$18,669.26** for medical benefits that have been paid by its group carrier, Blue Cross Blue Shield, and Respondent shall hold Petitioner harmless from any claims by its group carrier and by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Ax1, Rx12. Respondent shall be given a credit of **$1,019.43** for medical benefits that have been paid by its workers' compensation insurance carrier and Respondent shall hold Petitioner harmless from any claims by its group carrier and by any providers of the services for which Respondent is receiving this credit. Rx11.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes Petitioner is entitled to temporary total disability benefits. Evidence shows and Petitioner alleged she was temporarily totally disabled from October 24, 2014 through October 29, 2014 and from October 31, 2014 through February 3, 2015, a period of 14-4/7th weeks. Ax1. Respondent denied liability. Having found in favor of Petitioner, Respondent shall pay Petitioner temporary total disability benefits of **$1,184.63**/week for **14-4/7th** weeks, commencing **10/24/2014** through **10/29/2014** and **10/31/2014** through **02/03/2015**, as provided in Section 8(b) of the Act.

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

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein. Petitioner last treated for her right foot on February 26, 2015. She said she has not returned since then for treatment. Therefore, Petitioner's claim for disability, if any, is ripe for adjudication.

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (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.

Regarding (i) or the reported level of impairment, Respondent introduced Dr. Vora's impairment rating for the right foot. He found a 0% impairment rating for the lower extremity based on a diagnosis of right foot contusion. The doctor reasoned that it would have been anticipated to resolve without sequelae and that there would have been no radiographic abnormalities associated with this as directly related to the contusion. The Guides provide that in performing an AMA rating, the first step is defining a reliable diagnosis. Here, Dr. Vora failed to explain how obtained a diagnosis of foot contusion, having previously acknowledged in his Section 12 report that he found it difficult to determine diagnosis since Petitioner had already had surgery. The Arbitrator does not find Dr. Vora's diagnosis reliable in the context of the impairment rating. Dr. Vora arrived at a 0% rating based on his anticipation that such a condition would resolve without sequelae and that there would be no radiographic abnormalities. The doctor found Petitioner's foot was normal, functional and without objective pathology. She had subjective neuritis along the surgery site. The doctor also used a diagnosis of metatarsal fracture dislocation but again failed to explain how he arrived at this diagnosis instead of or along with foot contusion. The doctor also used a diagnosis of peripheral nerve impairment but acknowledged the diagnosis as a possibility only. Based on the foregoing, the Arbitrator assigns little weight to the AMA rating.

Regarding (ii), Petitioner's occupation was and continues to be a firefighter/paramedic. She is working full duty, without restriction and at the same rate of pay or more. She testified this job requires her to go up and down ladders, respond to emergencies, carry gear and lift patients. Petitioner said she is more cautious with her foot. On cross, she said she passed her fitness for duty after her treatment and was cleared to return to work. The Arbitrator finds these facts capable of increasing the level of permanent partial disability and therefore assigns more weight to this factor.

Regarding (iii), Petitioner's age at the time of the injury was 42 years. The Arbitrator finds that this factor may increase Petitioner's level of permanent partial disability because she may live with the effects of her right foot injury longer due to a longer work life expectancy. The Arbitrator assigns more weight to this factor.

Regarding (iv) or future earning capacity, the evidence shows Petitioner works full-time, without restriction in her same position at or more than the same rate of pay prior to her work accident. There is no evidence her future earning capacity has been or will be impaired. The Arbitrator assigns no weight to this factor.

Regarding (v) or evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Petitioner. Petitioner's uncontroverted testimony was detailed and credible regarding her disability relative to her right foot. Records confirm she underwent removal of the pre-existing exostosis, which

was aggravated as a result of her accident and underwent tarsal tunnel decompression. She explained tolerance but difficulty in work. She explained difficulty weight bearing and cautious use of her foot. She detailed lifestyle changes in playing football, playing basketball and running. The Arbitrator also notes that some of these complaints were present before the injury, although perhaps to a lesser degree. Petitioner says she experiences pain and numbness daily and takes over the counter medicine. The Arbitrator finds these complaints consistent with her treatment records.

Considering all of the factors pursuant to Section 8.1(b) in conjunction with Section 8(e), the Arbitrator concludes that the work accident caused injury to Petitioner's right foot resulting in permanent partial disability of **30%** loss of use of the right foot. Respondent shall pay Petitioner permanent partial disability benefits of **$735.37/week** for **50.1 weeks**, because the injuries sustained caused the **30%** loss of the right foot as provided in Section 8(e) of the Act.

Signature of Arbitrator Maria Bocanegra

4-21-2016
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 PEORIA)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Wilsdorf,

Petitioner,

vs. NO: 17 WC 16347

18IWCC0768

State of Illinois Police,

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, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 35-year old police officer, testified that her job entails "[r]id[ing] around on the motorcycle doing mostly traffic enforcement. So it's a lot of speed on the interstate, or if I am riding along and I see a violation I'll stop it." (T.10). She stated that she "… work[s] out of District 8 so it's Stark, Marshall, Tazewell, Woodford and Peoria counties." (T.11).

Petitioner testified that on 5/27/17 she "… had just filled my motorcycle up with gas, and I was leaving the gas station going west on Camp Street in East Peoria, as I approached I believe it's Altorfer Lane, as I approached the lane I was in the left lane and there was a line of cars in the right lane, when I got to about the back of one of the vehicles it swerved right into my lane and we sideswiped and I went flying off the bike." (T.11). She agreed that she was traveling about 20 to 30 miles per hour at that the time and that she went up in the air. (T.12). She noted that she "… landed on the pavement I believe on my right side, I don't actually remember hitting, I remember when I was in the air looking up thinking this is going to hurt, and then I remember like being on the ground on my back looking for my bike." (T.12). She indicated that "[a] couple people came running up to me. I reached out for my radio off the bike that I could

reach and called in and told them I had a wreck." (T.12).

Petitioner agreed that following the accident she was transported to OSF St. Francis. (T.13). She noted that before she got to the hospital she noticed that "[e]verything started hurting, so I started having some back pain. There was a – my [left] leg started hurting and just kind of everything started aching." (T.13). She agreed that at the hospital diagnostic studies were performed such as x-rays of her chest, left forearm, pelvis and low back. (T.13-14). She noted that she was released from OSF St. Francis after a "[c]ouple hours at most." (T.14).

In an emergency department provider note dated 5/27/17, Dr. Shawn C. Joseph of the Saint Francis Medical Center recorded that Petitioner was "... a state trooper and was traveling at 20-30 [mph] when another vehicle pulled out in front of her and she ended up hitting the driver side of the vehicle. Patient was wearing a helmet at that time as well as her bullet proof vest and protective riding gear. Patient reports being tossed over her bike and over the hood of the other vehicle. Patient believes she landed on her right side but rolled several feet. Patient denies loss [of] consciousness and was able to ambulate on scene. Patient notes pain to her left lower back as well as the entirety of her left upper leg and some pain to her right lower back where her button had been in place. Patient denies head pain, neck pain, chest pain, shortness of breath, abdominal pain. Patient denies other medical problems or daily medications." (PX3). X-rays of the lumbar spine, chest, left femur and pelvis revealed no acute abnormalities. (PX3). The diagnosis was 1) motorcycle accident, initial encounter, 2) left leg pain, and 3) acute bilateral low back pain without sciatica. (PX3). It was noted that the patient refused additional pain medicine and crutches, and was advised to follow up with her primary care physician on 5/30/17 to be cleared to return to work. (PX3).

Petitioner testified that from the day of the accident, 5/27/17, until she saw Dr. Hoffman on 6/2/17, she "... started having extreme pain running through my chest, my back was hurting so bad it hurt to move around at all. I had some pain on the right side of my body, I had pain on the left side of my body. It was pretty much anything from the neck down would ache at different points or hurt." (T.14).

Petitioner agreed that she came under the care of Dr. Hoffman in Dunlap on 6/2/17, and that she told Dr. Hoffman how she felt at that time. (T.15). When asked whether she was experiencing any problems in addition to the low back and left knee complaints recorded by Dr. Hoffman on that date, Petitioner responded: "[t]here were some other areas that were sore and then they seemed to get progressively worse over time." (T.15).

In a procedure note dated 6/2/17, Dr. Daniel R. Hoffman recorded that Petitioner is an Illinois State Trooper who was injured on 5/27/17 while on motorcycle patrol. (PX5). Dr. Hoffman noted that "... she was in EP at the corner of Camp and Altorfer when another vehicle cut her off causing her to hit them and flip off the bike onto the road. She was seen and evaluated at OSF, x-rays were taken. Since the accident patient complains of pain primarily in the lumbar sacral spine and the left knee." (PX5). Dr. Hoffman's assessment was "LS Strain[,] Knee Strain[,] Soft Tissue Injury." (PX5). Dr. Hoffman referred Petitioner to therapy, prescribed an MRI of the LS spine and ordered Ms. Wilsdorf off work until a recheck in one week. (PX5).

In a procedure note dated 6/6/17, Dr. Hoffman recorded that Petitioner was "... experiencing increasing pain in the chest wall primarily on right side." (PX5). Dr. Hoffman's assessment, in addition to the lumbosacral and knee strains and soft tissue injury was "[p]ossible [f]ractured [r]ibs." (PX5). In a separate slip dated 6/9/17, Dr. Hoffman indicated that Petitioner was completely off work until her recheck appointment on 6/30/17. (PX5). Dr. Hoffman reiterated the same diagnoses, with the addition of chest wall strain, and off work status in office notes dated 6/9/16, 6/30/17 and 7/21/17. (PX5).

Petitioner agreed that Dr. Hoffman ordered an MRI of her low back but noted that "... work comp wouldn't approve it..." (T.16). She also agreed that she saw Dr. Hoffman about three or four times and that she was kept off work during that timeframe. (T.16-17). She agreed that Dr. Hoffman eventually referred him to an orthopedic surgeon, and that at the time of this referral she was having chest pain, left knee pain and low back pain. (T.17). Petitioner noted that Dr. Hoffman's diagnoses included a suspected rib fracture, chest wall strain, left knee strain and low back strain. (T.17-18).

Petitioner agreed with the records if they show that she came under the care of Dr. Patrick O'Leary at Midwest Orthopedic on or about 7/6/17. (T.18). She agreed that she gave Dr. O'Leary a history of how she felt, and that he examined her and recommended physical therapy at that time. (T.18-19). She agreed that she underwent physical therapy from 7/6/17 to 8/15/17, and that she last saw Dr. O'Leary on 8/15/17 at which time she was released from his care. (T.19).

In an office note dated 8/15/17, Dr. O'Leary recorded that Petitioner was "[d]oing great. Her symptoms are largely resolved. She has had significant improvement in her back and leg pain and mostly all of her back pain. Her therapy has helped a lot. She wants to go back to work." (PX4). Following his examination, Dr. O'Leary concluded that "[a]t this point in time, [Petitioner] is doing very well. Her symptoms of the thoracolumbar strain have resolved after a motorcycle crash while in the line of work. I gave her some paperwork today to the effect that she has no restrictions and she can return to work without any type of restriction. Any issues or problems arise, she should contact me again." (PX4).

Petitioner agreed that she returned to work for Respondent on or about 8/15/17 upon Dr. O'Leary's recommendation. (T.20).

Petitioner testified that after Dr. O'Leary released her "I started having like the left top of my left foot started going numb, and then it would stretch up to the knee and they believed it was a foot issue, but it was like a constant once it started it never really got the feeling all the way back in my left foot, and it just tingles constantly." (T.20).

In a report dated 9/27/17, Dr. Fahed N. El Chami, DPM at Midwest Orthopaedic Center recorded that Petitioner was being seen "... for initial assessment for left foot and lower leg numbness. She stated that back in May she was involved in a motorcycle accident. She had a bad back sprain. She was seen and treated by Dr. O'Leary. She is doing much better with her back pain. However, after she was released to work about a month ago, she started experiencing numbness and tingling at the plantar aspect of the left foot. Sometimes the numbness goes up all

the way to the knee. She stated also sometimes when she stands up, she gets some numbness at the hips bilaterally. Cynthia stated that when she is walking she feels that there is sand in her boots. Nothing makes it worse and nothing makes it better. The numbness is always present [no matter] what kind of activities she is doing. Denied any other pedal complaint at this time." (PX4). Following his examination and review of the x-rays, Dr. El Chami noted that "I told Cynthia that I believed her symptoms are coming from upper, lower extremity and not initiated at the foot and possibly related to her back or hip injury. Cynthia will be referred to a neurologist... In the meantime, she was advised to keep the left foot protected and to inspect it daily. She was educated on neuropathic foot care and was also educated on proper supportive shoe gear as well... She will follow up with me on a p.r.n. basis." (PX4).

Petitioner testified that she continued to work until she saw a leg specialist on 9/27/17. (T.21). She agreed that the diagnosis was a peripheral neuropathy nerve issue, and that she was referred to a neurologist for her complaints, whom she eventually saw in November of 2017. (T.21). She also agreed that she underwent a test where they stuck her with needles on 11/1/17. (T.22).

In a progress note dated 11/1/17, Dr. Lisa E. Snyder of Illinois Neurological Institute – Physiatry recorded that Petitioner "... was injured in May of this year. She works as a State Trooper and she rides a motorcycle. She was involved in a collision while on her motorcycle and she was thrown over a car off her bike. She had extensive bruising along the left distal femur and left knee... [S]he indicates that about earlier mid August she started to notice some burning and tingling along the lateral side of the left foot extending up to the lateral leg to about the knee. No new trauma reported. She has not noticed any weakness. She is back to work with no restrictions. She runs regularly and she rides a motorcycle regularly at work. She does not notice any weakness or any other symptoms anywhere else. No burning or discomfort in the other extremities noted. Sometimes after prolonged sitting she will have some discomfort in her low back and some radiation diffusely into her legs, but it goes away [after] just a moment... No problems with the left foot or leg, or any back issues prior to this event are reported. She states that she runs regularly for exercise." (PX2). Dr. Snyder's assessment was "[n]europathy of left superficial peroneal nerve." (PX2). Dr. Snyder noted that she "... explained to Ms. Wilsdorf that an EMG/nerve conduction test could be done to clearly establish a diagnosis, but it is fairly obvious from a clinical examination what the concern is. Fortunately, she does not have any motor involvement. She is not interested in any medications for the burning that she experiences. It does not interfere with her function. She is able to work without restrictions. She is back doing her regular exercise program. It can take a while for nerves to heal after an injury, sometimes a year and even longer. At this point, she elected to defer on any further testing or treatment. I did tell her to contact me immediately if she should notice any worsening of her symptoms. But other than that, I would just continue to observe at this point." (PX2).

When asked whether she has elected to receive any further care or treatment for her leg since 11/1/17, Petitioner responded: "'[t]he doctor informed me that is [*sic*] it was a thing that would either come back the next day or a couple of weeks or a year or could never come back, there was nothing that she would suggest surgery for." (T.22). Petitioner agreed that this was for her left knee and the nerve injury to her leg. (T.22).

Petitioner agreed that she was never asked by the State to submit to a doctor for a disability evaluation. (T.23). She noted that currently she is a sergeant with the Illinois State Police and that she rides a motorcycle, performing the same duties she previously testified to. (T.23). She indicated that since her return to work her earnings "... were the same until I was promoted." (T.23).

Currently, Petitioner notices that "[w]hen I get up in the morning [her low back is] usually stiff. If I sit around for a long time it gets really stiff, so I try to stay moving most of the time because it will work it out." (T.24). She indicated that she does not notice anything about her hip or pelvis area, and noted that she has "[n]o problems with her chest or rib area. (T.24). With respect to her left leg, she noted that "[i]t's still numb, it tingles and sometimes in the winter it will burn, but it's still not there. It's not like I can – It's that weird feeling where it's just a constant tingling kind of like half numb." (T.25). She indicated that the numbness "... seems to start about on the left side of my foot, so it's a constant through here (indicating), and it's usually numb about halfway up my leg, and it usually stops about there (indicating)." (T.25). She stated that on the date of her testimony she did not notice anything about her left or right knees. (T.25).

On cross examination, Petitioner agreed with the records if they show she last saw Dr. O'Leary on 8/15/17 at which time he noted that her thoracolumbar spasm and strain had resolved. (T.26). She likewise agreed that she is currently back to full duty work with no restrictions. (T.26-27). She indicated that she is not currently seeing a doctor for either her back or foot condition, and that she is not undergoing any physical therapy. (T.27). As far as medications, she noted that "I usually take Ibuprofen, Aleve, aspirin on a daily basis." (T.27). She indicted that she took this medication prior to the accident, but "[n]ot as much." (T.27). She stated that "... when I get up in the morning when my back is really stiff then I usually take three or four aspirin or Aleve and it works itself out." (T.27-28). She indicated that this medication is not prescribed by her doctor. (T.28).

Petitioner denied having any prior injuries to her foot. (T.28). She also indicated that she does not have to wear any type of brace or protective device, and that she is able to perform her job satisfactorily. (T.28). She noted that her job performance has been satisfactory and that she has not received any complaints from her supervisors over job performance since her return. (T.29).

Petitioner testified that she had a previous workers' compensation injury involving her hand a couple years ago, "... but it was determined that it was nothing, so I don't believe a case was opened, but they did do a packet on it." (T.29).

The Commission notes that since the date of accident (5/27/17) occurred subsequent to the effective date of the amendment (9/1/11), an analysis pursuant to §8.1b of the Act will be necessary.

With respect to factor (i), the reported level of impairment, the Commission notes that no impairment rating was submitted into evidence. Thus, the Commission finds that this factor is entitled to no weight.

With respect to factor (ii), the occupation of the injured employee, the Commission notes that Petitioner was employed as a motorcycle patrol officer at the time of the accident and returned to full-duty work without restrictions on or about 8/15/17. The evidence also shows that she has since been promoted to sergeant, and that she continues to work in this capacity as of the date of arbitration. Given that Petitioner was able to return to her prior job following the incident, the Commission accords this factor lesser weight.

With respect to factor (iii), the age of the employee at the time of the injury, the Commission notes that Petitioner was 35 years old at the time of the incident. In light of Petitioner's relatively young age, and the longer period she would be expected to deal with the permanent nature of her disability, given her extended work/life expectancy, the Commission accords this factor greater weight.

With respect to factor (iv), the employee's future earning capacity, the Commission notes, once again, that Petitioner returned to her prior occupation following the accident, with no restrictions and was subsequently promoted to sergeant. As a result, the Commission finds that there is no evidence that the injury has negatively impacted Petitioner's future earning capacity, and accords this factor lesser weight.

Finally, with respect to factor (v), evidence of disability corroborated by the treating medical records, the Commission notes that as a result of the accident Petitioner suffered "pretty severe spinal strain", per Dr. O'Leary, and lumbosacral and left knee strains, as well as possible fractured ribs, per Dr. Hoffman. Petitioner was treated conservatively and eventually returned to full duty work without restrictions on or about 8/15/17 based on a release by Dr. O'Leary. Petitioner returned to her prior job as a motorcycle patrol officer at that time and subsequently developed numbness and tingling in her left leg and foot. She thereupon sought treatment with Dr. El Chami on 9/27/17 and was referred to neurologist Dr. Snyder, whom she saw one time on 11/1/17. Dr. Snyder diagnosed Petitioner with neuropathy of the left superficial peroneal nerve. Dr. Snyder noted that Petitioner declined any medications or treatment for the burning that she experiences, and was able to work without restrictions, noting that "[i]t can take a while for nerves to heal after an injury, sometimes a year and even longer." (PX2). There is no evidence that Petitioner has sought any treatment for either her spinal or left lower extremity injuries since.

Presently, Petitioner continues to complain of low back stiffness in the morning, for which she takes over-the-counter medication such as aspirin or Aleve, and that it eventually "works itself out." (T.24,28). She also indicated that she has no current problems with her chest or rib area. (T.24). With respect to her left leg, she noted that "[i]t's still numb, it tingles and sometimes in the winter it will burn, but it's still not there. It's not like I can – It's that weird feeling where it's just a constant tingling kind of like half numb." (T.25). She indicated that the numbness "... seems to start about on the left side of my foot, so it's a constant through here (indicating), and it's usually numb about halfway up my leg, and it usually stops about there (indicating)." (T.25). She stated that on the date of her testimony she did not notice anything about her left or right knees. (T.25). She indicated that she is not currently seeing a doctor for either her back or foot condition, and that she is not undergoing any physical therapy. (T.27).

18IWCC0768

Based on the above, and the record taken as a whole, the Commission modifies the award of the Arbitrator to find that Petitioner suffered the permanent partial loss of use of 10% of the left leg pursuant to §8(e)12 while affirming the Arbitrator's award of 10% person-as-a-whole pursuant to §8(d)2 of the Act.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 71.5 weeks, as provided in §§8(d)2 and 8(e)12 of the Act, for the reason that the injuries sustained caused the loss of use of 10% person-as-a-whole and 10% of the left leg, respectively.

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; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

DATED: DEC 13 2018
o:12/4/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSDORF, CYNTHIA
Employee/Petitioner

Case# **17WC016347**

STATE OF ILLINOIS POLICE
Employer/Respondent

18IWCC0768

On 5/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.99% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5354 STEPHEN P KELLY
ATTORNEY AT LAW LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

6140 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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

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

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

MAY 3 - 2018

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

18IWCC0768

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

Cynthia Wilsdorf
Employee/Petitioner

v.

State of Illinois Police
Employer/Respondent

Case # **17** WC **16347**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **March 21, 2018**. By stipulation, the parties agree:

On the date of accident, **5/27/17**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**81,120.00**, and the average weekly wage was $**1,560.00**.

At the time of injury, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**18,274.41** for extended benefits, for a total credit of $**18,274.41**.

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 $775.18/week for a further period of **82.25** weeks, as provided in Section **8(d)2 & 8(e)** of the Act, because the injuries sustained caused **10% loss of use of the person as a whole and 15% loss of the left leg**.

Respondent shall pay Petitioner compensation that has accrued from **5/27/17** through **3/21/18**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

5/2/18
Date

18IWCC0768

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working as a police officer for the Respondent on May 27, 2017. The only issue in dispute is the nature and extent of the Petitioner's injuries.

On May 27, 2017 the Petitioner sustained a work accident while in the employ of the Respondent as an Illinois State Patrolperson. On that date, the Petitioner testified that she was riding her State issued motorcycle when she was struck by a civilian with another vehicle. The Accident Report establishes that the civilian's vehicle pulled out in front of the Petitioner causing the collision. (Resp. Ex. 1) The Petitioner was traveling approximately 25-30 mph at the time of the crash. The Petitioner testified that she was thrown up into the air, and fell hard to the ground.

The Petitioner testified that she felt pain all over immediately following the accident. She was transported to OSF Hospital in Peoria, Illinois where multiple x-rays were taken to the low back, chest, pelvis and left leg. The diagnosis at the hospital on that date was 1) motorcycle accident, 2) left leg pain, and 3) acute bilateral low back pain. (Pet. Ex. 3) The Petitioner testified that after her release from the hospital, her pain got worse and therefore she sought medical care from Dr. Hoffman.

On June 2, 2017 the Petitioner first saw Dr, Hoffman. (Pet. Ex. 5) Dr. Hoffman diagnosed Petitioner with: 1) Low Back Strain, 2) Knee Strain, 3) Soft Tissue Injury; and ordered an MRI. Petitioner testified that she could not get the MRI authorized by the Respondent, so she did not have that study performed. On June 6, 2017, the Petitioner returned to Dr. Hoffman, and her pain was increasing. Dr. Hoffman provided an additional diagnosis of Possible Rib Fracture, added to the primary diagnosis in the case. (Pet. Ex. 5) The Petitioner testified that she continued to treat with Dr. Hoffman in June of 2017. On June 30, 2017, Dr. Hoffman referred the Petitioner to Midwest Orthopedic Center for her low back condition.

On July 6, 2017 the Petitioner saw Dr. Patrick O'Leary, a spine specialists at Midwest Orthopedic Center. Petitioner testified that Dr. O'Leary informed her that she had a slipped disc in her back. The Petitioner's complaints during this examination were mid back, low back, and neck pain. Dr. O'Leary opined that the X-rays confirmed a disc space collapse at L5-S1. (Pet. Ex. 9) In addition to the collapsed disc at L5-S1 Dr. O'Leary opined that the Petitioner was suffering from severe spinal strains. (Pet. Ex. 4) Dr. O'Leary opined that the Petitioner's condition was related to the described work accident. (Pet ex. 9) Dr. O'Leary ordered physical therapy, which Petitioner attended from July 6, 2017 to August 15, 2017. The Petitioner last saw Dr. O'Leary on August 15, 2017, at which time he released the Petitioner from his care to return to work full duty.

The parties stipulated that the Petitioner was off work from May 27, 2017 through August 15, 2017. The Petitioner testified that she returned to work full duty on August 16, 2017. The Petitioner testified that when she returned to work for the Respondent, she started to notice increase pain in her left lower leg associated with numbness in her left foot, which increased with her activities. The Petitioner testified that the pain got to a level that required her to go back to a leg specialist at Midwest Orthopedics.

On September 27, 2017 the Petitioner saw Dr. Chami, who diagnosed Petitioner with left leg peripheral neuropathy. (Pet. Ex. 4) Dr. Chami ordered an EMG/NCV.

On November 1, 2017 the Petitioner saw Dr. Lisa Snyder, who diagnosed Petitioner with neuropathy of left superficial peroneal nerve. (Pet. Ex. 2) This was the last medical treatment received by the Petitioner in this case.

18IWCC0768

The Petitioner testified that she still has low back pain in the mornings, and it takes a while for that pain to go away. The Petitioner further testified that she still has pain in her left lower leg with occasional numbness in her left foot.

CONCLUSIONS OF LAW

With regard to the issue of nature and extent, the Arbitrator notes that pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator makes the following findings listed below.

(i) Impairment. No permanent partial disability impairment report and/or opinion was submitted into evidence and therefore the Arbitrator gives no weight to this factor.

(ii) Occupation. Petitioner was employed as motorcycle patrol officer at the time of the accident, and was medically able to return to work in her prior capacity as a result of said injury. The medical evidence indicates Petitioner could return to work full duty and without any restrictions. Petitioner testified that she has been promoted in her job since her return to work. The Arbitrator gives considerable weight to this factor.

(iii) Age. Petitioner was 35 years old at the time of the incident. The Arbitrator gives some weight to this factor.

(iv) Future Earning Capacity. There was evidence that Petitioner's future earning capacity has not been impacted by this accident and therefore the Arbitrator therefore gives some weight to this factor.

(v) Evidence of Disability. There was evidence of disability corroborated by the medical records, which show that Petitioner suffered: a disc space collapse at L5-S1, severe spinal strains, a suspected rib fracture, and peripheral neuropathy in the left leg/peroneal nerve - requiring Petitioner to undergo diagnostic testing and conservative care. The medical evidence shows that Petitioner had a good recovery from her injuries with complaints of occasional pain and numbness in her back and left leg. Based on the evidence introduced at trial, the Arbitrator gives significant weight to this factor.

Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 10% loss of the person as a whole and 15% loss of use of the left leg, as provided in Sections 8(d)2 and 8(c) of the Act.

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

OWEN MARSHALL,

Petitioner,

vs. NO: 14 WC 29395

18IWCC0769

WALQUIST FARM PARTNERSHIP,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Union County, having been previously dismissed for lack of jurisdiction from the Illinois Appellate Court.

Procedurally, this matter proceeded to arbitration pursuant to Section 19(b) of the Act on August 7, 2015, before Arbitrator Nancy Lindsay. The Arbitrator issued her Decision on October 2, 2015, finding that Petitioner met his burden of proof and established that he sustained an accident on March 5, 2014 that arose out of and in the course of his employment by Respondent. However, the Arbitrator found that Petitioner's lumbar spine condition was not causally related to the March 5, 2014 accident. The Arbitrator therefore denied Petitioner's claim for medical expenses, prospective treatment, and temporary total disability (TTD) benefits.

The parties filed cross-Petitions for Review with the Commission. The Commission affirmed and adopted the Decision of the Arbitrator on July 13, 2016.

Petitioner appealed to the Circuit Court of Union County. The Circuit Court found that the Commission's Decision relative to accident was not against the manifest weight of the evidence.

However, the Circuit Court found that the Commission's Decision on causal connection, medical expenses (both past and future), and TTD benefits was against the manifest weight of the evidence and reversed the Commission's Decision on those issues. The matter was then remanded to the Commission for further findings of fact on the issues of medical expenses, prospective medical, and TTD.

Respondent attempted to appeal this claim to the Illinois Appellate Court on May 19, 2017. However, the Appellate Court dismissed Respondent's appeal for lack of jurisdiction finding that the Circuit Court's Remand Order to the Commission was interlocutory and not yet appealable.

Based upon the order of the Circuit Court, the Commission has no choice but to find that Petitioner's lumbar spine condition was causally related to the March 5, 2014 accident. The Commission notes that by the Arbitrator's Decision and the record, Respondent neither disputed the reasonableness and necessity of Petitioner's treatment nor the period of temporary disability. Respondent simply disputed liability for the payment of benefits. (T.18-20; PX4). The Commission therefore awards TTD benefits from March 6, 2014 through the date of arbitration, August 7, 2015. The Commission further awards the medical expenses as provided in Petitioner's Exhibit 4, totaling $369,848.51, as well as prospective treatment by way of post-operative care for Petitioner's lumbar spine; Petitioner had undergone L5-S1 bilateral laminectomies with decompression and fusion on October 31, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $446.67 per week for 74-2/7 weeks, commencing March 6, 2014 through August 7, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibit 4, totaling $369,848.51, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective treatment by way of post-operative care for Petitioner's lumbar spine.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

18IWCC0769

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. 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: DEC 13 2018

MJB/pm
D: 12-11-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paula Williams,

Petitioner,

vs. NO: 16WC 16192

State of Illinois,

18IWCC0770

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 30, 2018 is hereby affirmed and adopted.

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

18IWCC0770

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

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

No bond or summons required for State of Illinois cases.

DEC 13 2018

DATED:
o120418
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

WILLIAMS, PAULA
Employee/Petitioner

Case# **16WC016192**

STATE OF ILLINOIS
Employer/Respondent

18IWCC0770

On 1/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% 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:

5154 FOOTE MIELKE CHAVEZ & O'NEILL
CRAIG S MIELKE
10 W STATE ST SUITE 200
GENEVA, IL 60134

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
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

JAN 30 2018

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

18IWCC0770

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Paula Williams
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **16** WC **16192**

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 **January 5, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, May 15, 2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $36,071.36; the average weekly wage was $693.68.

On the date of accident, Petitioner was 45 years of age, *single* with no dependent children.

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

Respondent shall be given a credit of $22,727.63 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $22,727.63.

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 $462.45/week for 85 & 6/7th weeks, commencing May 15, 2016 through January 5, 2018, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 15, 2016 through January 5, 2018, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $22,727.63 for TTD benefits that have been paid.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator finds that the recommended prospective medical treatment is necessary and reasonable to alleviate Petitioner of the effects of her injury at work. Thus, the Arbitrator awards the prospective medical care in the form of a C5-C6 and C6-C7 anterior cervical discectomy and fusion, an L4-L5 laminectomy, and post-operative cervical bone growth stimulator as prescribed by Dr. Rinella pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

February 6, 2018
Date

JAN 30 2018

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

Paula Williams
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **16** WC **16192**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute include causal connection, Petitioner entitlement to temporary total disability benefits commencing on May 15, 2016 through January 5, 2018, and Petitioner's entitlement to prospective medical care in the form of a C5-C6 and C6-C7 anterior cervical discectomy and fusion, an L4-L5 laminectomy, and post-operative cervical bone growth stimulator as prescribed by Dr. Rinella. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. *Id.*

Employment & Background

Paula Williams (Petitioner) testified that he was employed as a Certified Nursing Assistant (CNA) by State of Illinois at the LaSalle Veteran's Home (Respondent) since approximately September of 2002 through the date of accident. Prior to working for Respondent, Petitioner testified that she worked with clients with developmental disabilities, assisted clients with home health needs, vital signs, activities of daily living, bathing, etc. In her position as a CNA for Respondent, Petitioner testified that she lifted and moved patients, assisted patients with activities of daily living, cleaning, personal care, etc.

Petitioner testified that she had no prior injury to her back or neck before the accident at work. She also testified that she did not miss any work or receive any medical treatment related to the back or neck before May 15, 2016.

On May 15, 2016, Petitioner sustained an undisputed accident at work. AX1. She testified that she was with a co-worker attempting to turn a bed-bound patient weighing approximately 350 pounds. Petitioner testified that she was turning the patient toward her while her co-worker was cleaning the patient standing on the opposite side of her. Petitioner testified that she leaned over the bed grabbing the far-side of the patient toward her when she noticed pain in her back. Petitioner reported the incident to her co-worker and supervisor. She explained that she wanted to go to the emergency room, and her supervisor indicated that was a good idea. Petitioner testified that her supervisor then directed her to the emergency room.

Medical Treatment

The medical records reflect that Petitioner went to St. Margaret's Hospital emergency room at 2:30 a.m. on May 15, 2016. PX2 at 9-10. She gave a history explaining that in her work as a CNA at the veterans' facility she helped move a large patient and felt pain in thoracic back as well as tightening in her back. *Id.* On physical

[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.

examination, it was noted that Petitioner had muscle spasm in the lower thoracic region. *Id.* Petitioner was prescribed an anti-inflammatory and muscle relaxer and placed off work. *Id.*

On May 18, 2016, Petitioner presented at South Holland Community Health Center with a history of "back pain" and "upper back pain" that began at work while moving a patient causing a sharp onset of back pain. PX3 at 9-11. Petitioner was prescribed a muscle relaxer and prednisone for five days. *Id.*

On June 2, 2016, Petitioner presented to Blair Rhode, M.D. (Dr. Rhode) at Orland Park Orthopedics with a history of neck and back injuries on May 15, 2016 while moving and rolling a 350-pound patient at work after which she began feeling back pain. PX4 at 39-40. Petitioner also reported that she began experiencing more significant neck pain two-to-three days later with periodic tingling to both arms and pain radiates into legs with the bulk of pain in the neck radiating across shoulders down the spine into the low back. *Id.* Physical therapy was ordered two-to-three times per week for four weeks and Petitioner was kept off work. *Id.* Petitioner continued to undergo treatment with Dr. Rhode including a lumbar epidural steroid injection that she reported did not provide much relief. *Id.*, at 47-48.

Petitioner testified that she was referred to Dr. Rinella by Dr. Rhode. The medical records reflect that Petitioner first presented to Dr. Rhode on December 23, 2016. PX5 at 5-6. Petitioner gave a consistent mechanism of injury at work on May 15, 2016 and reported no improvement of her symptoms after a course of physical therapy and epidural steroid injections. *Id.* She also reported "neck pain extending into her trapezial areas bilaterally. Her pain extends into her left arm. She also noted lumbosacral pain extending into her left posterior thigh and calf. She denies similar symptoms prior to the injury." *Id.* Dr. Rinella diagnosed Petitioner with a cervical and lumbar strain as well as radiculopathy that was work related. *Id.* He ordered a cervical spine MRI and noted that Petitioner's lumbar MRI revealed a disc herniation and central spinal stenosis that could explain her symptoms. *Id.* Dr. Rinella kept Petitioner off work. *Id.*

On January 25, 2017, Dr. Rinella ordered an epidural steroid injection at the C5-C6 level. PX5 at 5. On March 1, 2017, Dr. Rinella diagnosed Petitioner with cervical disc herniations at C5-C6 and C6-C7 causing cervical radiculopathy, a cervical and lumbar strain, as well as cervical and lumbar radiculopathy. *Id.*, at 6. He recommended a second cervical epidural steroid injection and noted that Petitioner might benefits from a C5-C6 and C6-C7 anterior cervical discectomy and fusion as well as an L4-L5 laminectomy. *Id.* Dr. Rinella ordered continued physical therapy and kept Petitioner off work. *Id.*

As of March 29, 2017, Dr. Rinella maintained that Petitioner required a C5-C6 and C6-C7 anterior cervical discectomy and fusion as well as an L4-L5 laminectomy followed by a post-operative cervical bone growth stimulator. PX5 at 7-8.

Section 12 Examination & Addendum Reports – Dr. Singh

On March 20, 2017, Petitioner saw Kern Singh, M.D. (Dr. Singh) at Respondent's request. RX2. Dr. Singh's report reflects that he took a history from Petitioner, examined her, reviewed various treating medical records, and rendered opinions regarding her lumbar condition and its relatedness, if any, to her injury at work. *Id.* Dr. Singh diagnosed Petitioner with a soft tissue lumbar muscular strain, which has resolved, and degenerative disc disease at L4-5. *Id.* He opined that there was no causal connection between Petitioner's then-current condition of ill-being in the lumbar spine and accident at work, and that she could return to work full duty. *Id.* In so concluding, Dr. Singh also opined that Petitioner's medical treatment had been excessive beyond four weeks of physical therapy three times per week. *Id.*

On September 6, 2017, Dr. Singh authored an addendum report addressing Petitioner's cervical condition and its relatedness, if any, to her injury at work. RX3. He diagnosed Petitioner with degenerative disc disease at C5-C6 and C6-C7. *Id.* He opined that the condition was unrelated to Petitioner's injury at work. *Id.*

Continued Medical Treatment

Dr. Rinella continues to recommend a C5-C6 and C6-C7 anterior cervical discectomy and fusion as well as an L4-L5 laminectomy followed by a post-operative cervical bone growth stimulator. PX5 at 9-14.

Deposition Testimony – Dr. Rinella

On August 16, 2017, Petitioner called Dr. Rinella as a witness and he gave testimony at an evidence deposition regarding Petitioner's spine condition and its relatedness, if any, to Petitioner's injury at work. PX1. Dr. Rinella is a board-certified orthopedic surgeon. PX1 at 5; PX1 (Dep. Ex. 1).

Dr. Rinella testified that he first saw Petitioner on December 23, 2016 as referred by Dr. Rhode at Orland Park Orthopedics. PX1 at 6. He noted Petitioner's initial history as follows:

> On that date she was a 46-year-old certified nursing assistant who had tenderness in her neck and back after a work-related injury on May 15, 2016. She was performing her typical duties, including turning a patient, at the time when she felt immediate pain. She was seen in the emergency room and diagnosed with a strain. She hadn't been able to return to work. I then outlined a lot of her treatment. Her symptoms were neck pain extending into her trapezial areas bilaterally, which is toward the shoulders. Her pain extended into her left arm. She also had low-back pain extending into her left posterior thigh and calf. She denied similar symptoms before the injury.

Id., at 6-7. Dr. Rinella also performed a clinical exam on that date noting the following:

> Her height and weight was 5'2" tall. She weighed 240 pounds. In terms of her spine, she had tenderness in neck and low back. She had full range of motion of her neck in all planes. Her Spurling's signs, which is a provocatory impingement test, were equivocal, meaning it was unclear whether it was clearly positive or negative. She had diminished sensation in her right thumb, which is the C-6 distribution.

Id., at 7-8. Dr. Rinella reviewed Petitioner's August 10, 2016 lumbar MRI and concluded that it showed an L4-5 disc herniation as well as central spinal stenosis. *Id.*, at 8-9. He testified that Petitioner's clinical presentation correlated with the MRI because "[h]er symptoms classically followed an L-5 distribution." *Id.*, at 10.

On the issue of causation as to the lumbar spine, Dr. Rinella testified that it was his opinion within a reasonable degree of medical certainty that there was a causal relationship between the accident of May 15, 2016 and Petitioner's subsequent symptoms and his diagnosis of December 23, 2016. PX1 at 11-12. Specifically, he testified as follows:

> Yes. I obviously met her six months after the fact, but she told me she had no symptoms previously, she was working in a full-duty capacity. Twisting injuries of this type are very common for aggravating the back. It's, unfortunately, common for nursing assistants to have similar issues just because they're really there to help people who are unsteady on their feet. And often that can happen in the narrow quarters where it's more difficult to have optimal lifting mechanics."

Id., at 12.

Dr. Rinella was further questioned regarding Petitioner's cervical spine condition. PX1 at 13. He testified that he reviewed the cervical MRI of January 25, 2017 and found that it showed "central and left sided narrowing at C5-6 and central right-sided narrowing at C6-7." *Id.* Dr. Rinella explained how these findings correlated to Petitioner's symptoms indicating that:

> [Petitioner] had pain into both trapezial areas. Now, often when a nerve is pinched, it starts in the neck and it can go variably different distances down the arm, in part, due to what level is involved and, in part, just because the full nerve root isn't always included, as well as the peripheral nerves. So in this case, trapezial pain of this nature is very common as an initial demonstration of a cervical radiculopathy, much like buttock pain alone may be an early presentation of a lumbar radiculopathy. So she had the trapezial pain on both sides, and she also had symptoms going all the way down her arm. Now, interestingly, she had pain down her left arm but numbness in the right thumb, again, showing and, in part, an objective finding on the contralateral side, just showing that I think both levels are involved.

Id., at 14-15.

On the issue of causation as to the cervical spine, Dr. Rinella testified that it was his opinion within a reasonable degree of medical certainty that there was a causal relationship between the accident of May 15, 2016, and Petitioner's subsequent cervical symptoms and his diagnosis of December 23, 2016. PX1 at 14. He explained that "it definitely aggravated the nerve roots as she had no previous symptoms in her neck or arms." *Id.* Dr. Rinella explained that it is very common for a patient's reported symptoms to go from thoracic complaints to cervical complaints to lumbar complaints as the condition develops in the days and weeks following the injury. *Id.* at 15. He also explained that his opinions are supported by the Orland Park Orthopedics treatment records in the weeks following the accident. *Id.*, at 16. Specifically, he explained that his diagnosis of cervical and lumbar radiculopathies was related to the May of 2016 injury at work as it was consistent with the earlier findings of Dr. Rhode at Orland Park Orthopedics. *Id.*, at 17.

Dr. Rinella concluded that Petitioner was unable to return to work as a nurse's assistant because she would be a danger to herself and others at work. PX1 at 17-18. He also reiterated his recommendation for surgery consisting of an anterior cervical discectomy and fusion as well as an L4-5 laminectomy because Petitioner had failed conservative treatment including physical therapy and injections. *Id.*, at 19. Dr. Rinella indicated that both procedures could be done in a single surgery, followed by a post-operative electrical stimulator, which were reasonable and necessary medical treatment modalities to alleviate Petitioner from the effects of her injury at work. *Id.*, at 19-21.

Dr. Rinella also reviewed Dr. Singh's report. PX1 at 23. In his opinion, Dr. Singh's report ignored Petitioner's cervical spine condition, diagnosis of radiculopathy, and the objective, abnormal neurologic changes that corresponded with Petitioner's MRI over several visits compared to Dr. Singh's one-time examination of Petitioner. *Id.*, at 23-24. He further stated that over his multiple examinations of Petitioner, he noted no "malingering or exaggerate[on] in any way." *Id.*, at 25. Finally, Dr. Rinella believed that Petitioner "would do extremely well" with surgery and that, without it, her symptoms and disability were permanent. *Id.*, at 27.

On cross-examination, Dr. Rinella testified that he did not review Dr. Rhode's treatment records Petitioner's physical therapy records beyond some Silver Cross Hospital records reflecting Petitioner's injection. PX1 at 29. He also testified that he recommends surgery to a very small percentage of his patients, less than ten percent.

Id., at 34.

Additional Information

Regarding her current condition of ill-being, Petitioner testified that she turns and tosses a lot at night because she is in a lot of pain. She explained that she can perform activities of daily living, but at a slower pace. Petitioner also testified that her kids go shopping with her now. She testified that she has difficulty walking for long distances and sitting for extended periods of time. She is currently taking Ibuprofen 800mg as prescribed by Dr. Rhode for her neck and back pain. She explained that she takes this medication as needed approximately two-to-three times per day. Petitioner testified that she experiences constant neck and back pain. She also testified that she has not received any benefits after April and that she has not been released back to work by either Dr. Rinella or Dr. Rhode.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Considering the record as a whole, the Arbitrator finds that Petitioner's claimed current conditions of ill-being in the cervical and lumbar spine is causally related to the injury sustained at work on May 15, 2016. In so concluding, the Arbitrator relies upon the credible testimony of Petitioner, which is consistent overall with the medical records, and the opinions of Petitioner's treating physician, Dr. Rinella. Dr. Rinella opined that the mechanism of injury was competent to cause Petitioner's post-accident symptomatology based on his multiple examinations of Petitioner, review of objective diagnostic studies, and lack of prior medical treatment or symptoms in, or radiating from, the cervical spine or lumbar spine. Dr. Singh examined Petitioner on one occasion whereas Dr. Rinella based his opinions on a more complete understanding of Petitioner's medical condition. In consideration of the totality of the record, the Arbitrator finds the opinions of Dr. Rinella to be persuasive and accords them greater weight than those of Dr. Singh. Thus, the Arbitrator finds that Petitioner has established a causal connection between her current cervical and lumbar spine conditions of ill-being and accident at work.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work as claimed in reliance on Petitioner's credible testimony as well as the opinion of her treating physician, Dr. Rinella. Petitioner's condition has not improved after her accident at work and, as Dr. Rinella has opined, surgical intervention is required. Thus, the Arbitrator awards the recommended prospective medical care in the form of a C5-C6 and C6-C7 anterior cervical discectomy and fusion, an L4-L5 laminectomy, and post-operative cervical bone growth stimulator as prescribed by Dr. Rinella pursuant to Section 8(a) of the Act as this treatment is reasonable and necessary to alleviate Petitioner from the effects of her injury at work.

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

Considering the causal connection analysis explained above, the Arbitrator turns to Petitioner's claim that she is entitled to temporary total disability benefits from May 15, 2016 through January 5, 2018.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that she was unable to work*. *Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The record reflects that during the claimed temporary total disability periods Petitioner was either placed off work or under light duty work restrictions as imposed by Dr. Rhode and/or Dr. Rinella, which were not or could not be accommodated by Respondent. Thus, the Arbitrator finds that Petitioner has established that she was temporarily totally disabled during the claimed temporary total disability period from May 15, 2016 through January 5, 2018. Respondent shall receive a credit for $22,727.23 in temporary total disability benefit payments that have been made as agreed by the parties. *See* AX1.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julie Robichaud,
Petitioner,
vs.

NO: 14WC 33162
18IWCC0771

University of Illinois,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 13, 2018 is hereby affirmed and adopted.

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

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

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

DATED: DEC 14 2018

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Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

ROBICHAUD, JULIE
Employee/Petitioner

Case# **14WC033162**

UNIVERSITY OF ILLINOIS
Employer/Respondent

18IWCC0771

On 2/13/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1497 MORICI FIGLIOLI & ASSOCIATES
ROBERT H BUTZOW
150 N MICHIGAN AVE SUITE 100
CHICAGO, IL 60601

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

0075 POWER & CRONIN LTD
JOHN P FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

0902 UNIVERSITY OF ILLINOIS
CLAIMS MANAGEMENT
1737 W POLK-M/C 940 SUITE B9
CHICAGO, IL 60612

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

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

FEB 13 2018

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
AMENDED ARBITRATION DECISION

Julie Robichaud
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **14 WC 33162**

Consolidated cases:

18IWCC0771

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **November 15, 2017 and December 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

O. ☐ Other _____

FINDINGS

On **07/30/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the Petitioner earned $**92,985.88**; the average weekly wage was $**$1,788.19**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** children under 18.

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**.

ORDER

Respondent shall pay to the Petitioner out-of-pocket medical expenses in the amount of $1,689.95, as provided in Section 8(A) of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability of $735.37/week for 33.46 weeks, because the injuries sustained caused the 20% loss of the right foot, as provided in Section 8(e) of the Act.

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

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

KSSteffen

Signature of Arbitrator Ketki Shroff Steffen

February 12 2018

Date

FEB 13 2018

FACTUAL HISTORY

The Petitioner testified that she has been employed by the Respondent for the past eighteen (18) years. She had initially been hired as an academic professional, but as of May 10, 2014, the Petitioner testified that position changed to full civil service, and she began working as a physical therapist. The Petitioner testified that because of the change in her employment status with the Respondent, she was required to have a swipe badge to record her attendance and to accrue retirement benefits. The Petitioner was waiting for the okay from her employer to obtain her badge. The Petitioner testified that as of July 30, 2104, she had not yet obtained her swipe badge; and on that date, she was given an email from the payroll department through her office manager, Jim Ptaszek, directing her to personally pick up her new badge at the Respondent's Westside Research Office Building located at 1747 West Roosevelt Road, Chicago, IL (PX2).

Petitioner testified that she was not allowed to leave the workplace or "clock-out" without the express permission of her supervisor. On July 30, 2014, the Petitioner's 1:00 p.m. physical therapy appoint was a "no-show", and the Petitioner then asked her supervisor, Lynnea Barnes, for permission to walk over to the Westside Research Office Building to pick-up her badge (PX1). The Petitioner testified that she was not on her lunch break, and was still "on the clock", when she took her backpack, containing her work computer, and proceeded eastbound on a direct route along Wood Street to pick up her swipe badge at the Westside Research Office Building (PX3, RX2).

The Petitioner testified that she had never been to this location before. As she neared the intersection, she noticed many blind students on the sidewalk, and she maneuvered around them to the left, which was also in the direction of the traffic control device, where she could press the button to cross the street. She testified that there was a dip in the sidewalk, and her foot hit the dip in the sidewalk and she tripped and fell. She twisted her right ankle and fell on a dip/crack on the public sidewalk along Wood Street, at or near its intersection with Roosevelt Road (PX4, RX1, RX2, RX3).

Petitioner also testified on cross examination that she was not rushing to reach the building where her badge was located. She testified that she was wearing a backpack with her work computer in it. She explained that the computer with her for

security reasons. She agreed that she did not use the computer during her errand. She testified that her job does not generally require her to walk to different locations on campus, and that this was a one-time occurrence, to pick up her swipe badge.

Petitioner was cross-examined regarding the location where she fell. Photographs of the location were admitted into evidence. The photographs show a crack or a height discrepancy between two slabs of sidewalk in the area where Petitioner fell.

Petitioner does not dispute that the area where she fell is not located on University property. A witness for the University, Carly Rizor, testified the area where the Petitioner fell is adjacent to the Chicago Lighthouse for the Blind. This facility is not affiliated with the University/Respondent and they are not responsible for the maintenance of the sidewalk in that area. The Petitioner also admitted that she understood that the area in question was open to the general public.

After her fall, the Petitioner testified that she felt immediate pain in her ankle and could not walk. She was then transported via ambulance to the Emergency Room at University of Illinois Hospital by the Chicago Fire Department where she received initial medical treatment. At University of Illinois Hospital, the Petitioner continued to experience pain in her right ankle and x-rays were taken. A diagnosis was then made of a closed right ankle fracture of the distal fibula, and the Petitioner was provided an air cast and crutches (PX5).

In regard to her additional treatment, Petitioner testified that on August 1, 2017, she saw Dr. Alan League at the University of Illinois Hospital. He treated her for her right ankle. He diagnosed a right avulsion fracture and ankle sprain, secondary to a work-related injury while walking from one location to another location on campus. Dr. League prescribed a cam boot and placed her off work for a period of one week (PX5).

The Petitioner testified that she continued to see Dr. League for periodic check-ups to monitor the healing of fibula, but her condition was not improving (PX7). The Petitioner testified that Dr. League prescribed a week of bedrest, and after a bone stimulator failed to improve her condition of a non-union fracture, Dr. League performed a right ankle lateral malleolus open reduction and internal fixation with calcaneus autograft bone graft (PX6). The Petitioner testified that this surgery helped stabilize her

ankle and allowed it to be more functional. The Petitioner testified that she continues to have some residual pain, loss of range of motion and loss in sensation (numbness) in her right ankle, although her symptoms have greatly improved. She also testified that she takes the over the counter pain medication, Naprosyn, and that she has difficulty squatting and has to use a stool while performing some of her job duties as a physical therapist for the Respondent.

FINDINGS/ANALYSIS

In support of the Arbitrator's Decision relating to "C", whether an accident occurred that arose out of and in the course of the Petitioner's employment by the Respondent, the Arbitrator finds the following facts:

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. O'Dette v. Industrial Comm'n, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980). A claimant bears the burden of proving that his or her injury arose out of and in the course of the employment. *Baldwin v. Illinois Workers' Compensation Comm'n, 409 Ill. App. 3d 472, 477, 949 N.E.2d 1151, 351 Ill. Dec. 56 (2011); First Cash Financial Services, 367 Ill. App. at 105.* An injury occurs 'in the course of' employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment.

It is undisputed that Petitioner, Julie Robichaud, needed to obtain a valid work badge to continue her duties and that her employer specifically allowed/directed her to go obtain the badge during her work hours. It is obvious and evident that she was injured on route to performing an act as instructed by her employer and as might be expected of an employee. Therefore, the Arbitrator finds that Petitioner was injured in the course of her employment.

As to the "arises out of" prong, an injury that originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury, satisfies such a requirement. "For an injury to

'arise out' of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Co. v. Industrial Comm'n, 129, Ill. 2d 52, 58, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989).* "There are three categories of risks an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Institute of Technology v. Industrial Comm'n, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000).* The mere fact that the claimant's duties took her to the place of injury and that, but for her employment, she would not have been there, is not sufficient, of itself, to support a finding that her injuries arose out of her employment. *Illinois Bell Telephone Co. v. Industrial Comm'n, 131 Ill. 2d 478, 485-86, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989); Caterpillar Tractor Co., 129 Ill. 2d at 63.*

Therefore, in Illinois, a pure unexplained fall is not compensable, as it does not satisfy the "arising out of" requirement. *Builders Square, Inc.,* 339 Ill.App.3d at 1010. An injury resulting from a neutral risk, that is one to which the general public is equally exposed, does not arise out of the employment. *Caterpillar Tractor Co.,* 129 Ill.2d at 59, 133 Ill.Dec. 454, 541 N.E.2d 665. By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public. *Illinois Consolidated Telephone Co.,* 314 Ill.App.3d at 353, 247 Ill.Dec. 333, 732 N.E.2d 49 (Rakowski, J., concurring). In itself, the act of traversing a flight of stairs does not expose a claimant to a greater risk of harm than that faced by the general public. *Id.* at 478. Employment is not associated with injuries sustained as a consequence of risks to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the worksite, or performing some work-related activity contributes to the risk of falling. *See Illinois Consolidated Telephone Co.,* 314 Ill.App.3d at 352, 247 Ill.Dec. 333, 732 N.E.2d 49 (Rakowski, J., concurring); *Nabisco Brands, Inc. P. Industrial Comm'n,* 266 Ill.App.3d 1103, 1107, 204 Ill.Dec. 354, 641 N.E.2d 578 (1994).

Therefore, the narrow issue in this case is whether tripping on a crack/defect in a sidewalk that is open to the public while on a one-time employment related errand

meets the 'arising out of' requirement in Petitioner's case. The Arbitrator finds that the Petitioner's accident did arise out of her employment.

In reaching this conclusion the Arbitrator notes that the Petitioner was injured due to a defect in the sidewalk along Wood Street at or near its intersection with Roosevelt Road. Petitioner was on route from her work place to another of her employer's location so she could get her work badge. The sidewalk she was on is open to the public and was in a condition of disrepair. The photograph and testimony indicate that there are other cracks and defects in the area. Petitioner was carrying a backpack with her work laptop during this time. She was specifically asked to go to the building and return back within the time period of her canceled appointment. The path that she took was logical and reasonable to achieve her purpose. The Arbitrator finds that although the sidewalk in question can also be used by the general public, the Petitioner, by virtue of the direction of the Respondent to obtain her swipe badge, was exposed to a special hazard or risk when she tripped and fell on the crack/dip in the sidewalk. The Arbitrator notes that unlike members of the general public, the Petitioner was required to navigate through this area of the sidewalk as a result of her job duties with the Respondent, and she was exposed to this tripping hazard incidental to her employment, *see Brais v. Illinois Worker's Compensation Comm'n, 2014 Ill. App. (3d) 120820 WC (2014).*

Because of the hazard of the cracks in the sidewalk, the Arbitrator declines to find that this is a neutral risk. Although the public also faces this risk, Petitioner became exposed to this additional risk by virtue of the special directive from her employment. This was an additional risk because Petitioner's regular job as a therapist does not subject her to the hazards of road or traveling. The Arbitrator finds support for her position in the Appellate Court's finding in *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC where the court ruled that an employee who tripped on a bunched or kinked mat in an area open to the general public (but controlled by her employer) met the 'arising out of' requirement. *Springfield Urban League, id. t*he Court upheld the Commission's finding of a "dangerous condition" and ruled that the route the employee had to take was attendant with a special risk or hazard and the hazard becomes part of the employment. The Court declined to adopt the employer's interpretation based on *Tinley Park Hotel and Convention Center v.*

Industrial Comm'n, 356 Ill. App. 3d 833, 826 N.E.2d 1043 (2005) where that the employer is only liable if the claimant faces this risk with a higher frequency. Rather the Court ruled the Claimant established sufficient proof of a special risk or hazard through testimony describing the kinked or bunched condition of the mat.

Similarly, in this case the Petitioner has given credible testimony that there was a crack/defect in the sidewalk akin, that she was carrying her work laptop and was traveling on a path from her regular employment location to another location for work related activity. The fact that the sidewalk could be used by the general public is not detrimental to Petitioner's case.

This reasoning is echoed in *Dukich v. IWCC,* 2017 IL App (2d) 160351WC where, although the court denied compensation, the Court specifically noted that the Petitioner who slipped on a rainy wet surface was not exposed to any specific defect. Therefore, Illinois caselaw on this issue supports the proposition that it is not the public nature of the accident location or even the frequency of Petitioner's travels that is the sole determinative factor in a case. Rather, it is the additional street hazard risk that an employee faces when traveling for employment, that gives rise to an employer's liability.

In order to reach this conclusion, the Arbitrator does not necessary need to categorize a Petitioner as a traveling employee i.e. someone who is required to regularly travel to fulfill their employment duties. Rather, even a one-time travel that exposes an employee to a special hazard or a defect is sufficient for a finding that the injury arose out of and in the court of employment.

Lastly, the Arbitrator would like to note the following in support of her decision. The fact that Petitioner did not have to carry her work laptop with her but choose to do so is immaterial. Regardless, the fact that she was carrying it when she tripped is relevant. Secondly, slip and fall caselaw distinguished between injuries caused by 'natural accumulations of snow/ice or rain in parking lots as opposed to 'hazardous conditions' such as defective/cracked sidewalks or kinked mats. Lastly, in assessing the overall evidence, the employer's lack of control over the cracked sidewalk become irrelevant because of the nature of the employer-employee relationship. The employer is wholly in control. The employer requires the employee to have the badge, controls where and when the badge can be obtained, does not provide a ride or other means for

the employee to get the badge thereby forcing the employee to go out on the street to obtain the badge. The employee cannot refuse to follow any of these directives. Under these circumstances, for an employer to suggest that the employee could have obtained the badge on her own time and on her own dine, is noteworthy. Even if we require employees to perform such work-related functions during non-work hours, how can we assure that the governmental agency that was issuing the badge is open during non-work hours. Such an analysis is not meant to evoke a sympathetic argument in Petitioner's favor but rather show the reality of the average employee's work-life. Therefore, based on the totality of the caselaw and the factual scenario in this matter, the Arbitrator concludes the Petitioner suffered an accident arising out of and in the course of her employment.

In support of the Arbitrator's Decision relating to "F" whether to Petitioner's current condition of ill-being is causally related to the injury, and "J", were the medical services provided to Petitioner reasonable and necessary and whether Respondent paid all appropriate charges for all reasonable and necessary of medical services, the Arbitrator finds the following facts:

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the accident she sustained on July 30, 2014. The unrebutted testimony of the Petitioner establishes that because of her fall, she sustained a fracture to her right ankle. There is no contrary evidence or medical opinion presented to the Arbitrator.

Dr. Alan League, the Petitioner's treating orthopedic surgeon, diagnosed a right avulsion fracture and ankle sprain, secondary to a work-related injury while walking from one location to another location on campus. The Respondent offered no evidence in rebuttal of Dr. League's opinion.

The Petitioner testified that she received all her medical care through the Respondent's medical facilities at the University of Illinois Hospital. The Arbitrator finds that all this treatment was reasonable and necessary; and was rendered for attempting to provide relief from the right ankle fracture caused by her work injury. The Petitioner's treatment was submitted to Petitioner's Group insurance (Cigna) provided by the Respondent. The Respondent has offered no evidence that the treatment provided to the Petitioner was not reasonable, necessary or causally related to the July 30, 2014 work accident.

Accordingly, the Arbitrator finds that the Respondent has not paid all appropriate charges for the medical expenses incurred because of the right ankle injury sustained by the Petitioner, and that out-of-pocket paid by the Petitioner which has been submitted into evidence as Arbitrator's Exhibit #1, constitutes reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. Therefore, the Petitioner is entitled to reimbursement of those payments, which amount to $1,689.95.

In support of the Arbitrator's Decision relating to "L", nature and extent of the injury, the Arbitrator finds the following facts:

The Arbitrator finds that the Petitioner has sustained a loss of use of her right foot as a result of and arising out of the July 30, 2014 work accident. It is undisputed that the Petitioner sustained a distal fibula fracture which necessitated a right ankle lateral malleolus open reduction, internal fixation with calcaneus autograft bone graft which was performed by Dr. Alan League on June 10, 2016. The severity of this injury is clearly noted in the operative report by Dr. League where he observed a bony separation in the nonunion site; and to repair this injury he was required to harvest bone from the leg and used plates and screws to fuse the facture (PX6).

After recovering from this surgical procedure, the Petitioner could return to work in a full duty capacity. Up to the present date, she continues to experience various symptoms in her right ankle and foot. These symptoms include stiffness and numbness which increase due to cold or with activities such as running, walking on uneven ground, and squatting. To alleviate these continued symptoms the Petitioner stated she takes over the counter pain medication, Naprosyn.

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factor:
(i) the reported level of impairment;
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of injury;
(iv) the employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

With regard to subsection (i) of §8.1b (b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b (b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a physical therapy specialist at the time of the accident and that she was able to return to work in her prior capacity as a result of said injury, and because of this the Arbitrator therefore gives no weight to this factor.

With regard to (iii) of Section 8.1(b) of the Act: the age of the petitioner, at the time of his work injury was 50 years old. The Arbitrator considers the Petitioner to be a middle-aged individual. Thus, the Petitioner's permanent partial disability resulting from this work injury will have a greater impact upon her activities in the future than that of a younger individual, and the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner remains employed by the Respondent and no testimony was produced indicating that the Petitioner's future earning capacity was effected by the workplace injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regards to (v) of Section 8.1(b) of the Act; evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner has demonstrated evidence of her disability which is corroborated by the medical records. The medical records from the University of Illinois Hospital, the chart notes, and the surgical report from Dr. Alan League all document the nonunion of the right distal fibula fracture, which required the placement of surgical hardware. The Petitioner credibly testified that she has continued to experience on-going symptoms of numbness and pain with activities such as squatting and running. The Petitioner's complaints with

respect to her right foot and ankle stand unrebutted and [illegible] the medical records from her treating orthopedic specialist. [illegible] last office note of January 13, 2017, Dr. League recorded that the Petitioner [illegible] ned of numbness to the 3rd and fourth toes dorsally to the right foo[illegible] fied that her ankle is more stable following the surgery. However, certain activitie[illegible] as squatting down, are difficult for her. It is also difficult for her to run [illegible] en terrain to keep up with her nine-year-old child. She testified that she [illegible] ally takes osyn, but only to 2 or 3 times a month. She does not take any prescription cations.

Based upon the above factors, and the record taken [illegible] Arbitrator that the [illegible] sustained permanent partia[illegible]y [illegible] t foot to the [illegible] 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

Ernesto Nunez,
Petitioner,

vs.

NO: 15WC 14146

18IWCC0772

Nippon Express,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, notice, 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 6, 2018 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: DEC 14 2018
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NUNEZ, ERNESTO
Employee/Petitioner

Case# **15WC014146**

NIPPON EXPRESS
Employer/Respondent

18IWCC0772

On 3/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & EVANS
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

3227 HOLECEK & ASSOCIATES
THOMAS KIEFT
PO BOX 64093
ST PAUL, MN 55164

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

Ernesto Nunez
Employee/Petitioner

v.

Nippon Express
Employer/Respondent

Case # 15 WC 14146

Consolidated cases: N/A

18IWCC0772

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **January 23, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

18IWCC0772

FINDINGS

On **December 24, 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 **$28,466.88**; the average weekly wage was **$547.44**.

On the date of accident, Petitioner was **37** years of age, *married* 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 **$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 has paid **$17,257.10** under a group plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT AND FURTHER FAILED TO PROVE THAT HIS CONDITION OF ILL BEING IS CAUSALLY RELATED TO HIS EMPLOYMENT WITH RESPONDENT, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED.

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

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

Signature of Arbitrator

March 6, 2018
Date

MAR 6 - 2018

ICArbDec- p. 2

Statement of Facts

Petitioner Ernesto Nunez testified in Spanish through an interpreter. Petitioner began working for Respondent Nippon Express in 2012 or 2013. He began working as a machine operator in the receiving department. He would also do jobs in the picking department from time to time.

Petitioner testified that he began each day unloading cameras and printers in the receiving department. These products arrived in shipping containers. He testified that they were stacked as tall as he is, over 6 feet. He testified that he would unload cameras by hand, stack them onto wooden pallets 4 boxes high and 6 boxes per layer. He estimated the boxes weighed between 25 and 30 pounds, and that he would build 30 to 40 pallets a day.

He testified that once pallets were built, he would wrap them in plastic using a wrapper. Petitioner demonstrated how he would use the wrapper to wrap the pallets. He placed his left hand on top of the wrapper and his right hand below. He would wrap plastic several times around each pallet. Petitioner demonstrated that he held the wrapper at or above shoulder level while wrapping the pallet, with his arms extended.

After he wrapped the pallet, he testified he moved them to a different location using a long jack, a type of forklift. He testified that he drove the jack with his left arm and used his right arm to control the various levers. Once pallets were moved, he would use a "stand up" to stack the pallets, one on top of another. He used his left arm to steer this stand up and used his right arm to maneuver the controls.

Petitioner testified he used a scanner to track the products. The scanner is like a gun with a laser light and different buttons weighing 2 to 3 pounds. He testified he held the scanner with his left hand and pushed buttons on the scanner with his right. He testified he frequently scanned at or above shoulder level. He testified that he scanned two to three hours per day.

Petitioner testified that he also processed boxes containing camera bags and printers. He built pallets of these products in a similar fashion as he had the cameras. He testified he would have to reach overhead to unpack and restack these items. He also testified he would unload and repackage other products including paints, papers, video cameras, and ink in a similar fashion.

The printers were done differently. Petitioner testified he would wrap the printers with plastic, but used a clamping machine to move them. He indicated his left arm was outstretched while operating the clamping machine. This is another type of forklift truck. He operated this machine for at least three to four hours per day.

Petitioner also testified he also would pick orders. To pick orders, Petitioner testified he would manually lift boxed printers or cameras to fill orders. He would use the scanner to process the orders for shipping. He testified he frequently uses scanners overhead when picking orders. Petitioner identified two types of picking. One was a truckload and the other was a custom order. Both required use of scanners and the wrappers to complete the job. Both required some work at or above shoulder level.

Petitioner testified he would work in receiving and picking every day. He would do scanning every day. While he operated the clamp machine and stand up forklift, he was not using his left arm overhead. Driving a forklift to move pallets from one end of the warehouse to the other was a part of his job. Petitioner testified that his

work would depend on when shipments came, but he wrapped pallets every day. Petitioner testified that when he was picking, he would drive his forklift to the location where the product was located. He denied he would use the forklift to lower the products. He would use it if they were on the shelves, not if they were on the floor.

Michelle Campos testified that she is the regional HR manager for Respondent's Midwest region. She had been working in the HR department for Respondent since 2012. Respondent is a third-party logistics company. Canon products are shipped directly from Japan to their facility in Aurora. Shipments are broken down and distributed to various areas of the warehouse. As an HR person, she became familiar with the job duties within the receiving department. She identified RX 6 and RX 7. They show Ms. Campos standing by a pallet with printers. Ms. Campos is 5'2" tall. The printers depicted are stacked three high and come to the height of Ms. Campos shoulder level. These pallets with the printers arrive at the facility already wrapped with plastic. Nippon personnel do not wrap these products. When the printers are received in shipment, a clamp truck is used to clamp the load, place it on a pallet and then stack it with a forklift.

Roberto Martinez testified that he has been employed by Respondent for 22 years. He started working in the receiving department, doing the same job as Petitioner. Mr. Martinez was eventually promoted to supervisor within the receiving department, and was eventually promoted to assistant manager. He is very familiar with the job duties within the receiving department.

He testified that the amount of over-shoulder or overhead work varies. Some employees are hired to drive the equipment and other employees are hired mainly for manual labor. Petitioner drove the clamp machine as well as a slip sheet and a stand-up machine. Overhead work in this position is minimal. During approximately the last five working days of the month, Petitioner would be working in the picking department. Otherwise he was working in the receiving department. In the receiving department, stocking inventory would involve using a stand-up machine to put product on the top racks. Once the pallet is up to that location, scanning is done with a scanner or radiofrequency device. Scanning involves just a quick pull of the trigger. Stacking the inventory involves driving to one location, raising up the forks, putting the pallet in, scanning the location, bringing the forks back down and then grabbing a second pallet for stacking. During this process, the operator would put away two or three pallets per minute. Scanning takes approximately 1.5 seconds for each pallet, to pull the trigger and allow the scanner to read the location. Camera boxes often weigh approximately 19.5 pounds. The boxes stand 10 inches high and are manually stacked onto wooden pallets. The boxes are stacked onto the pallets, six on a layer and four layers high, and then wrapped with plastic three or four times around the pallet. There is no element of the wrapping that would require over shoulder level work. Printers arrive at the facility on the pallet already wrapped in plastic, and the pallets arrive double stacked.

Mr. Martinez testified that the clamp truck and the standup were the two machines Petitioner operated. RX 8 depicts the seated forklift, which is the clamp truck or a regular forklift. At the bottom of RX 8 are photos of a standup forklift. Operating these machines does not require elevating the arm above the head level. The arm would be extended outward. The individuals depicted in these photographs are approximately 6 feet tall. RX 9 and RX 10 depict the camera boxes previously discussed, stacked six on a level and four high. RX 11 and RX 12 show these boxes are stacked 44 inches up from the floor, including the 6-inch pallet. Compared to Mr. Martinez, these boxes come up to the base of his sternum. Wrapping this product with plastic does not require overhead work.

Mr. Martinez testified that an element of the job which would require reaching overhead involves product which is stacked up on the floor and reaching out to bring product down to put it on a pallet. This job is normally done

by a team of three people, two of whom put the product on a pallet while one person drove, and then they rotate after every 10 pallets or so. This type of work is required only two or three times a month.

Mr. Martinez testified Petitioner would work in picking at times. Picking does not require overhead work because pallets can only be stacked to a maximum of 52 inches high, the height limited by customer compliance requirements. Shelving units at the facility have shelves approximately 60 or 61 inches high, another reason product cannot be stacked too high. There were no elements of petitioner's job that would have required him to use the plastic wrap above shoulder level to wrap products on a skid.

He testified that cameras arrive in a shipping container stacked on cardboard pallets, with the pallets double stacked. They are unloaded with a forklift, placed on the floor single height and then transferred to wooden pallets to a height of 44 inches. Workers will grab a product from the floor load to build an order, which would involve some work at or above shoulder level. Working with floor loads at or above shoulder level occurs two or three times a month.

Petitioner testified on rebuttal that product on pallets was double stacked and the plastic wrap is cut with a knife which required reaching overhead. Cameras boxes were taken by hand from above shoulder level to build a pallet. Mr. Martinez was recalled and testified that the cameras coming in from the container are double stacked and removed with a fork lift. Once the double stack is out of the container, workers will single it outside of the container. To remove the plastic wrap, a worker would only reach about chest high. From time to time, a worker may cut the plastic wrap with one pallet stacked on another.

Petitioner testified that on December 24, 2014, while driving a machine, he started to have left shoulder pain. He testified he reported it on December 24, 2014. He testified he told Robert Martinez he was having chest pain. He told Mr. Martinez he did not know what the pain was from. He did not tell Mr. Martinez it was caused by work. Petitioner continued to work. Petitioner began work on that day at 7:00 AM. He testified that injury occurred in the afternoon, around midday. Then, after reviewing his accident report, he testified maybe it happened at 8:00 AM.

Petitioner testified he first saw Dr. Gustavo Sanchez-Vargas (referred to in the record as both Dr. Sanchez and Dr. Vargas). The records of Dr. Sanchez-Vargas were admitted as RX 2. The records note treatment prior to December 24, 2014. Petitioner was seen on December 5, 2014 for 2 days of abdominal pain and rectal bleeding. The records also reflect assessment of anxiety. On December 6, 2014, Petitioner was seen for a routine examination. On December 13, 2014, Petitioner reported feeling weak and tired for the last two weeks for no reason. The doctor notes new onset uncontrolled diabetes. Petitioner reported severe stress due to family issues (RX 2, p 1-4). Petitioner filled out an incident report on January 14, 2015 claiming his anal pain and bleeding were a due to operating the Clamp machine for hours (RX 3).

On December 24, 2014, Petitioner saw Dr. Sanchez-Vargas at 10:24 AM. He complained of chest pain since earlier that morning, lasting several hours. The pain radiated to the shoulder and left arm, not associated with exertion but aggravated with deep breathing. Dr. Sanchez-Vargas noted Petitioner's recent diagnosis of diabetes with sugar levels above 200. Petitioner reported he was very anxious with family problems, financial issues and work demanding long hours. Dr. Sanchez-Vargas diagnosed costochondritis, diabetes and anxiety disorder (RX 2, p 5). On January 13, 2015, Petitioner complained of feeling weak and tired for no reason for 2 weeks. He notes no headache or chest pain. On January 17, 2015, Petitioner complained of persistent anal pain aggravated by sitting for hours at his work place (RX 2, p 6-7). Petitioner had further follow up with Dr.

Sanchez-Vargas for weakness and tiredness and diabetic control through September 9, 2015 (RX 2, p 8-19). The records include Petitioner reporting on March 21, 2015 that he had an accident at work and has a partial rotator cuff tear (RX 2, p 10).

Petitioner filled out an accident report on January 14, 2015. The report states that he was injured at 8:00 AM on December 24, 2014. The pain was from operating the stand up and clamp machines. Petitioner testified that he did not fill out the form earlier because Respondent did not want to do a report. They changed their minds on January 14, 2015. Petitioner testified he had failed the test to be certified to drive a forklift twice. He denied his certification was expiring. He was told he would not be able to operate the forklift and would have to do more manual labor. He filled out the accident form the next day. Mr. Martinez testified that the forklift testing is an OSHA requirement that drivers be recertified every couple of years. Petitioner took the testing on January 13, 2015 because he was up for recertification. He failed the test twice.

Petitioner sought treatment from Monica Silva, D.C. beginning January 16, 2015 (PX 2). Petitioner complained of left-sided neck and shoulder pain. He stated that he moves a steering wheel with his left hand and that he has to support the left upper extremity in an elevated position for long periods of time. On 12/25/14, he was moving the wheel when he experienced sharp shooting pain on the left side of his neck that traveled into the left anterior and posterior shoulder, with numbness, tingling and pain that traveled into the medial three fingers. He reported he had seen his primary physician because he was concerned that the problems might be related to his heart. Petitioner reported he had never experienced these symptoms in the past. Dr. Silva diagnosed a cervical sprain/strain and a left shoulder sprain/strain. Dr. Silva provided chiropractic treatment through February 6, 2015. Dr. Silva ordered an MRI of the left shoulder on February 9, 2015 and an MRI of the cervical spine on February 17, 2015. An MRI of the left shoulder performed February 11, 2015 revealed tendinosis of the distal supraspinatus tendon with a less than 50% interstitial tear of the tendon. An MRI of the cervical spine performed February 18, 2015 revealed a small herniated disc at C5-6. Dr. Silva ordered Petitioner off work from January 16, 2015 through January 26, 2015 and ordered light duty restrictions from January 26, 2015 through February 27, 2015. She forwarded FMLA forms to Respondent on January 30, 2015 (PX 2).

Petitioner testified he was referred to Northwestern Medical Group and Northwestern Medical Faculty Foundation by Dr. Silva. He saw Dr. Marra on February 26, 2015. Petitioner reported complaints of left shoulder and neck pain after doing repetitive forklift work at his job. He reported the injury occurred on December 24. After physical exam and review of the MRIs of the cervical spine and the left shoulder, Dr. Marra diagnosed a partial thickness rotator cuff tear. Dr. Marra gave Petitioner a corticosteroid injection into the shoulder, prescribed anti-inflammatory medication, referred Petitioner to Dr. Patel to assess the neck condition. He ordered physical therapy and took Petitioner off work (PX 3). Petitioner saw Dr. Patel on March 4, 2015. Dr. Patel diagnosed cervical spondylosis. Dr. Patel saw no cause for pain or numbness radiating into the upper extremity. The physical exam was not consistent with cervical radiculopathy. Dr. Patel found no treatment was needed for the cervical spine. He suggested possible consultation with a neurologist for the numbness and tingling, and referred Petitioner back to Dr. Marra for the left shoulder condition (PX 3). On April 16, 2015, Dr. Marra administered a second injection into the shoulder and kept Petitioner off work (PX 3).

The records note that on April 21, 2015, the medical office had a conversation with Respondent and was advised that Petitioner was out on FMLA and has been off work for 12 weeks. If he is unable to return to work, they need a letter stating why and when. The office called the patient and explained that when he is next seen on 5/28, he needs to speak with Dr. Marra because he is not registered as workers' compensation. He needs

to move forward with his employer to apply for a leave of absence (PX 3). Respondent forwarded correspondence to Petitioner on April 27, 2015 advising him that his 12 week FMLA had expired, but that they would extend his leave until after his next medical visit on May 28, 2015. He was advised that he could apply for long term disability (RX 4). Ms. Campos testified that she did not receive any updated medical after she sent this letter. She did not hear from him at all. Respondent therefore treated Petitioner as having resigned as of June 2, 2015 (RX 5). Petitioner testified he did not return to work for Respondent because he was fired.

On May 28, 2015, Petitioner reported to Dr. Marra that he had about three weeks pain relief from the second injection but the pain had recurred. Dr. Marra recommended surgical intervention for a rotator cuff repair. He ordered Petitioner off work (PX 4). Petitioner underwent a left arthroscopic rotator cuff repair and left arthroscopic subacromial decompression at Elmhurst Memorial Hospital on June 24, 2015 (PX 5).

Petitioner had post-operative care with Dr. Marra (PX 4). On July 2, 2015, Dr. Marra's records noted Petitioner was doing well postoperatively and was taking Norco. He ordered continued use of a sling. On August 13, 2015, Petitioner reported to Dr. Marra that he had no pain, was not taking any medication and was doing home exercises. Dr. Marra notes therapy was not approved. He recommended physical therapy and recommended Petitioner remain off work. On September 24, 2015, Petitioner reported some increased pain since his prior visit. Petitioner was not taking any medication and he was doing home exercise. Dr. Marra again ordered physical therapy and prescription anti-inflammatory medication (PX 4).

Petitioner was examined at Respondent's request by Dr. Daniel Troy on October 12, 2015. Dr. Troy took a history of Petitioner developing neck and shoulder pain on December 24, 2014 with no specific accident. He notes that Petitioner talked about working extra hours and was very busy but that it was very unclear how his job duties were connected to the underlying injuries. Dr. Troy reviewed the treating medical records from Dr. Sanchez-Vargas, Dr. Silva, Dr. Marra and Dr. Patel through the September 24, 2015 office note and including the MRI studies and operative report. Dr. Troy performed a physical examination of the cervical spine and both shoulders. Dr. Troy opined that Petitioner's condition of left shoulder impingement and adhesive capsulitis is not causally related to Petitioner's employment. He notes that Petitioner was recently diagnosed with diabetes and based upon the lack of causality at work it is his opinion that the cause of Petitioner's left shoulder impingement appears to be more probably associated with diabetes than it does from any type of work injury. Dr. Troy found Petitioner's treatment reasonable and necessary but not work related. He opined that Petitioner was capable of return to work with restrictions and would benefit from four to eight weeks of therapy (RX 13).

On December 15, 2015, Dr. Marra disagreed that the rotator cuff tear was caused by Petitioner's diabetes. He opined that Petitioner's job, which requires repetitive work, is a confident cause of his rotator cuff tear. Dr. Marra further noted that while diabetes can decrease the incidence of successful rotator cuff repair and increase the incidence of stiffness, it is not associated with rotator cuff tearing as repetitive overhead work is. On February 4, 2016, Dr. Marra noted that Petitioner was doing home exercises. He recommended a work conditioning program. He released Petitioner to work with light duty restrictions. On March 17, 2016, Dr. Marra noted that Petitioner was doing fine and had no specific complaints and no weakness. He had not had physical therapy but he had been performing exercises on his own. Dr. Marra released Petitioner to return to work and continue with home exercises (PX 4).

Dr. Marra testified by evidence deposition taken on March 10, 2017 (PX 1). He testified regarding his treatment of Petitioner beginning on February 26, 2015. Dr. Marra testified that Petitioner complained of left

shoulder and neck pain which had occurred after performing repetitive work at his job. He reviewed the MRIs of Petitioner's neck and left shoulder. Dr. Marra treated Petitioner only for the shoulder condition. After physical examination, Dr. Marra diagnosed a symptomatic partial thickness rotator cuff tear with possible cervical radiculopathy. Dr. Marra performed cortisone injections on February 26, 2015 and April 16, 2015. On May 28, 2015, Dr. Marra discussed surgical repair of the shoulder condition. On June 24, 2015, Dr. Marra performed arthroscopic rotator cuff repair with arthroscopic subacromial decompression. Dr. Marra testified regarding Petitioner's postoperative recovery including work restrictions, pain medication, and use of a sling. Physical therapy was not approved, but Petitioner engaged in a home exercise program. On March 17, 2015, Dr. Marra released Petitioner to full duty work.

A hypothetical question was posed to Dr. Marra asking him to assume certain facts regarding Petitioner's job duties. The question asked him to assume Petitioner had been working for Respondent since the fall of 2013; that he performed the same basic job functions on a daily basis working full time; that on most days he would begin his day by stacking camera boxes weighing 30 pounds, stacking these boxes on pallets four deep and six high; that he would then wrap each pallet with plastic shrink wrap reaching out with his left arm and walking around the pallet to wrap the product on the pallet; that this wrapping required work from floor level to above shoulder level; assume that he would wrap at least 20 of these pallets per day; that he would then move these pallets with a long jack forklift using his right hand to control handles and using his left shoulder, arm and hand to steer the forklift; he operated this forklift for at least two hours per day; assume that he would also process printers weighing approximately 17 pounds each; that he would stack these printers on pallets four deep and five high; that he would wrap each pallet with plastic wrap in a similar fashion as the camera boxes; that he would use a clamp fork to move the pallets for shipping and picking and that he operated the controls on this forklift the same way he operated the controls on the other forklift, that he used a two-pound scanner usually held at or above shoulder level to scan the items for processing; that by the fall of 2014, he began to develop pain in his left shoulder and the pain required medical treatment beginning in December 2014. The hypothetical question to Dr. Marra continued with medical/clinical facts consistent with the medical records of Dr. Marra.

Based upon the factual scenario presented in the hypothetical question, Dr. Marra opined that the work activities as described in the hypothetical question might or could have caused, aggravated or accelerated Petitioner's shoulder condition. Dr. Marra testified that diabetes would not cause a partial thickness rotator cuff tear in a 37-year-old male. Dr. Marra testified that he released Petitioner to return to work full duty on March 17, 2016 and has not seen him since. Dr. Marra testified that repetitive overhead work goes to the heart of his opinion that Petitioner's condition is related to the work activities.

Petitioner testified that he is now working for a company for refrigerators as an operator. He is making $17.40 per hour. He testified that one or two times per week he takes medication. His left hand goes numb. He takes Advil or Ibuprofen. He has a bothersome pain. He will have to stop activities such as his job. He continues his home exercise program. He has had no medical treatment since Dr. Marra released him on March 17, 2016. Has seen no other doctors and has not been given any prescription medication.

Conclusions of Law

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

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. An injury occurs "in the course of" employment when it occurs during employment and at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties or engages in some incidental employment duties. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. A claimant also bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission, 449 N.E.2d 1345, 1348 (Ill. 1983) citing Rosenbaum v. Industrial Com. (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122.* [Claimant has the burden of showing by a preponderance of credible evidence that his injury arose out of and in the course of employment, which requires a showing of causal connection.] An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n, 224 Ill. 2d 53, 65, 862 N.E.2d 918, 308 Ill. Dec. 715 (2006).* In a repetitive trauma case, issues of accident and causation are intertwined. Therefore, a review of the evidence allows both issues to be resolved together. *Boeltcher v. Spectrum Property Group and First Merit Venture Realty Group, 97 W.C. 44539, 991 I.C. 0961.*

Petitioner is not claiming a specific accident in this matter. He provided no specific incident occurring and provided no such history to the doctors. In fact, he denied a specific accident. Petitioner is seeking recovery for his condition of ill being in the neck and left shoulder based upon a theory of repetitive trauma based upon the multiple duties required in the performance of his job for Respondent. Petitioner testified at length as to the duties of his job with emphasis on those activities that required above shoulder use of his left arm. He testified to the physical demands of unloading of containers, wrapping pallets and using the scanner among his activities. Respondent presented the testimony of Michelle Campos and Roberto Martinez as well as various photographs which dispute much of Petitioner's testimony as to nature and frequency of these activities as well as other aspects of his testimony.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence. The Arbitrator observed the witnesses and their demeanor. The Arbitrator notes that Petitioner was often evasive in his answers, particularly on cross examination. He contradicted himself on numerous details of his testimony including the time of the accident, his reporting and the preparation of the accident reports and how much time he spent on various activities other that forklift driving. His medical histories are not consistent with his testimony. He initially did not mention his shoulder or any work activity on December 24, 2014 to Dr. Vargas-Sanchez. He advised he had the pain for several hours even though the accident report stated it occurred within an hour of starting work and he was at the doctor that same morning. His later testimony and accident report discuss the driving of the machine, never any lifting or other work activity now claimed to be causative. Petitioner's varied and inconsistent histories of the incident undermine his claim that he suffered accidental injuries arising out of and in the course of his employment.

Petitioner's motivation is also suspect. His medical treatment before December 24, 2014 notes anxiety and stress at home and with family. He was weak and tired and diagnosed with uncontrolled diabetes. He continued working his regular job until he failed his forklift certification tests on January 13, 2015. Only then did he file multiple accident reports for his shoulder and bleeding anus, claiming both were from prolonged sitting and operating the forklifts. Petitioner's conduct in failing to respond to Respondent's and his own treating doctor's request to provide ongoing evidence of disability in April 2015 raised further question of his true motives.

In contrast, the testimony of the Respondent witnesses, who had must less reason to be untruthful, was logical and persuasive. They acknowledged that there was some above shoulder activity but testified credibly that the motion was not extensive or repetitive. Mr. Martinez testified that the above shoulder work was minimal. There was no need to raise the arm to perform wrapping or driving the various forklift machines. He also testified that the picking was only done by Petitioner a few days per month. Floor loads were only done a few times per month. Some heavier jobs were done with a crew of three rotating members. He also credibly contradicted Petitioner on the details, frequency and difficulty of other elements of the job duties.

Based upon these multiple factors, the Arbitrator finds the Petitioner's testimony is not credible. The Arbitrator finds that Petitioner's job duties were as described by Ms. Castro and Mr. Martinez.

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. Illinois Industrial Comm'n, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502, 109 Ill. Dec. 634 (1987)*; see also *Johnson v. Industrial Comm'n, 89 Ill. 2d 438, 442-43, 433 N.E.2d 649, 60 Ill. Dec. 607 (1982)*. Although medical testimony as to causation is not required in every workers' compensation case, 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 claimant's work activities caused the condition complained of." *Nunn, 157 Ill. App. 3d at 478; see also Johnson, 89 Ill. 2d at 442-43.* Petitioner offered the causation opinion of Dr. Marra. Respondent offered the report and opinions of Dr. Troy.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); Fickas v. Industrial Comm'n, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).* Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission, 309 Ill. 91, 138 N.E. 211 (1923).* The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705.* If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S., 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003).* A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

The Arbitrator notes the Dr. Sanchez-Vargas and Dr. Silva were never provided an accident history other than driving a forklift and offered no causation opinion. Petitioner provided no detailed work description to Dr.

Marra. His records and testimony simply reflect he was told that Petitioner complained of left shoulder and neck pain which had occurred after performing repetitive work at his job. Dr. Marra's records reflects that as of April 21, 2015, Petitioner was advised that he needs to speak with Dr. Marra because he is not registered as workers' compensation. The Commission has determined a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions caused the injuries but failed to detail what repetitive motions the Petitioner engaged in and the frequency of the motions. *Gambrel v. Mulay Plastics, 97 IIC 238.*

To address this element of proof, Dr. Marra was presented with an extended hypothetical question containing detail of the alleged job duties performed by Petitioner. Based upon this hypothetical question, Dr. Marra opined that that the work activities as described in the Dr. Marra testified that repetitive overhead work goes to the heart of his opinion that Petitioner's condition is related to the work activities. As noted above in the discussion of the testimony, the Arbitrator does not find Petitioner's description of his job duties, which mirror the facts submitted in the hypothetical question, credible. Dr. Marra provided no opinion based upon the actual facts of Petitioner's physical demands as testified to by Ms. Castro and Mr. Martinez which are far less strenuous and involve much less overhead activity. A treating doctor's findings and opinions can be undermined, or even disregarded, through reliance on inaccurate or incomplete information." See *Ravji v. United Airlines, 2012 WL 440353 at 13 (Ill. Indus. Comm'n) interpreting Horath v. Industrial Commission, 96 Ill.2d 349 (Ill. 1983).* Where none of the doctors who saw Petitioner had sufficient evidence regarding his work activities to form a reliable causation opinion, there is an absent credible evidence, and the burden of proof, which is on claimant, is dispositive. *Nelson v. County of De Kalb, 363 Ill. App. 3d 206, 211, 840 N.E.2d 795, 298 Ill. Dec. 682 (2005).* Dr. Marra's opinion was based on inaccurate facts assuming repetitive overhead activity. Absent credible and persuasive evidence of repetitive overhead work, there is no credible medical opinion finding causation.

In addition to the Petitioner's failure of proof on causation, Respondent offered the opinion of Dr. Troy that Petitioner's condition of left shoulder impingement and adhesive capsulitis is not causally related to Petitioner's employment The Arbitrator has reviewed Dr. Troy's report and finds this opinion persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on December 24, 2014 and further failed to prove by a preponderance of the evidence that any condition of ill being is causally related to his employment with Respondent.

In support of the Arbitrator's decision with respect to (J) Medical, (K) Temporary Compensation, and (L) Nature & Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Medical, Temporary Compensation and Nature & Extent are moot. Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREGORY TALLEY,

Petitioner,

vs. NO: 15 WC 8698

SELECT STAFFING,

Respondent.

18IWCC0763

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein, and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, and temporary total disability (TTD) benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

In the case at bar, the Arbitrator found in favor of Petitioner on the issues of accident and causal connection, but to a limited extent. The Arbitrator found that Petitioner had sustained a left wrist sprain and left elbow sprain as a result of the December 5, 2014 accident, wherein Petitioner tripped and fell on a metal pallet strap at work. However, the Arbitrator found that Petitioner had reached maximum medical improvement (MMI). The Arbitrator therefore found that Petitioner's current condition of ill-being was not causally related to the December 5, 2014 work accident.

The Arbitrator did not find Dr. Volarich, Petitioner's Section 12 examiner, persuasive, and instead, relied on the testimony of Respondent's Section 12 examiner, Dr. Lehman. Specifically, the Arbitrator found compelling Dr. Lehman's testimony regarding a surveillance video he saw of Petitioner walking his dog, and concluded that Petitioner was able to use his left upper extremity in a normal fashion. The Arbitrator does not specifically refer to Respondent's Exhibits 17 and 18 in her Conclusions of Law, which are the surveillance report and video, respectively. In the Arbitrator's Findings, the Arbitrator simply states the following with nothing more:

> The Archangel Investigations and Protection Surveillance Report was entered into evidence at the time of arbitration as Respondent's Exhibit 17. The Archangel Investigations and Protection Surveillance Video was entered into evidence at the time of arbitration as Respondent's Exhibit 18. Petitioner's Facebook Postings were entered into evidence at the time of arbitration as Respondent's Exhibit 19. (Arbitrator's Decision, pg. 14).

A review of this evidence, specifically, Respondent's Exhibits 17 and 18, demonstrates that not only do the dates on the report and video not match, but Dr. Lehman's description is not what is on the video. Further, the descriptions in the written report and the video do not match. The dates on the video are April 7, 2017 and April 8, 2017 and shows Petitioner walking a dog using his right arm or simply standing/talking outside. (RX17; RX18). The Commission gives little weight to this evidence.

The remaining evidence, which includes Petitioner's testimony, Dr. Volarich's testimony, and more importantly, Petitioner's medical records, provide a sound basis for finding causal connection for Petitioner's current condition of ill-being. Further, "[a] chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Here, Petitioner testified that he had sustained a prior work injury in July 2009, wherein he sustained a hairline fracture to his left forearm. (T.13; T.15-16; T.48-49). Petitioner's treating orthopedic surgeon, Dr. Paul Scherer, and Dr. Volarich noted Petitioner's prior injuries and treatment to the left elbow, which included decompression of the radial nerve around the elbow in 2000, and loose bodies as seen in a CT scan from July 2009. (PX1, pgs. 14-15; 25; PX4). Petitioner

denied any ongoing left elbow problems since July 2009. (T.49). Both Drs. Scherer and Volarich further noted that Petitioner had had no problems with his left shoulder, left hand, or left wrist prior to December 5, 2014. (PX1; pgs. 9-10; PX4).

Respondent's Section 12 examiner, Dr. Lehman, diagnosed Petitioner with a partial rotator cuff tear, carpal tunnel syndrome, and a loose body fracture of the left elbow. (RX14; RX15, pg. 25). He opined, however, that Petitioner's current condition was unrelated to the December 5, 2014 accident. (RX14; RX15, pgs. 25-26; 31; 58-59).

Dr. Lehman had reviewed the February 3, 2015 MRI film of the left shoulder, which, according to Dr. Lehman, revealed a partial thickness rotator cuff tear, an inferior posterior labral tear, tendinosis of the long head of the biceps tendon, and acromioclavicular hypertrophy synovitis, with a Type 2 acromion narrowing of the subacromial space. (RX15, pg. 19). Dr. Lehman also stated that he reviewed an EMG/NCV report that Petitioner completed on April 7, 2015, which indicated bilateral carpal tunnel syndrome. (RX15, pg. 20). With these findings, Dr. Lehman opined that Petitioner's carpal tunnel syndrome and left elbow condition were pre-existing, and that the MRI findings for the left shoulder were chronic and long-term in nature. (RX14; RX15, pg. 18; 20; 26-27; 54).

Notwithstanding Dr. Lehman's opinions, the record demonstrates that from July 2009 to December 5, 2014, Petitioner was asymptomatic for any condition of his left arm; he had no complaints, was not under any type of medical care or treatment, and was working without restriction.

Following the December 5, 2014 trip and fall at work, the chain of events in this claim demonstrates that Petitioner's injuries were caused by that accident. There was no delay in treatment as Petitioner went to the emergency room on December 5, 2014. X-rays of the left hand, wrist, elbow, and shoulder were taken at the emergency room and later reviewed by Physician Assistant Larry Barnes, of Gateway Regional Occupational Health Services, on December 9, 2014. Although Mr. Barnes noted that the x-rays were negative for fractures and dislocations, his examination revealed decreased range of motion in the left shoulder, left elbow, and left hand/wrist due to pain; there was diffuse tenderness to palpation; there was also swelling noted in the dorsal aspect of the left hand, thenar eminence, and the left thumb; grip and pinching were slightly decreased; and, there was a mild decreased sensation to light touch in the left thumb. He diagnosed Petitioner with a left hand and wrist sprain, left elbow sprain, and left shoulder sprain. (PX2; PX3; PX4).

Petitioner was then prescribed a conservative course of treatment that included, prescription medication and physical therapy. When his condition did not improve, especially in his left shoulder, Mr. Barnes, ordered an MRI that was completed on February 3, 2015. The impression indicated multiple partial thickness tears of the rotator cuff involving the supraspinatus, infraspinatus, and subscapularis; there was no evidence of a full-thickness rotator cuff tear; there was a tear of the inferior posterior labrum, and tendinosis versus intrasubstance partial tear of the

long head of the biceps tendon with anterior subluxation from the bicipital groove, and acromioclavicular hypertrophy and synovitis with type 2 acromion and narrowing of the subacromial space. Petitioner's diagnoses on this date were left shoulder strain with multiple tendon tears and impingement and left elbow sprain. (T.21-22; PX2; PX4).

Petitioner next consulted with Dr. Scherer, who examined Petitioner on February 19, 2015. Physical examination revealed slight weakness to thumbs-down abduction on strength testing; Petitioner had anterior shoulder pain with Speed maneuver; he had mild tenderness over the top of the acromion and spine of the scapula suggesting some myofascial pain component; and, carpal tunnel compression test was positive. Dr. Scherer also reviewed the emergency room x-rays and the MRI of the left shoulder. (T.22; PX4). He believed that Petitioner appeared to have a traction neurapraxia of the median nerve, which was causing some tingling in his thumb following his fall onto the outstretched hand with dorsiflexed wrist. Dr. Scherer indicated that the neurapraxia could be at the level of the base of the thumb; he believed it was likely at the level of the carpal tunnel. As to Petitioner's left shoulder, Dr. Scherer noted significant injury, including subluxation of the long head of the biceps and tearing of the upper margin of the subscapularis. Petitioner received two injections to his left shoulder with temporary relief. (PX4).

Petitioner's Section 12 examiner, Dr. Volarich, opined that as a result of the December 5, 2014 accident, Petitioner sustained internal derangement of the left shoulder, which was a partial rotator cuff tear, a labral tear, partial biceps tendon tear, and impingement. (PX1, pg. 8; 11-12). Petitioner also had a left elbow medial compartment contusion with possible ulnar neuropathy, as well as a left wrist contusion causing post-traumatic carpal tunnel syndrome. (PX1, pg. 8; 11-12). Other than Petitioner being overweight, Dr. Volarich testified that Petitioner had no other risk factor for carpal tunnel syndrome. (PX1, pgs. 10-11). He also did not believe that Petitioner's drumming activities caused his carpal tunnel condition. Dr. Volarich stated, "He would have to be playing probably, you know, three and four hours a night, plus practicing almost everyday during the week to come up with enough repetitive activities with the hands to make drumming the cause." (PX1, pg. 24). Petitioner confirmed that he played drums, but that he had not played drums in approximately three years. (T.44).

Dr. Volarich further opined that Petitioner's conditions were not the result of any degenerative condition. (PX1, pg. 10).

> He has got a labral tear, which is a traumatic injury, and the mechanism of injury that he gave me where he fell onto his left elbow and jammed his left shoulder is classic for mechanism to tear the labrum in the shoulder. He has got a partial rotator cuff tear that may be attrition, but it can also be post-traumatic. He has got impingement symptoms now that are due to the hooked acromion that he didn't have before this injury. So I believe that any degenerative changes that he had in the past were asymptomatic and

> were aggravated by this injury, jamming injury to the shoulder. (PX1, pg. 10).

In comparing the two left elbow injuries in 2009 and 2014, Dr. Volarich said the mechanisms of injury were completely different.

> The 2009 injury was a hyperextension injury of the elbow. It means it went back further than it should when you straighten the elbow out. This one is falling onto a flexed elbow and forearm on the ground contusing the ventral surface of the wrist, contusing the medial compartment of the elbow and then jamming the left shoulder. (PX1, pg. 16).

Thus, in consideration of the record in its entirety, the Commission finds that Petitioner's current condition of ill-being, as it relates to his left shoulder, left elbow, and left wrist, is causally related to the December 5, 2014 work accident. Respondent's reliance on Dr. Lehman's opinion that all of Petitioner's condition were pre-existing is simply not supported by the evidence in the record nor the chain of events in this claim.

As such, the Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's Exhibit 4, and notes the parties' stipulation that Respondent is entitled to a credit under Section 8(j) of the Act, of $30,743.15 for medical bills paid through its group medical plan.

The Commission further awards prospective medical as prescribed by Dr. Volarich. Dr. Volarich had recommended that Petitioner receive pain management for his ongoing neuropathic pain symptoms in the left upper extremity; a home exercise regimen was also recommended for the shoulder, elbow, wrist, and hand until Petitioner was evaluated by a surgeon; and, finally, surgery was recommended for Petitioner's left upper extremity. Dr. Volarich suggested that Petitioner consult with Dr. Michael Milne regarding surgery for the left shoulder, and with Dr. Timothy Farley for surgery to the left elbow and wrist. (PX1, pg. 9). Notwithstanding causation, Respondent's Section 12 examiner, Dr. Lehman had opined that Petitioner would benefit from a carpal tunnel release on the left hand, as well as a left shoulder arthroscopy based on his type II acromion to relieve the pressure on the rotator cuff. (RX14; RX15, pgs. 32-33; RX16, pgs. 86-87).

The Commission also awards TTD benefits from December 9, 2014 through February 25, 2015 per the parties' stipulation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed October 30, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $241.33 per week for a period of 11 2/7 weeks, from December 9, 2014 through February 25, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $2,718.90 for TTD previously paid and $2,718.90 in non-occupational indemnity disability benefits, for a total credit of $5,437.80.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibit 4 pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $30,743.15 for amounts paid under its group health plan under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the prospective treatment as prescribed by Dr. Volarich.

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

DEC 12 2018

DATED:

Michael J. Brennan

MJB/pm
O: 11-20-18

052

Thomas J. Tyrrell

Kevin W. Lamborn

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

TALLEY, GREGORY
Employee/Petitioner

Case# **15WC008698**

SELECT STAFFING
Employer/Respondent

18IWCC0763

On 10/30/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0781 KEEFE & GRIFFITHS PC
DANIEL KEEFE
10 S BROADWAY SUITE 500
ST LOUIS, MO 63102

1886 LEAHY EISENBERG & FRAENKEL
SANDY ECHEVESTE
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gregory Talley
Employee/Petitioner

v.

Select Staffing
Employer/Respondent

Case # 15 WC 8698

Consolidated cases: N/A

18IWCC0763

An *Application for Adjustment 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 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 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 not* causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$18,824.00**; the average weekly wage was **$362.00**.

On the date of accident, Petitioner was **45** 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 **$2,718.90** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,718.90** in non-occupational indemnity disability benefits, for a total credit of **$5,437.80.**

Respondent shall be given a credit of **$30,743.15** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of December 5, 2014, Petitioner's request for prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of **$241.33**/week for **11 6/7 weeks**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$2,718.90** for TTD, **$0** for TPD, **$0** for maintenance, and **$2,718.90** in non-occupational indemnity disability benefits, for a total credit of **$5,437.80.**

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.

Melinda M. Pope-Sullivan

Signature of Arbitrator

10/26/17

Date

ICArbDec19(b)

OCT 30 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Gregory Talley
Employee/Petitioner

Case # 15 WC 8698

v.

Consolidated cases: N/A

Select Staffing
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he 48 is years old and has been engaged to his fiancée for 18 years in January. He testified that he was involved in a previous workers' compensation trial about three or four years ago for a pinched nerve in his right forearm. He testified that he had had other prior workers' compensation claims including a hairline fracture on a bone right below the elbow in the left forearm.

Petitioner testified for the sake of completeness that he did recall other past workers' compensation injuries and claims including the following: a claim on August 13, 2013 against Kienstra Block and Brick, in which he "basically got hit by a forklift and drug;" a March 2, 2004 claim also against Kienstra Block and Brick; and a claim in 1991 against Melvin Price Support Center, where he was chipping ice off a sidewalk, stepped on a piece of ice and fell on his back. Petitioner then recalled a claim against Barnett Company in approximately 1993, but could not recall the injuries or the circumstances. Similarly, Petitioner could not recall what happened in 1990 when he was working for Lake County City Management. Petitioner did, however, recall that in 1990 while working for the U.S. Army Commissary he fell on his back. He testified that it was fair to say that he had had a number of prior work injuries. Petitioner could only recall the left forearm hairline fracture while he was walking to his car, slipped on grass and his left arm went back and twisted as the only injury involving his left wrist, forearm or shoulder.

Petitioner testified that on or about December 5, 2014, he was working through Respondent Select Staffing, a temporary placement company, at the Target Warehouse. Petitioner described his job was basically picking orders with a wrist computer until there were no more orders. He testified that when the orders stopped, he was transferred to the "other side" to help get boxes for email orders. He testified that on December 5, 2014, his job was carrying boxes from one place to another location in the warehouse. He testified that on that date, as he was collecting boxes, he had a big stack in his hands and was walking and a metal strap was on the floor. He testified that he did not see it because he had boxes in front of him and he was walking. He testified that he then tripped and fell face first, basically with his arms out and he heard a pop in his left shoulder. He then testified he felt a pop in his left shoulder when he fell. He also testified that he felt numbness in his fingers and pain in his wrist, but that he did not notice pain in his left elbow at the time of the accident but then testified that his whole arm was hurting.

Petitioner testified that the gentleman he was working with walked with him to report the accident to his supervisor. He testified that he requested an ambulance that was not called so he had to pay for a cab to go to the emergency room. He testified that his accident happened around 11:00 p.m. and that he arrived

at the emergency room after midnight. He testified that while in the emergency room, they did x-rays and sent him home and that he was placed on light duty and instructed to follow-up with a specialist. He testified that he was referred to Dr. Scherer but that before seeing Dr. Scherer, he was in treatment at Occupational Health through Select Staffing.

Petitioner testified that an MRI of his left shoulder was ordered before he saw Dr. Scherer and that Dr. Scherer reviewed the left shoulder MRI with him and also ordered nerve studies. He testified that Dr. Scherer diagnosed him with carpal tunnel syndrome and a torn rotator cuff and recommended surgery for his shoulder and median nerve, but that the treatment was never approved. He denied having any additional treatment for either his shoulder or his wrist since the surgery was denied.

As to current problems with the left shoulder, Petitioner testified that due to pain he cannot take care of himself. He testified that his fiancée bathes him, shaves him and gets him ready for work. He testified that his fiancée has to help him with bathing and shaving because he cannot properly use his arms to reach behind to wash his back or properly lather his hair. He denied having any of these problems before the accident. He testified that he has noticed weakness in his left arm, that when he tries to hold a cup he has to change hands because he cannot hold it for very long and that he is constantly dropping things with his left hand. Petitioner demonstrated, using his right arm, that he could only lift his left arm to shoulder height.

As to current problems with the left shoulder, Petitioner testified that he has numbness that goes through his elbow to his ring finger, middle finger and thumb. He testified that when the weather gets colder, he has increased tingling in his fingers and that they are more "achy." He testified that occasionally it is difficult to sleep, that he takes an aspirin, that he lays on his back and in the middle of the night if he rolls to his right, he wakes up right away. He testified that most of the time however, he is woken up by his fingers being tingly, numb and hurting in his shoulder.

Petitioner testified that he and his fiancée have a Facebook account in the names of Gregory and Christina Talley. He testified that his fiancée does most of the posting on Facebook, that he only posts on Facebook one or two times per week or maybe ten times per month, and that the rest of the time he just "trolls."

Petitioner testified that following his injury on December 5, 2014, he was able to return to work for Respondent on light duty. He testified that the light duty assignment consisted of answering the phones and writing down notes, and that he told Select Staffing it was difficult for him to write with his left hand. He testified that the light duty restrictions were not to lift above a certain height or above a certain weight and further testified that writing with his left hand was not restricted.

Petitioner testified that he walks his two dogs on a leash, that one is black lab female weighing about 60 pounds and that the other is a 70-pound male chow shepherd mix. He testified that he does not walk both dogs at the same time and that when the dogs are not being rowdy he tries to use his left hand, and that when they get rowdy or try to run, he uses his right hand.

Petitioner testified that he is not aware of any outstanding medical bills related to the treatment that he has had for this work injury.

On cross examination, Petitioner testified that on December 5, 2014, it was his left foot that became caught on the strap. He testified that he was walking past several skids that had different sized boxes on them. He testified he that did not see the strap since he had boxes in his hand and was carrying them at

waist height. He testified that he was carrying 6-8 boxes, that the boxes were flat and that they weighed about 20 pounds.

On cross examination, Petitioner testified that he fell and landed on the floor face-down on his stomach, and that as soon as he landed he heard a pop in his shoulder. He testified that when he got up, he started feeling numbness in his elbow and into his fingers and that he had aching pain in his shoulder. Petitioner indicated where he had numbness and pain in his left arm by pointing to the outside of his left elbow, to the ring, middle and thumb in his left hand and to his left shoulder on top and around.

On cross examination, Petitioner testified that he got off the floor on his own and reported the accident to the Select Staffing supervisor whose name he could not remember. He testified that he filled out an accident report and that they did a drug screen and took his picture before he left for the hospital. He testified that he could not remember the name of the witness, but did remember that he was working through a different temp service named HireLevel. The Arbitrator notes that such witness was not present at the hearing to testify on Petitioner's behalf.

On cross examination, Petitioner testified that the day after his accident he went to the Select Staffing office by bus to complete the Injured Associate's Statement. He testified that he hand-wrote on the Injured Associate's Statement how the accident occurred. He testified that on that same Injured Associate's Statement, he marked on a diagram of the human body where his pain was located and that he signed the statement certifying that his answers were accurate and complete.

On cross examination when asked whether he did not report that he hurt his shoulder right away, Petitioner testified "I told them I landed on my arm. I did not know what was going on but it was more of numbness in my elbow and fingers, and I did report that I was hurting on my shoulder." He testified that he could not remember whether he marked he had pain in his shoulders on the pain diagram or not.

On cross examination, Petitioner testified that he has been going to the Gateway Regional Medical Center emergency room for many years for his asthma attacks and that he continues to go to the emergency room for treatment. He agreed that at the Gateway Regional Medical Center emergency room a history was taken of how he fell and hurt himself, and that he understood the questions he was asked and was able to provide complete, accurate and truthful answers. He testified that he could not remember whether he complained of left shoulder pain or not at the Gateway Regional Medical Center emergency room, but that he did remember that he complained of pain radiating down his left arm. He agreed that he told the doctors that all of his pain was in his left wrist.

On cross examination, Petitioner testified he was given restrictions of no use of the left wrist, that he took those restrictions to Respondent, that light duty was offered and that he signed a form agreeing to work light duty. He testified that he believed that he worked light duty that one day only, that he did not think he went back and that he was told to stay home. He testified that Respondent told him to stay home because he could not answer phones and take notes at the same time. He testified that he was unaware of whether his restrictions stated that he could not write or answer the telephone.

On cross examination, Petitioner agreed that after the accident on December 5, 2014, he continued to go to Gateway Regional Medical Center for treatment for his asthma attacks. He agreed that he was at the emergency room on December 13, 2014 and testified that he did not complain of left wrist, left elbow or left shoulder pain because he was there for an asthma attack. He agreed that he was hospitalized at Gateway Regional Medical Center on December 19th and 20th for asthma and testified that he did not mention any left shoulder, wrist or elbow pain because he passed out at home for asthma. He testified that

while he was hospitalized, he was not asked by any doctors whether he had any complaints of pain anywhere and that they were more concerned about his asthma.

On cross examination, Petitioner agreed that he believed that the very first time he complained of left shoulder pain was on February 3, 2015. He testified that he had the left shoulder MRI and was made aware of what it revealed. He testified that when he saw Dr. Scherer, he took a history from him regarding his accident, his past medical history and his symptoms. He testified that he gave Dr. Scherer complete, accurate and truthful answers. He testified that after he saw Dr. Scherer, he returned to the emergency room several times for his asthma.

On cross examination, Petitioner testified that he never had right wrist carpal tunnel surgery in the past. He testified that he saw Dr. Lehman for an independent medical examination on July 14, 2015. He testified that during the IME with Dr. Lehman, he reported that he worked maintenance. He testified that at that time, he was cutting grass on a Z-turn at the Melvin Price Center through the maintenance shop. He agreed that he told Dr. Lehman that he walks his dogs and that he played drums, but that he had not played drums in three years.

On cross examination, Petitioner testified that he saw Dr. Volarich for an independent medical examination six months after the IME with Dr. Lehman. Petitioner denied that during his IME that he told Dr. Volarich that he did not play any musical instruments. He testified he told Dr. Volarich that he plays video games on the computer, that he spends most of his days watching TV and that he walks his dogs holding the leashes in his right hand when the dogs are rowdy. He testified that he told Dr. Volarich he could not play drums like he used to play, that the last gig he played drums at was on November 29, 2014 and that his band played rock music. He agreed that playing the drums was very physically demanding and highly repetitive.

On cross examination, Petitioner testified that he remembered past medical treatment and that on October 30, 2014, he went to Gateway Regional Medical Center and gave a history that he fell from a height of four steps and hit his head after he passed out from an asthma attack. He testified he could not, however, remember going to Gateway Regional Medical Center emergency room on August 4, 2014 complaining that he tripped in a hole. He did, however, remember that he went to the Gateway Regional Medical Center emergency room on August 4, 2014 where he gave the doctors a history that he was born with a club foot. Petitioner testified that he remembered going to the Gateway Regional Medical Center emergency room on April 7, 2014, but that he did not remember giving the doctors a history that he was born with a club foot on the right which made him prone to accidents.

On cross examination, Petitioner agreed that on July 10, 2009 he was treated at the Gateway Regional Medical Center emergency room for left elbow pain in his forearm, that he had a CT scan and that doctor explained to him what the CT scan revealed. He testified that the doctor did not tell him that he had loose bodies in his left elbow or that he needed any left elbow surgery. He denied having left elbow problems since the fracture. He agreed that he went to the Gateway Regional Medical Center emergency room on June 19, 2009 after slipping on wet grass and landing on his left elbow and agreed that he gave a history that he hyperextended his left elbow. He also agreed that he remembered going to Gateway Regional Medical Center on February 20, 2008, complaining of burning pain in his left elbow after lifting bars of soap at work.

On cross examination, Petitioner agreed that when he saw Dr. Volarich for his own IME that he gave a history that after the December 5, 2014 accident, he had worked for Staffmark in October and November of 2015 and that, before working for Staffmark, he worked through Express Temp Services from April of 2015 through October of 2015. He further agreed that most of his jobs since 2001 had been through

various staffing agencies. He testified that he is not presently looking for work because he is currently working as a forklift driver and has been working as a forklift driver since January 4, 2017. He testified that he still watches videos, movies and plays computer games.

On cross examination, Petitioner testified he did not file 14 prior workers' compensation claims and testified that the Illinois Workers' Compensation Commission records were wrong if they reflected that he had fourteen prior workers' compensation claims. Petitioner testified as follows regarding his prior Illinois Workers' Compensation claims: he did not recall filing a workers' compensation claim for a left wrist injury with a date of accident of June 5, 2009 while working for Customized Distribution Services; he recalled working for Customized Distribution Services, but did not recall filing a workers' compensation claim for his left elbow with a date of accident on February 20, of 2008; he recalled that he worked for Kienstra Block and Brick but did not recall filing a claim for a left elbow strain with a date of accident of March 20, 2004, but then testified "basically on that Kienstra Block and Brick I basically got ran over by a forklift – and it drug me." Mr. Talley then testified, "Actually, I recall the forklift hit me and that was my sprained ankle and if you're talking about the elbow, it was from a block, basically, that pulled my arm down." Additionally, Petitioner could not recall working at Carylon Corporation on October 7, 1999, when he tripped and fell landing on spray gun; he also could not recall working at the Levy Organization and injuring his left hand on February 18, 1996.

On redirect, Petitioner denied having any prior complaints involving the left shoulder before the accident at issue. He testified he first noticed complaints in his left shoulder after the work injury and that "It was at the hospital whenever I heard the pop and it was hurting at work before I went to the hospital and it got worse after that." He testified that he recalled telling Gateway Occupational Health Services on December 9, 2014 that he had a shoulder injury.

On redirect, Petitioner testified he had a chance to review Dr. Volarich's IME report dated January 19, 2016 before his testimony at the time of arbitration. Initially, Mr. Petitioner testified he did not recall anything in the report, then he recalled a little of the examination, then he testified that some of the information he reviewed in Dr. Volarich's IME report "seemed kind of way off" but that he could not recall which parts those were. He testified that the report was accurate, however, in terms of his complaints and medical history.

The transcript of the deposition of Dr. David Volarich was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Volarich testified that his areas of specialty include nuclear medicine, occupational medicine and independent medical examinations and that he is board-certified in all of those areas. (PX1).

Dr. Volarich testified that he evaluated Petitioner at his attorney's request on January 19, 2016 and that he later prepared another letter dated February 29, 2016 after reviewing additional medical records and films. He testified that he made three diagnoses as a result of the accident of December 5, 2014, which included internal derangement of the left shoulder (partial rotator cuff tear, labral tear, partial biceps tendon tear and impingement) status post non-operative treatment; left elbow medial compartment contusion with symptoms of ulnar neuropathy, incompletely evaluated and treated; and left wrist contusion causing post-traumatic carpal tunnel syndrome, status post non-operative treatment. He testified that the injuries required medical treatment to fix them and that they still required additional medical treatment. He testified that Petitioner has not reached maximum medical improvement with respect to the fall that he suffered on December 5, 2014 and that he made several treatment recommendations, including pain management for his ongoing neuropathic pain symptoms in the left upper extremity, a home exercise program for the shoulder, elbow, wrist and hand until he can be seen by a surgeon, that Petitioner see Dr. Milne for evaluation and surgical treatment of the left shoulder internal derangement and that Petitioner also see Dr. Farley for surgical repairs to the left elbow and left wrist. (PX1).

Dr. Volarich testified that he did not have any history of left wrist or left shoulder complaints before Petitioner's work injury. He testified that he did not believe that it was possible for Petitioner's left shoulder complaints to be caused simply through long-term chronic degeneration in a type 2 acromion. He testified that Petitioner had a labral tear which was a traumatic injury, and that the mechanism of injury that he gave where he felt onto his left elbow and jammed his left shoulder was a classic mechanism to tear the labrum in the shoulder. He testified that Petitioner had a partial rotator cuff tear that may be due to attrition, but that it could also be post-traumatic. He also testified that Petitioner had impingement symptoms that were due to the hooked acromion that he did not have before the injury. He testified that he believed that any degenerative changes that Petitioner had in the past were asymptomatic and were aggravated by the jamming injury to the shoulder. (PX1).

Dr. Volarich testified that Petitioner did not have any of the classic risk factors that could cause carpal tunnel syndrome without a traumatic event and that the only risk factor that he might have was that he was overweight. He testified that as to the left elbow, Petitioner had signs and symptoms of ulnar neuropathy and that he told him that he struck the "funny bone" area when he fell on the pavement. He testified that Petitioner had some preexisting arthritic changes in the elbow because of a past fracture that he sustained in 2009 and that it showed a loose body in the joint, and that Petitioner indicated that the fracture had healed without too much problem and that he had no symptoms in the elbow after it healed up to the time that he fell in December of 2014. (PX1).

On cross examination, Dr. Volarich agreed that he was not a treating physician for Petitioner and testified that he saw him only once for the IME. When asked if he was aware that Petitioner had had prior worker's compensation claims, Dr. Volarich responded that he believed that Petitioner had something on his elbow in the past. He testified that he was aware of a June 2009 claim involving the left and right wrists involving a burning sensation and that he was also aware of a February 2008 claim involving a burning sensation in the left elbow. He testified that Petitioner indicated that everything had healed well and that he was not aware of any permanent impairment from any of those past incidents. (PX1).

On cross examination, Dr. Volarich testified that there were still loose bodies in the posterior aspect of the left elbow but that it was not around the area of the ulnar nerve. He testified that it was most likely some pieces of surface cartilage that had broken loose from the fracture at the trochlea. He testified that the loose bodies would most likely cause some lost range of motion and that Petitioner did not have quite full flexion and could not turn his palm up quite as good as on the right side, which he thought was due to the past fracture. He testified that the 2009 injury was a hyperextension injury of the elbow and that this one was falling onto a flexed elbow and forearm on the ground, contusing the ventral surface of the wrist, contusing the medial compartment of the elbow and then jamming the left shoulder. He agreed that this was assuming the reported mechanism of injury was correct for both of those descriptions. (PX1).

On cross examination, Dr. Volarich agreed that in his report he stated that Petitioner was unable to drive a car. He testified that Petitioner reported that he had trouble using the left arm and that he had trouble turning the wheel. When asked whether he was aware that Petitioner mentioned to the other examining physician that he walked large dogs on a daily basis, Dr. Volarich responded that he saw in some of the medical records that he was walking a dog and that there were pictures of dogs posted on Facebook. He testified that Petitioner reported to him that he used to play in a friend's band, but that he had not been able to do that since he hurt his left arm. (PX1).

On cross examination, Dr. Volarich testified that Petitioner reported that he had not been able to find a job since the injury partly because of pain and limited use of the upper extremity, that he had tried a couple of different jobs for short periods of time and that when he saw him he was not working. He testified that he did not know why Petitioner was no longer with the two jobs that he had held. He denied having asked Petitioner whether he drove a car in order to get to those two jobs. He testified that he did not know

whether Petitioner stopped working those jobs due to physical limitations or whether it was the nature of a short-term job. (PX1).

On cross examination, Dr. Volarich agreed that Petitioner indicated to him that he reported immediate pain in the left shoulder at the emergency room visit. He testified that the emergency room record just talked about the wrist and elbow initially, that they did a shoulder x-ray and that they did not really mention much about the shoulder. When asked whether the pain diagram from the initial emergency room visit had no markings at or near the shoulder and whether this would affect his opinion of the injury at all, Dr. Volarich responded that he did not think so because symptoms evolved after an injury of this type to an extremity. (PX1).

On cross examination, Dr. Volarich testified that there was nothing in the records that he saw that Petitioner had a prior diagnosis of carpal tunnel syndrome. He denied being aware that Petitioner had surgery on his right wrist for carpal tunnel syndrome in the past. He testified that he knew that he had a radial nerve decompression at the right elbow in 2000, but was not aware that Petitioner had a carpal tunnel release. He testified that he did not recall seeing a scar on that wrist when he did the physical examination. He agreed that a computer used and evidenced the ability to use the wrists, hands and fingers. He testified that he did not ask Petitioner how much on a daily basis he was actually using the computer, but that he did mention that he was using it on a daily basis to look for work. When asked if someone with severe limiting bilateral carpal tunnel syndrome would have problems using a computer on a daily basis, Dr. Volarich responded affirmatively and stated that the individual would typically be slower. (PX1).

On cross examination, Dr. Volarich agreed that Petitioner had worked at two prior jobs and was currently looking for a third job. When asked if that indicated that Petitioner was able to work, Dr. Volarich responded that he thought Petitioner was trying to do something to make some money and that he was going to have a hard time because his dominant arm had been injured and was not yet repaired. He testified that he thought Petitioner was going to be working short periods of time at multiple jobs and either quitting because he could not do it or being laid off because he could not do it. He testified that he did not ask Petitioner whether he quit or was laid off because of not being to perform his job for the two prior jobs. (PX1).

On cross examination, Dr. Volarich agreed that he believed that the left carpal tunnel syndrome was caused by an acute injury. When asked to explain the meaning of the EMG report evidencing bilateral carpal tunnel syndrome, Dr. Volarich responded that he could not explain why it was positive in the right wrist and testified that Petitioner was not symptomatic in the right wrist. He testified that he did not think that the right carpal tunnel syndrome was related to this injury at all. (PX1).

On cross examination, Dr. Volarich testified that a labral tear was typically acute after this type of an injury and that it was hard to tell what was acute or chronic on an MRI or CT scan. He testified that one could infer by inference that it was old if there was a lot of degenerative change, but that the best one could do was infer and that there was no way to tell. When asked if he noticed any degenerative changes in the left shoulder MRI, Dr. Volarich responded that he thought there were some at the AC joint that he did not really see any at the glenohumeral joint where most of the labral pathology was. He testified that if there was a complete tear, one would expect to see effusion in the joint because of the tear and bleeding into the joint and that he did not see anything that was like that. He testified that labral tears usually did not cause a lot of effusion because they were not very vascular. He testified that it was possible that Petitioner had preexisting tendinosis of the left shoulder or preexisting degeneration of the labrum, but that he really did not see a lot of fraying of the labrum or maceration of the labrum. He testified that he thought the tendinosis or tendinopathy was partly old. He testified that rotator cuff tears sometimes were degenerative and occurred just because of overuse over a long period of time, but that he typically saw that in the 60+-year-olds and would not expect that finding in a 40-year-old. (PX1).

On redirect when shown the initial emergency room report dated December 6, 2014 that referenced a history of a 45-year-old male with left shoulder pain after a fall and asked whether that suggested he gave at least some form of history suggesting that his left shoulder might be affected, Dr. Volarich responded affirmatively. (PX1).

The medical and billing records of Gateway Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on February 4, 2015, at which time it was noted that he was seen in follow-up for a left shoulder strain and a left elbow sprain. It was noted that Petitioner stated that he was still having pain that he rated at 8-9/10 despite continuing with home exercise program taught by physical therapy and various medications. The assessment was noted to be that of (1) left shoulder strain with multiple tendon tears and impingement; (2) left elbow sprain, unchanged. Petitioner's medications were refilled and he was instructed to continue applying both moist heat and ice compresses. Petitioner was also referred to Illinois Southwest Orthopedics. Petitioner was instructed to remain on modified work with no work using his left arm until the evaluation. Included within the records was an interpretive report for an MRI of the left shoulder performed at Gateway Regional Medical Center on February 3, 2015, which was interpreted at revealing (1) multiple partial-thickness tears of the rotator cuff involving the supraspinatus, infraspinatus and subscapularis; no evidence of full-thickness rotator cuff tear; (2) tear of the inferior posterior labrum; (3) tendinosis versus intrasubstance partial tear of the LHBT with anterior subluxation from the bicipital groove; (4) acromioclavicular hypertrophy and synovitis with type 2 acromion and narrowing of the subacromial space; these findings may be related to clinical symptoms of subacromial impingement. (PX2).

The records of Gateway Occupational Health reflect that Petitioner was seen on January 12, 2015, at which time it was noted that he was seen in follow-up of his left shoulder and left elbow sprain. It was noted that Petitioner stated that he had not had any improvement and still rated his pain at 8/10 despite taking several medications. It was noted that Petitioner also stated that he was going to physical therapy and that during physical therapy, they were trying to work on range of motion of his left shoulder and still having difficulty getting his left arm raised above 90 degrees in the horizontal position and that when they tried to elevate it above that, he got a sharp pain and they felt and heard popping sounds. The assessment was noted to be that of (1) left shoulder sprain with impingement and weakness; (2) left elbow sprain. Petitioner was instructed to continue with current medications and was ordered to undergo an MRI of the left shoulder. It was noted that Petitioner would discontinue physical therapy until they had the MRI report. It was also noted that work restrictions would be continued at that time. At the time of the January 5, 2015 visit, it was noted that Petitioner was seen in follow-up for a contusion to the left wrist, forearm, elbow and sprain of the wrist. It was noted that Petitioner had had two therapy sessions so far and that he stated that he continued to have pain up to an 8-9/10. It was noted that the therapy seemed to help along with the heat, but that he was still getting intermittent numbness into the left thumb as well as pain from the elbow that radiated down towards the wrist. It was noted that Petitioner had been unable to work since the last visit due to work restrictions, as they did not have limited duty available. The assessment was noted to be that of contusion of the left elbow; left wrist sprain remains symptomatic. Petitioner was given refills of his medications and was instructed to continue therapy as ordered. Petitioner was instructed to remain on work restrictions. (PX2).

The records of Gateway Occupational Health reflect that Petitioner was seen on December 16, 2014, at which time it was noted that he was seen in follow-up of a left hand and wrist sprain, left elbow sprain and left shoulder sprain. It was noted that Petitioner stated that he was still having quite a bit of discomfort in all of these areas and rated his pain at 9/10. It was noted that Petitioner also stated that his left thumb felt like he had some numbness along with pain. It was noted that Petitioner stated that he did not have much range of motion, but that he had been wearing the sling as directed and had been taking Aleve, Tylenol and Tramadol as directed. The assessment was noted to be that of (1) left hand/wrist sprain;

(2) left elbow sprain; (3) left shoulder sprain. Petitioner's medications were refilled and he was instructed to continue with Tylenol as needed. Petitioner was also instructed to continue wearing the sling but to remove it a few times a day to work on range of motion as well as to apply both moist heat and ice compresses. Petitioner was instructed to undergo physical therapy and to return to work modified duty December 16-23, 2014 with no working using the left arm. At the time of the December 9, 2014 visit, it was noted that Petitioner was seen for an initial evaluation of an injury to his left upper extremity that occurred at work on December 5, 2014. It was noted that Petitioner stated that he tripped on a pallet and fell onto the concrete floor with a FOOSH-type injury and was seen at Gateway Regional Medical Center on December 6, 2014. It was noted that Petitioner stated that he had significant pain throughout his left upper extremity, rating his pain at 9/10. The assessment was noted to be that of (1) left hand/wrist sprain; (2) left elbow sprain; (3) left shoulder sprain. Petitioner was instructed to continue taking both Aleve and Tylenol, alternate heat and ice and continue wearing the splint. It was noted that Petitioner would be returned to modified work December 9-16, 2014 with no work using the left arm. (PX2).

The medical and billing records of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 6, 2014, at which time it was noted that he complained of left wrist and left elbow pain and that his pain was 8/10. It was noted that Petitioner stated that he was working at the Target warehouse when he tripped on a pallet and landed on his left wrist, that it was not painful and difficult to move and that he also hurt his left elbow when landing on the concrete. It was noted that Petitioner had swelling present in the left hand and left wrist. Petitioner underwent x-rays of the left hand and left wrist on December 6, 2014, both of which were interpreted as unremarkable radiographs. Petitioner underwent x-rays of the left elbow on the same date, which were interpreted as revealing (1) no fracture or acute osseous abnormality of the left elbow; (2) left elbow degenerative changes. Petitioner also underwent x-rays of the left shoulder on the same date, which were interpreted as revealing no fracture or acute osseous abnormality of the left shoulder. Petitioner was discharged to home ambulatory with diagnoses of wrist sprain; elbow-forearm sprain. The differential diagnoses were noted to be that of abrasion, bursitis, closed fracture and dislocation. It was noted that Petitioner would need to follow-up as directed by worker's compensation. (PX3).

The records of Gateway Regional Medical Center reflect that Petitioner underwent physical therapy for the timeframe of March 26, 2015 through April 17, 2015. At the time of the Initial Evaluation/Examination on March 26, 2015, it was noted that Petitioner stated that on December 5, 2014, he was at work carrying some boxes when his feet got tangled in plastic packaging wrap and that he fell onto his left arm. It was noted that Petitioner's chief complaint was that of pain in the left shoulder and limited motion, that he noted some popping and that he denied the feeling of instability but that he noted some local shoulder swelling. It was also noted that Petitioner had intermittent numbness in the left thumb that "travel[ed] up to the elbow." The Discharge Summary dated May 7, 2015 noted that Petitioner had undergone six treatments and missed two and that there was no further contact from Petitioner. (PX3).

The medical and billing records of Illinois SW Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on February 19, 2015 for evaluation of his left shoulder. It was noted that Petitioner had no problems with his left shoulder or left hand until he fell at work when he tripped on a strap that was on the floor but still underneath and was therefore anchored to a pallet, and that he landed hard onto his left hand. It was noted that Petitioner had had numbness in the left thumb and pain in the left shoulder that radiated to the elbow since that time. It was noted that Petitioner appeared to have a traction neurapraxia of the median nerve, which had caused some tingling in his thumb following a fall onto the outstretched hand with dorsiflexed wrist. It was noted that the neuropraxia could be at the level of the base of the thumb but that Dr. Scherer thought it was most likely at the level of the carpal tunnel. It was noted that the neuropraxia was expected to resolve fully with observation. As to the left shoulder, Dr. Scherer noted that Petitioner had evidence of a significant injury which had resulted in some subluxation of the long head of the biceps and tearing of the upper margin of

the subscapularis. It was noted that it was possible that Petitioner's shoulder symptoms may quiet down with non-operative management and that if he had persistent symptoms, surgery would consist of biceps tenodesis and repair of the upper edge of the subscapularis. Petitioner was given an injection into the anterior subacromial space and he was instructed to continue the Naprosyn. Petitioner was recommended to undergo physical therapy for the shoulder. It was noted that Petitioner would be kept on restricted duty and that he was given a cock-up splint. (PX4).

The records of Illinois SW Orthopedics reflect that Petitioner was seen on March 19, 2015, at which time it was noted that he did not get much benefit from the cortisone shot in the left shoulder. It was noted that Petitioner's chief complaint was diffuse shoulder pain, superior lateral left shoulder region with elevation and that he had been having a great deal of difficulty sleeping because of pain in the shoulder. It was noted that Petitioner's claim had been denied and that he was recommended to get physical therapy through his regular medical insurance instead. A cortisone injection to the AC joint was offered and given on that date. It was noted that relative to the numbness in the left hand it had not really changed and seemed to be waxing and waning. Petitioner was recommended to undergo an EMG/nerve conduction study to see if there was evidence of carpal tunnel syndrome which may have preexisted the fall and may have been exacerbated by the traction on the median nerve and/or strain causing swelling on the flexor tendons traversing the carpal tunnel. It was noted that Petitioner was off work and that the same restrictions were again imposed. (PX4).

Included within the records of Illinois SW Orthopedics were medical records from Gateway Regional Medical Center for a date of service of December 13, 2014, at which time Petitioner was seen for a sudden onset of shortness of breath. It was noted that Petitioner was seen with a sling in place on his left arm and that he denied weakness, numbness and acute injury. Petitioner was also seen at Gateway Regional Medical Center on January 25, 2015 for an asthma exacerbation and on December 19, 2014 for a COPD exacerbation. At the time of the December 19, 2014 visit, it was noted that Petitioner had circulation, motion and sensation intact but that his range of motion was limited in the left wrist. At the time of the January 25, 2015 visit, it was noted that Petitioner's extremities all appeared grossly normal with no appreciable pain with palpation. Petitioner was also seen on February 5, 2015 with complaints of shortness of breath as well as on February 8, 2015 for a diagnosis of asthma with acute exacerbation, at which time no musculoskeletal deficits were noted on examination and no injuries were reported. (PX4).

Also included within the records of Illinois SW Orthopedics were medical records from Gateway Regional Medical Center for a date of service of February 11, 2015, at which time Petitioner's diagnosis was noted to be that of asthma with acute exacerbation. The records further reflect that Petitioner was also seen on February 27, 2015, at which time his diagnosis was noted to be that of asthma with acute exacerbation. (PX4).

The IWCC list of Petitioner's Prior Claims was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The documentation reflects that Petitioner filed nine different Applications for Adjustment of Claim including the claim at issue, and that five of the cases were ultimately dismissed. (RX1).

The Select Remedy Solutions Personnel Services ISO Search Results was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The documentation reflects that Petitioner filed a claim for a date of accident of June 5, 2009 involving the left wrist, that Petitioner filed a claim for a date of accident of February 20, 2008 involving the left elbow and that Petitioner filed a claim for a date of accident of March 2, 2004 involving an unidentified elbow.[1] (RX2).

[1] The Arbitrator takes judicial notice of the fact that the IWCC Case Information System identified 04 WC 19940 as having been filed for a date of accident of March 2, 2004 involving an alleged left elbow injury.

The Select Remedy Incident Report & Root Cause Investigation was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report noted that Petitioner's first date on the assignment was that of December 1, 2014 and that the date of injury was that of December 5, 2014. It was noted that Petitioner stated that he was walking around a pallet going for more boxes when he snagged his toe upon a loose strap, causing him to fall to the floor. No witnesses were identified. It was noted that upon investigation, Tim Cox, Senior Safety Consultant, observed Petitioner's work area and that general housekeeping was good and that he did not see any straps on the floor. (RX3).

Petitioner's Resume and On-Line Job Application were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Job Description was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The Employer's Injury Illness Report was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The report noted that the accident was reported on December 5, 2014 at 11:20 p.m. and that Petitioner tripped and fell over a strap that was still attached to a pallet while he was walking past it to gather boxes for packers. The Notification of Modified/Alternative Work was accepted and signed by Petitioner on December 6, 2014. It was noted that Petitioner's identified restrictions were that of no use of the left arm until cleared by workmen's comp and that his job duties would consist of answering phones and filing. (RX6).

The Injured Associate's Statement dated December 6, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The statement was signed by Petitioner on December 6, 2014 and noted that the body parts injured were that of a wrist, elbow and forearm sprain. The document captioned "Mark Injury body part" and completed by Petitioner on December 6, 2014 noted stabbing pain from the left elbow down to the left wrist. No indications were made on the left shoulder. (RX7).

Pictures of Petitioner taken on December 5, 2014 were entered into evidence at the time of arbitration as Respondent's Exhibit 8.

Petitioner's Chart Marking Injured Body Parts dated December 6, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The documents were effectively duplicative of those as contained in Respondent's Exhibit 7. (RX9; RX7).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 10.

The Gateway Regional Medical Center Emergency Department Record dated December 6, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 11. The records were duplicative of those as contained in Petitioner's Exhibit 2. (RX11; PX2).

The Notification of Modified/Alternative Work Document was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The document was duplicative of that as contained in Respondent's Exhibit 6. (RX12; RX6).

The Payout Ledgers (TTD and Medical) were entered into evidence at the time of arbitration as Respondent's Exhibit 13. The IME Report of Dr. Richard Lehman dated July 14, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 14.

Part 1 of the transcript of the deposition of Dr. Richard Lehman (taken on September 22, 2016) was entered into evidence at the time of arbitration as Respondent's Exhibit 15. Dr. Lehman testified that he is an orthopedic surgeon and is board-certified in orthopedic surgery and sports medicine. He testified that the types of surgeries that he performs are primarily arthroscopic shoulder and knee surgeries related to sports-related injuries. He testified that he performed an IME of Petitioner on July 14, 2015. (RX15).

Dr. Lehman testified that Petitioner stated that he was a packer who was walking and gathering boxes, and that he tripped on a strap that was attached to a pallet. He testified that when he saw Petitioner, he stated that he had pain in his left shoulder and left wrist since the incident. He testified that Petitioner stated that he had a history of carpal tunnel syndrome in the past and that on the day that he was seen, most of his discomfort was referable to discomfort with elevation of his shoulder and use of his left shoulder. He testified that he did not believe that Petitioner told him exactly how long he had had carpal tunnel syndrome or if he just stated that it was a long period of time. He testified that Petitioner did not indicate to him that the carpal tunnel syndrome was a pain complaint relating to the date of injury and that he told him that he had had carpal tunnel syndrome and symptoms of tingling for a period of time before. (RX15).

Dr. Lehman testified that Petitioner stated that he had had previous accidents and problems in the past with pinching of his radial nerve, but had never had problems in his shoulder or wrist (absent the carpal tunnel syndrome which he stated that he had). He testified that Petitioner stated that he had had treatment in the past including physical therapy and cortisone injections for his shoulder, and that he stated that he continued to have numbness in his hands and also pain in his left shoulder. He testified that Petitioner stated that he was a drummer and had a long history of drumming, but that he had not been drumming for approximately a year before the incident. He testified that Petitioner stated that he had two dogs, that he walked his dogs and that he stated that he had been a drummer for a period of time. (RX15).

Dr. Lehman testified that Petitioner indicated that he was taking Tramadol and an inhaler. He testified that the physical examination of the left shoulder evidenced complaints of pain with elevation, that he had mild weakness in the thumbs down position, that he had tenderness in the anterior front part of the shoulder, that he had a positive Hawkins sign for impingement syndrome and that he had tenderness in the acromioclavicular joint. He testified that in terms of the physical exam of the wrist and hand, Petitioner had numbness in all of his fingers except his thumb, that he had excellent abduction of his fingers, that he had no evidence of loss of adduction, that he had full extension and full flexion of his wrists and that he had normal extension of his thumb. He testified that it would be almost impossible to have carpal tunnel syndrome and not have involvement of the thumb and that Petitioner's Phalen's test was negative as well. He testified that carpal tunnel syndrome was common in drummers and that drummers commonly had wrist and hand complaints. (RX15).

Dr. Lehman testified that he reviewed medical records that showed that Petitioner had several emergency room visits after the accident and that there was no mention of issues relating to the wrist, hand, shoulder or any upper extremity during any of the visits. He testified that if Petitioner was still exhibiting pain in the left upper extremity, one would think that he would have mentioned it at his emergency room visits. He testified that the MRI of the left shoulder performed on February 3, 2015 revealed evidence of a partial thickness rotator cuff tear involving the supraspinatus, infraspinatus and subscapularis, that there was no evidence of a full thickness rotator cuff tear and that there was no significant glehohumeral effusion, which would suggest that this was not an acute process. He testified that there was noted to be an inferior posterior labral tear and tendinosis of the long head of the biceps tendon which was a degenerative process and that there was an acromioclavicular hypertrophy synovitis with a type 2 acromion narrowing the subacromial space. He testified that generally, a partial thickness rotator cuff tear would be consistent with degeneration or tendinosis of the rotator cuff. He testified that the changes on the MRI were long-term and chronic in nature and not acute. (RX15).

Dr. Lehman testified that he reviewed records regarding previous injuries from 2009 and 2008 for elbow and wrist injuries, respectively, and that the June 19, 2009 note from Gateway Regional Medical Center noted that Petitioner had slipped on wet grass and landed on his left arm with a hyperextension injury to his left elbow. He testified that the CT scan of his elbow revealed an intraarticular fracture involving the trochlea, the ulna and a loose body in the posterior aspect of his shoulder. He testified that people that had intraarticular fractures generally developed an arthritic component and that he thought that it changed the biomechanics of the upper extremity including the ability to straighten the elbow. He also

testified that he was aware that Petitioner had previous other worker's compensation claims, including a June 5, 2009 injury for the wrist, a February 20, 2008 injury for the left elbow and a March 20, 2004 elbow strain and contusion to the hand. (RX15).

Dr. Lehman testified that he reviewed the surveillance video as well as several Facebook posts, and that the video showed Petitioner walking his dog, exiting his residence, using his arm normally and holding onto a handrail and that it appeared to be normal mechanics, normal range of motion and normal function of his left upper extremity. He testified that the surveillance showed that Petitioner could use his left arm and hand and rotate his shoulder when taking care of the dogs. (RX15).

Dr. Lehman testified that the diagnosis that he gave for Petitioner was that of a partial rotator cuff tear, carpal tunnel syndrome and a loose body in the posterior aspect of his shoulder. He testified that he did not believe that any of these diagnoses were a result of Petitioner's fall on December 5, 2014 and that he did not think that the partial rotator cuff tear, carpal tunnel syndrome or loose body had any relation to the fall. He testified that Petitioner had a history of carpal tunnel syndrome and that there was nothing suggestive of an acute injury in the x-rays that he performed. He testified that there did not appear to be anything acute on the MRI and that the findings were long term, chronic and consistent with Petitioner's age, that he had a preexisting elbow injury which was going to overload his left shoulder and that he injured his shoulder and did not have any complaints for a fairly long period of time. He testified that if there were an acute trauma, on MRI he would expect to see fluid and secondary changes where the rotator cuff had impacted the bony insertion. He testified that if the rotator cuff acutely pulled out of the bone there would be secondary bony changes and bone marrow edema, and that none of those were evidenced. He testified that these were also the types of pathology that were seen as people age. (RX15).

Dr. Lehman testified that he felt that the weakness in the examination was subjective. As to the significance of the physical examination of Petitioner's left wrist and hand, Dr. Lehman testified that it was a little bit confusing. He testified that people with carpal tunnel syndrome almost 100% had numbness in the thumb, so it brought into question an inconsistency. He testified that on examination Petitioner indicated that he was sore in the AC joint, that he had some complaints of soreness in the biceps and that he basically had diffuse soreness in the anterior aspect of his shoulder and that he did not believe that these were consistent with the MRI findings. (RX15).

Dr. Lehman testified that he did not believe that the December 5, 2014 incident exacerbated, altered or in any way changed the areas that Petitioner complained of during the IME and that none of the injuries were related to the fall as described by Petitioner. He testified that he believed that Petitioner had an appropriate work-up but that he did not believe that the treatment was related to the injury of December 5, 2014. He testified that he did not believe that Petitioner's symptoms were consistent with an acute process from the fall so he did not believe that he required any further treatment as it related to the fall. When asked if he felt that Petitioner had any symptom magnification, Dr. Lehman responded that he was diffusely tender in the areas that you would not expect to be tender on physical examination. He testified that he felt that Petitioner exhibited evidence of symptom magnification as related to tenderness and complaints to the anterior and lateral aspect of the shoulder. He testified that he thought that Petitioner had reached maximum medical improvement as it related to the December 5, 2014 accident and that any wrist strain that Petitioner may have suffered on the date of the accident would not be a causative factor for carpal tunnel syndrome. He testified that he believed that Petitioner was able to work after his injury, that as of the date of the IME he felt that he could work and that he could certainly work as it related to the December 5, 2014 incident. He further testified that he felt that Petitioner's permanent partial disability was 0% as it related to the incident. (RX15).

On cross examination, Dr. Lehman testified that he did not believe that Petitioner had any prior left shoulder injuries. He testified that he did not have any independent recollection as to whether Petitioner was right- or left-handed and that it was not contained in his report. He testified that he confined his

examination to Petitioner's left upper extremity. He testified that if someone had full unrestricted motion, generally he would not examine the other extremity. He testified that if there were additional records that showed something else other than full range of motion, it could change his opinion. (RX15).

On cross examination, Dr. Lehman testified that it was his opinion that he did not believe that Petitioner suffered an acute injury of the left shoulder in the fall of December 2014. He denied being board-certified in diagnostic imaging, nuclear medicine, occupational medicine or as an independent medical examiner. (RX15).

On cross examination, Dr. Lehman testified that, as a physician, if someone had an abnormal set of symptoms it altered how much credibility they put in those symptoms. He testified that if one had carpal tunnel syndrome, the thumb should be numb and that if one had a rotator cuff tear, one should not have tenderness in the areas of the shoulder that do not reflect areas of damage. He testified that if someone had an acute injury to their rotator cuff, he would expect to find effusion on an MRI scan done two months after the injury and that one would have significant fluid in the subacromial space and in the glenohumeral joint, and that it could be up to six months after the injury because the fluid continued to get regenerated because the rotator cuff was not working. (RX15).

Part 2 of the transcript of the deposition of Dr. Richard Lehman (taken on January 17, 2017) was entered into evidence at the time of arbitration as Respondent's Exhibit 16. On continued cross examination, Dr. Lehman testified that if he saw someone who indicated that his hands were numb and they did not get worse with a Phalen's test, he questioned whether he was getting a "straight answer." He testified that his interpretation of the MRI may have differed a little bit as compared to the radiologist that performed it, but that it did not differ in terms of measuring the subacromial space nor the type of morphology of the acromion. (RX16).

On cross examination, Dr. Lehman testified that on the video, Petitioner was seen pulling on the lead displaying strength and range of motion of his left hand, wrist, elbow and shoulder, and then grabbing the handrail of the steps with his left hand while turning completely around and maintaining the grip on the handrail. He testified that he has a big dog that if he had a bad left arm, he did not think he could care for the dog. He agreed that it seemed suspect to him that a patient would have the kind of complaints that Petitioner described and still be able to take care of the dogs. (RX16).

On cross examination, Dr. Lehman agreed that given the pathology on the MRI, he believed that Petitioner would be a candidate for surgery. He testified that he thought that symptom magnification made an individual suspect in terms of the physical exam and how accurate someone was really relating their symptoms. He agreed that it was his opinion that Petitioner was being less than honest about the severity of his symptoms. (RX16).

On redirect, Dr. Lehman agreed that Petitioner stated that he had numbness in all of his fingers except his thumb which was medically inconsistent with a carpal tunnel diagnosis. He agreed that he testified that someone with an acute rotator cuff shoulder injury would have effusion or fluid on the MRI taken two months after typically and that he did not find any fluid or effusion in Petitioner's MRI from February of 2015. (RX16).

The Archangel Investigations and Protection Surveillance Report was entered into evidence at the time of arbitration as Respondent's Exhibit 17. The Archangel Investigations and Protection Surveillance Video was entered into evidence at the time of arbitration as Respondent's Exhibit 18. Petitioner's Facebook Postings were entered into evidence at the time of arbitration as Respondent's Exhibit 19.

The Gateway Regional Medical Center records dated October 30, 2014 were entered into evidence at the time of arbitration as Respondent's Exhibit 20. The records reflect that Petitioner was seen for

respiratory distress. It was noted that Petitioner apparently fell from a height down approximately four stairs and was short of breath. It was noted that Petitioner was intubated in the emergency room and sent to the ICU. The assessment was noted to be that of acute hypercarbic respiratory failure secondary to asthma exacerbation, resolved. (RX20).

The Gateway Regional Medical Center records dated August 4, 2014 were entered into evidence at the time of arbitration as Respondent's Exhibit 21. The records reflect that Petitioner was seen on August 4, 2014, at which time it was noted that he tripped in a hole about a half an hour ago and that his right ankle hurt. It was noted that Petitioner stated that he was born with a club foot. The assessment was noted to be that of a right ankle sprain. (RX21).

The Gateway Regional Medical Center records dated April 7, 2014 were entered into evidence at the time of arbitration as Respondent's Exhibit 22. The records reflect that Petitioner was seen on April 7, 2014, at which time it was noted that he stated that he twisted his right ankle on Wednesday and that the pain was still present. It was noted that Petitioner stated that he was born with a "clubbed foot" on the right which made him prone to accidents. The assessment was noted to be that of a foot sprain. (RX22).

The Gateway Regional Medical Center records dated July 10, 2009 were entered into evidence at the time of arbitration as Respondent's Exhibit 23. The records reflect that Petitioner was seen on July 10, 2009, at which time it was noted that he underwent a CT of the left elbow which was interpreted as revealing (1) intra-articular fracture involving the trochlea of the ulna; (2) loose joint bodies noted along the posterior joint space. (RX23).

The Gateway Regional Medical Center records dated June 6, 2009 were entered into evidence at the time of arbitration as Respondent's Exhibit 24. The records reflect that Petitioner was seen on June 5, 2009, at which time it was noted that he complained of a burning sensation to his right wrist, that he stated he was lifting boxes at work and that he heard and felt a pop. Included within the records was reference to the 15 times Petitioner had presented to the emergency department since January 22, 2002, which included a visit on February 20, 2008 for a chief complaint of mild elbow injury and a final diagnosis of left medial epicondylitis. (RX24).

The Gateway Regional Medical Center records dated June 19, 2009 were entered into evidence at the time of arbitration as Respondent's Exhibit 25. The records reflect that Petitioner was seen on June 19, 2009, at which time it was noted that he stated that he slipped on wet grass that morning and landed on his left arm. It was noted that Petitioner stated that his elbow was hyperextended and that he had swelling of the right [*sic*] elbow. X-rays of the left elbow performed on that date were interpreted as revealing no radiographic evidence of bone or joint disease of the left elbow. The impression was noted to be that of a left elbow sprain. (RX25).

The Gateway Regional Medical Center records dated February 20, 2008 were entered into evidence at the time of arbitration as Respondent's Exhibit 26. The records reflect that Petitioner was seen on February 20, 2008, at which time it was noted that he complained of burning pain to the left elbow after lifting bars of soap at work that evening. The impression was noted to be that of left medial epicondylitis. (RX26).

CONCLUSIONS OF LAW

The Arbitrator notes at the outset that Petitioner bears the burden of proving that he incurred an accidental injury that arose out of and in the course of his employment with Respondent on December 5, 2014 and that his current condition of ill-being is causally related thereto. The Arbitrator notes that because there is conflicting evidence concerning the alleged accident, the credibility of Petitioner necessarily

becomes paramount, and that, in this case, the multitude of inconsistencies in the evidence necessarily causes the Arbitrator to find that Petitioner was not a credible witness and to place little, if any, evidentiary weight upon his testimony.

Specifically, the Arbitrator finds that Petitioner's testimony was often contradicted by the objective evidence submitted at hearing. On direct, Petitioner was able to testify to various prior workers' compensation injuries, but on cross examination he could not recall many specifics of the prior claims for which he received various monetary recoveries. (RX1). Furthermore, on cross examination Petitioner recalled going to Gateway Regional Medical Center on August 4, 2014 and giving a history that he was born with a club foot, but he did not remember giving a history that he tripped in a hole during that visit. Similarly, Petitioner recalled going to Gateway Regional Medical Center on April 7, 2014 but did not remember giving doctors a history that he was born with a right club foot which made him prone to accidents. Furthermore, the Arbitrator is gravely concerned with Dr. Lehman's suggestion that Petitioner displayed symptom magnification during his IME. (RX15).

In sum, the Arbitrator finds that a review of the record as a whole reveals numerous inconsistencies in Petitioner's allegations, the testimony proffered concerning the alleged work accident and the alleged resulting injuries. As a result thereof, the Arbitrator finds that Petitioner was not a credible witness and places little, if any, evidentiary weight upon his testimony.

With respect to disputed issue (C) pertaining to the issue of accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on December 5, 2014.

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

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

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

of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶21.

In the case at hand, the Arbitrator finds that Petitioner was exposed to a risk distinctly associated with his employment and that he was injured while at a place where he might reasonably have been expected to be while performing his duties when he was injured at the time of the accident at issue. Petitioner testified that on December 5, 2014, his job was carrying boxes from one place to another location in the warehouse. He testified that on that date, as he was collecting boxes, he had a big stack in his hands and was walking and a metal strap was on the floor. He testified he did not see it because he had boxes in front of him and he was walking. The Arbitrator notes that the histories of accident as contained in the medical records and as reported to the IME physicians were fairly consistent, although the Arbitrator also notes that there was significant inconsistency in the body parts allegedly injured in the fall. Having considered Petitioner's testimony and having reviewed the documentary evidence submitted into evidence at the time of arbitration, the Arbitrator finds that Petitioner has met his burden of proof in establishing that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on December 5, 2014.

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of December 5, 2014.

In so finding that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of December 5, 2014, the Arbitrator places greater reliance upon the opinions offered by Dr. Lehman than those offered by Dr. Volarich in this matter. The Arbitrator notes that both physicians apparently examined Petitioner for Section 12 examinations and that no opinions were offered by Dr. Scherer, one of Petitioner's treating physicians in this case.

It is noteworthy to the Arbitrator that Dr. Volarich was not provided with the EMG/NCV report to review and was apparently not aware that Petitioner had bilateral carpal tunnel syndrome that, by his own admission to Dr. Lehman, pre-dated the accident at issue. (RX14; RX15). Dr. Volarich testified that he believed that the left carpal tunnel syndrome was caused by the acute injury, but admitted on cross examination that he could not explain why the EMG/NCV was positive in the right wrist and testified that Petitioner was not symptomatic in the right wrist. (PX1). Dr. Lehman, on the other hand, testified that Petitioner did not indicate to him that the carpal tunnel syndrome was a pain complaint relating to the date of injury and further told him that he had had carpal tunnel syndrome and symptoms of tingling for a period of time before. (RX15). Furthermore, the Arbitrator notes that while Petitioner denied any numbness in the left thumb when seen by Dr. Lehman at the time of the IME, Petitioner testified at the time of hearing to having numbness in his left thumb. As indicated previously, the Arbitrator finds that this is yet another inconsistency that causes the Arbitrator to place little, if any, evidentiary weight on Petitioner's testimony.

Furthermore, the Arbitrator places great weight upon Dr. Lehman's testimony that he reviewed the surveillance video as well as several Facebook posts, and that the video showed Petitioner walking his dog, exiting his residence, using his arm normally and holding onto a handrail and that it appeared to be normal mechanics, normal range of motion and normal function of his left upper extremity. (RX15). Like Dr. Lehman who testified that the surveillance showed that Petitioner could use his left arm and hand and rotate his shoulder when taking care of the dogs, the Arbitrator agrees that the surveillance video suggests that Petitioner is, in fact, able to use his left upper extremity in a normal fashion. (RX15). The Arbitrator further agrees with and places significant evidentiary weight on Dr. Lehman's testimony that it seemed suspect to him that a patient would have the kind of complaints that Petitioner described and still be able to take care of the dogs, particularly given the weight of the dogs as testified to by Petitioner at the time of arbitration. (RX16).

Having reviewed and considered the evidence as a whole, the Arbitrator finds that Petitioner sustained a left wrist sprain and left elbow sprain as a result of the December 4, 2014 incident and that Petitioner has attained maximum medical improvement from his injuries. As such, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of December 5, 2014.

With regard to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Respondent has paid all reasonable related and necessary medical bills.

At the time of arbitration, Petitioner testified that he was unaware of any outstanding medical bills related to this work injury. Furthermore, Petitioner agreed that Respondent paid medical bills totaling $30,743.15 under Section 8(j) of the Act related to this work injury for which Respondent was entitled to a credit. (AX1). As such, the Arbitrator finds that Respondent has paid all reasonable related and necessary medical bills.

With regard to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of December 5, 2014, Petitioner's request for prospective medical treatment is hereby denied.

With regard to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits for the timeframe of December 9, 2014 through February 25, 2015. (AX1). The Arbitrator further notes that Respondent's Exhibit 13 is a payout reflecting that temporary total disability benefits were paid to Petitioner for the timeframe of December 5, 2014 through February 25, 2015, a period of 11 6/7th weeks. (RX13).

Petitioner testified that following his injury on December 5, 2014, he was able to return to work for Respondent on light duty. He testified that the light duty assignment consisted of answering the phones and writing down notes, and that he told Select Staffing it was difficult for him to write with his left hand. Petitioner testified that the light duty restrictions were not to lift above a certain height or above a certain weight and further testified that writing with his left hand was not restricted. On cross examination, Petitioner testified that he was given restrictions of no use of the left wrist, that he took those restrictions to Respondent, that light duty was offered and that he signed a form agreeing to work light duty. He testified that he believed that he worked light duty that one day only, that he did not think he went back and that he was told to stay home. He testified that Respondent told him to stay home because he could not answer phones and take notes at the same time. He testified that he was unaware of whether his restrictions stated that he could not write or answer the telephone. No witness testimony was proffered by Respondent disputing Petitioner's assertion that he was told to stay home.

The Arbitrator notes that Dr. Lehman did not see Petitioner for the Section 12 examination until July 14, 2015, at which time he opined that as of the date of the IME he felt that Petitioner could work and that he could certainly work as it related to the December 5, 2014 incident. (RX15). As such, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframe of December 9, 2014 through February 25, 2015, a period of 11 6/7th weeks. Respondent is entitled to a credit for temporary total disability benefits already paid which, per stipulation of the parties, was that of $2,718.90. (AX1).

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRIS SMITH,

Petitioner,

vs. NO: 14 WC 12530

McLAUGHLIN BODY,

Respondent.

18IWCC0773

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and 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.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On March 10, 2014 Petitioner was a Painter's Helper for Respondent. While hanging thirty-five pound Caterpillar fuse boxes, he was climbing up a ladder with a broken wheel when the ladder began to fall. The ladder was sixteen feet tall. Due to the broken wheel, the ladder was rocking while Petitioner was climbing it. He thought the ladder was going to fall, so he jerked up to try to hang the box and then steady the ladder. When he jerked up he felt something pop on the backside of his elbow.

2. Petitioner reported the accident and began receiving medical treatment. He was diagnosed with a sprain and was released to light duty.

3. Petitioner eventually began treating with Dr. Cobb, who performed an EMG. Dr. Cobb prescribed an elbow cast, due to his elbow swelling and pain, and tingling in his fingers. On March 25, 2014 Dr. Cobb administered a cortisone injection and recommended physical therapy.

4. On April 23, 2014 Petitioner was started on Gabapentin. He was released to driving a forklift at work.

5. On April 25, 2014 a positive Tinel's sign was found at the ulnar nerve of Petitioner's left elbow. His Gabapentin dosage was increased due to his increased sensitivity and pain. Dr. Cobb had Petitioner carry 10 pounds. His job duties required him to carry up to 70 pounds. Gradually Dr. Cobb increased the weight, and Petitioner eventually returned to full duty.

6. Petitioner was initially on Gabapentin, but Respondent refused to pay for it and Petitioner was not in a position to pay for it out of pocket.

7. On May 21, 2014 mild tenderness to palpation over medial epicondyle and mild Tinel's over ulnar arm at the elbow was found. On that date his Gabapentin prescription was refilled, as it helped with his sensitivity. Petitioner was released to full duty.

8. Back at full duty, Petitioner experienced pain with heavy lifting, and made the decision that he was not able to continue in this capacity.

9. Petitioner testified that his elbow issues have not fully resolved. He still has swelling and a dull, throbbing pain on the backside of his elbow.

10. Petitioner previously injured his shoulder in 2010. He was unable to lift his arm. However, he testified that this is a different pain that he now feels after the accident in question.

11. Petitioner is now a long-haul truck driver, a position he has held since 2014. After three or four days of driving, he now gets elbow stiffness and joint pain. He gets a pop in his elbow and swelling whenever he does any heavy lifting.

12. As a Truck Driver Petitioner picks up and delivers loads. Occasionally he must throw chains and binders to secure loads, but 99% of the time the loads have already been secured.

13. Petitioner injured his left elbow working for Respondent July 27, 2011. He underwent surgery in October of that year and settled that claim along with the claim for his 2010 accident for a total of $43,434.03, which represented a 15% loss of use of his left elbow and a 12.65% loss of use of his person as a whole for his left shoulder injury.

14. Petitioner last saw Dr. Cobb May 21, 2014. At that time Dr. Cobb told Petitioner his symptoms had resolved with conservative treatment. He has not treated with anyone

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for his elbow since then.

15. Dr. Coe had previously examined Petitioner in 2013 in relation to his 2011 elbow injury. At that time Petitioner had left elbow sensitivity, an ulnar nerve scar and difficulty with activities requiring forceful use of his left arm.

16. On March 25, 2016 Dr. Coe examined Petitioner in relation to the case at bar. Petitioner complained of pain at the inner border of his left elbow, worse with motion, as well as numbness and tingling radiating down his left forearm. Dr. Coe testified that Petitioner had permanent partial disability in his left arm caused by the accident in question.

17. Respondent requested an Independent Medical Examination (IME) from Dr. Mash. Petitioner testified that Dr. Mash did not ask him what he was having difficulty with, did not take any history at all, and only asked Petitioner to lift his arm.

18. According to his IME Report, Dr. Mash examined Petitioner September 12, 2016. Petitioner complained of throbbing and nagging pain. Dr. Mash reviewed reports from Dr. Coe and records from treating physicians and characterized the complaints therein as an exacerbation of left elbow medial epicondylitis, which had resolved. He opined that Petitioner's current symptoms were not worse as a result of the accident in question. Dr. Mash also stated that Petitioner's subjective complaints were not supported by objective findings. He noted a 0% impairment rating as a result of the accident.

The Commission views the evidence slightly different than the Arbitrator, and thus modifies the award for permanent partial disability (PPD). The Commission notes that Dr. Mash found an impairment rating of 0%, however, testimony reveals that he performed a less than cursory exam on Petitioner before rendering his opinion.

Petitioner was a Painter's Helper at the time of accident. He was 46 years old at the time.

Petitioner was released to full duty work, but was still given a refill of Gabapentin, as he still had complaints of pain, stiffness and sensitivity. Accordingly, there seems to be no loss of future earnings capacity for Petitioner.

Based on the testimony and evidence, the Commission modifies the PPD award from an additional 5% loss of use of Petitioner's left arm down to an additional 2.5% loss of use. This 2.5% award is in addition to the existing 15% loss of use award that was part of a previous workers' compensation claim settlement for Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $339.10 per week for a period of 6.325 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused Petitioner a 2.5% loss of use of his left arm, in addition

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to an existing 15% loss of use award that was part of a previous workers' compensation claim.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,400.00. 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: DEC 14 2018
O: 11/1/18
DLG/wde
45

David L. Gore

Stephen Mathis

DISSENT

I respectfully dissent from the Decision of the majority. The majority modified the Decision of the Arbitrator to reduce the award for loss of the use of his left arm from 5% to 2.5%. I would have found that Petitioner did not sustain his burden of proving that the current work-related accident caused any additional impairment to his left arm and denied any additional permanent partial disability benefits.

Petitioner sustained a prior work-related injury to his left elbow on December 2, 2012. That claim was settled on August 16, 2013 for $43,434.03, representing loss of the use of 15% of his left arm. He alleged a new injury to his left elbow on March 10, 2014, while hanging fuse boxes.

In my opinion, Petitioner's testimony was not credible. He testified to ongoing pain and disability that was not corroborated by the medical record. In addition, he displayed many indications of drug-seeking behavior. He repeatedly went through prescriptions of pain medication in one half of the period of time the prescriptions were intended to last. Finally, in his last treatment note, Petitioner's treating doctor, Dr. Cobb, noted that Petitioner's aggravation of the previous condition of ill-being of his left arm had resolved and released him to full duty. The record also indicates that Petitioner worked at full duty without complaints or difficulty thereafter. Dr. Cobb's

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determination was supported by Respondent's Section 12 medical examiner, Dr. Mash, who opined that the temporary exacerbation of Petitioner's left-arm condition had resolved, and his minimal subjective complaints were not supported by objective findings. Dr. Mash also performed an impairment rating under AMA Guides in which he found 0% impairment to his left arm due to the instant accident. I find the opinions of orthopedic doctors, Dr. Cobb and Dr. Mash, more persuasive than Petitioner's Section 12 medical examiner, Dr. Coe, an occupational doctor.

Because of Petitioner's lack of credibility, the opinions of his treating orthopedist and Respondent's Section 12 medical examiner, and his ability to return to work at full duty without any difficulty, I would have found that Petitioner did not sustain his burden of proving that the current work-related accident caused any additional impairment to his left arm and denied any additional permanent partial disability benefits. Accordingly, I respectfully dissent from the decision of the majority.

DLS/dw
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Deborah L. Simpson
Deborah L. Simpson

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

Chris Smith
Employee/Petitioner

v.

McLaughlin Body
Employer/Respondent

Case # **2014** WC **12530**

Consolidated cases: **(N/A)**

18IWCC0773

An *Application for Adjustment 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 **Rock Island**, on **February 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 10, 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 **$29,388.32**, and the average weekly wage was **$565.16**.

At the time of injury, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, commencing on the date of this order, of $339.10/week for 12.65 weeks, because the injuries sustained resulted in an additional 5 % loss of the use of the left arm, over and above the previously paid 15 % of the arm from the prior settlement, as provided in § 8(e) of the Act.

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

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

Signature of Arbitrator

2/27/18
Date

In support of the Arbitrator's decision relating to causal connection and nature and extent, the Arbitrator finds the following:

On March 10, 2014, Petitioner was employed by Respondent in a position that required him to hang car parts on a paint line. The parts could weigh up to 50 pounds and were physically large. The job required him to stand on a ladder, bend down and grab the parts, and hang the parts on hooks or T-bars.

On March 10, 2014, Petitioner was standing on a ladder, and holding a part. As he leaned to his left, he felt the ladder shift. To try to steady himself and the ladder, Petitioner lunged forward. In doing so, he felt a pop in his left arm and developed pain and discomfort in that arm, particularly in the elbow area. He reported the incident to his supervisor and was directed to Concentra, a health care provider. He went later that day. On that visit to Concentra, he was treated by Dr. Patricia Dunbar. Her examination showed mild swelling in the medial aspect of the elbow and a positive Tinel's sign for cubital tunnel syndrome. The diagnosis was left medial elbow sprain and ulnar neuritis. Petitioner was prescribed a muscle rub and extra-strength Tylenol, was instructed not to use his left arm, had it placed in a sling, and was instructed to periodically ice it. He was put on light duty wiping rails with his right arm only.

On March 12, 2014, Petitioner went back to Dr. Dunbar. He was still experiencing pain in the arm, his elbow was tender and swollen, and he experienced tingling in some of his fingers. He was prescribed Skelaxin to take.

On March 21, 2014, Petitioner went back to Dr. Dunbar. He was experiencing the same symptoms and his range of motion was limited, and he had trouble sleeping. He was prescribed hydrocodone and the doctor ordered an MRI.

On March 25, 2014, Petitioner saw Dr. Tyson Cobb, an orthopedist, on referral from Dr. Dunbar. Again the Petitioner had positive findings on examination, and the doctor diagnosed him with medial epicondylitis and left cubital tunnel syndrome. The MRI was interpreted as showing no definite pathology. He was given a cortisone injection. On April 1, 2014, he returned to Dr. Cobb, who sent Petitioner to a physical therapy session and ordered an EMG (a nerve test). From April 7, 2014, through April 15, 2014, Petitioner engaged in physical

therapy at Plaza Physical Therapy. On April 16, 2014, Dr. Anthony Kwan performed an EMG on Petitioner, which showed no nerve damage in Petitioner's elbow.

On April 23, 2014, Petitioner went back to Dr. Cobb, who prescribed him Gabapentin. Dr. Cobb certified Petitioner to return to work driving a forklift. On April 25, 2014, Petitioner returned to Dr. Cobb, who certified him to lift 20 pounds as a weight restriction for one week, then 40 pounds after that.

The Petitioner was seen by Dr. Cobb for the last time on May,21, 2014. He reported that he had been doing his regular work for two weeks and was tolerating it well. He reported minimal pain since he had stopped using Gabapentin. He was wearing his splint at night and reported it was helping him with his cubital tunnel symptoms. On exam, the doctor noted mild tenderness to palpation over the medial epicondyle and mild Tinel over the ulnar nerve at the elbow. His Gabapentin was renewed, and he was allowed to continue full duty. (PX 3)

On May 23, 2014, Petitioner left his work at Respondent. At some point thereafter, he went to work as a truck driver making long hauls. He testified that he experiences pain in the left elbow when cranking dollies and when doing heavy lifting.

On March 26, 2015, Petitioner was examined by Dr. Jeffrey Coe. Dr. Coe found that Petitioner was still experiencing pain and discomfort; Petitioner still was experiencing sensitivity in the inside of his left elbow with radiating tingling down his arm and into his fingers. Petitioner's symptoms had worsened since he stopped taking Gabapentin, which he could no longer afford due to his lack of insurance. Dr. Coe stated, to a reasonable degree of medical certainty, that Petitioner had a permanent partial disability in his left arm caused by the injury of March 10, 2014.

Prior to the accident, Petitioner had suffered an accident that caused him elbow problems in his left arm. He filed a workers' compensation claim in that case and received a settlement was for a 15% loss of the use of his left arm. (RX 1) In that case, surgery was performed. Though no records of that procedure were admitted into evidence, Dr. Coe indicated that he reviewed the reports as well as performing an examination related to that claim. He said that the prior surgery consisted of an ulnar nerve transposition and left medial

epicondylectomy. (PX 6) Dr. Coe testified that on his most recent examination, the Petitioner exhibited new findings consisting of tenderness to palpation of the medial epicondyle. (PX 7 at 41, 42) However, he also acknowledged that the Petitioner had tenderness of the medial epicondyle when he was last seen by Dr. Cobb following his initial surgery on February 15, 2012. (Id at 45) The Arbitrator notes that Petitioner had returned to full duty after the previous injury and was not seen for treatment for a period of about two years.

Respondent sent the Petitioner to see Dr. Mash, an orthopedic surgeon, on September 7, 2016 for a Section 12 examination. Dr. Mash noted a positive Tinel on examination. He determined that the Petitioner had sustained a temporary aggravation of his pre-existing conditions in the accident. He wrote that the Petitioner's medial epicondylitis had resolved. He referenced the AMA Guides, but did not perform a standard evaluation. He was of the opinion that since the Petitioner had a temporary aggravation, his current symptoms were not causally related to his accident. He went on to opine that without causation, the Guides were not relevant. (RX 2)

Respondent adopts the conclusions of Dr. Mash and contends that any current condition the Petitioner may have is not causally related to the accident. It further argues that Dr. Cobb felt that the Petitioner's condition had resolved by May 21, 2014.

The Arbitrator does not agree with the Respondent's interpretation of Dr. Cobb's final examination notes. As stated above, the Petitioner had improved but was not free of symptoms. The doctor's examination was also not completely negative. He still elicited mild tenderness and a positive Tinel's sign. He noted the Petitioner was still using his splint and renewed his prescription. The Petitioner testified that his symptoms have remained as he performed some of his job duties as a truck driver. His complaints to Dr. Coe in March 2015 and to Dr. Mash in September 2016 were basically consistent with what he reported to Dr. Cobb during his final visit in May 2014. While the Petitioner has not gone back for any further treatment, the ongoing symptoms and lack of any intervening event point to the conclusion that his current conditions, originally diagnosed by Dr. Cobb, are causally related to his accident of March 10, 2014.

The Arbitrator has considered each of the factors in § 8.1(b) of the Act, and the consideration of those factors is listed below:

With regard to subsection (i) of §8.1b(b), the Arbitrator gives no weight to the reference to the AMA Guides contained in Dr. Mash's report. As stated above, the doctor did not perform an examination as described in the Guides.

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 parts hanger on a paint line at the time of the accident and an over the road truck driver currently. Both jobs require the use of the arms, so the Arbitrator gives moderate weight to the fact that the Petitioner has and will experience some discomfort performing certain aspects of those jobs.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. The Arbitrator gives moderate weight to this factor, as the Petitioner will presumably work for a fair amount of time while experiencing the above referenced discomfort.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner is working full duty. No evidence was presented which would indicate any future wage loss. No weight is given to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the consistent complaints and examination findings of both Drs. Turner and Cobb, which are referenced above. The evidence establishes that the Petitioner sustained aggravation injuries consisting of mild left medial epicondylitis and mild left cubital tunnel as a result of the accident. The Arbitrator give moderate weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner now has permanent partial disability to the extent of 20% loss of use of his left arm pursuant to § 8 (e) of the Act. Since Respondent is to receive a credit of 15% based on a previous settlement, this award reflects a 5 % loss of his use of the left arm.

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

Aletha Washington,
Petitioner,

18IWCC0774

vs.

NO: 09 WC 38167

Chicago Transit Authority,
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, accident, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2017, is hereby affirmed and adopted.

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

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

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

DATED: DEC 14 2018
o11/15/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0774

WASHINGTON, ALETHA
Employee/Petitioner

Case# 09WC038167
10WC020254

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 7/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1702 GRAZIAN & VOLPE PC
VOLPE, RICHARD S
5722 W 63RD ST
CHICAGO, IL 60638

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

18IWCC0774

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

Aletha Washington
Employee/Petitioner

Case # 09 WC 38167

v.

Consolidated cases: 10 WC 20254

Chicago Transit Authority
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **May 12, 2017**. After reviewing all the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 23, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$48,921.60**; the average weekly wage was **$940.80**.

On the date of accident, Petitioner was **59**years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner has not proven by a preponderance of the evidence that her current condition of ill-being is causally related to the accident dated July 23, 2009. 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.

Aletha Washington
09 WC 38167

FINDINGS OF FACT

The parties agree that on July 23, 2009, Ms. Aletha Washington, (the "petitioner") and the Chicago Transit Authority ("Respondent") were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. They agree that on that date the petitioner sustained accidental injuries that arose out of and in the course of her employment with the Respondent and that the petitioner gave the respondent notice of the accident. They further agree that in the year preceding the injuries, the Petitioner earned $48,921.60 and that her average weekly wage was $940.80. The disputed issues are: (1) is the Petitioner's current condition of ill-being causally connected to the injury alleged; (2) were the medical services provided to the petitioner at Jackson Park Medical Center reasonable and necessary; and [1](3) the nature and extent of the injury.

Petitioner's testimony regarding the claimed accident on 7-23-09

Petitioner testified that she was hired by the respondent as of October, 1999. In 2009, her position was that of a full-time train car servicer, assigned out of Midway station. Her job duties were cleaning entire trains, including but not limited to train car windows and doors. On 7-23-09, Petitioner was in the process of cleaning a train's windows when she pulled the red door handle located above the doors. When the doors only partially separated, she put her hands into the rubber door strips to further separate the doors. They closed on her hands.

Petitioner testified that as required by Respondent's protocol, she completed a report for her claimed injury on duty; and she also received first aid. RX1.

Petitioner testified that "both her hands swelled up right away, she ran cold water on them and applied an ice pack before she was transported to Concentra Medical Center ("Concentra")". Petitioner further testified that when she was seen at Concentra, she voiced complaints of injuries to both hands. The Arbitrator notes that the patient statement taken at Concentra is "I was trying to hold the train door opened (sic) but the door closed on me and smashed my right hand". History of present illness is: "Patient presents with right hand crush injury x 1 day". RX4.

X-rays of the right hand were taken and she was released the same day. She did not return to Concentra for follow-up because she wanted to see her choice of physician. An x-ray of the left hand performed at Diplomate American Board of Radiology, i.e., Dr. Perry Rudich, on August 8, 2009, was read as "No erosion or destruction of bone is seen. No fracture or dislocation is seen. No visualized bony, joint or soft tissues abnormalities are noted. Impression: Normal examination". Petitioner was also seen at the VA hospital on or about 8-28-09, where x-rays were taken of her right hand. PXs 1 & 3.

[1] The outstanding bill in the amount of $5,946.00 is for service dates from 7-31-09 to 10-14-09.

Petitioner testified that she next sought treatment for her injured hands with Dr. Michael Foreman at Jackson Park Medical Center. The treatment provided at that facility consisted of "electronic patches on her hands for her nerves", warm compresses, lidocaine patches and use of a TENS unit. Petitioner further testified that she never received a bill from Dr. Foreman's office nor does she know if his bill was paid.

Petitioner was referred to Dr. Ostric with whom she treated from 8-31-09 to 10-19-09; receiving the same treatment that she received with Dr. Foreman. Petitioner testified that regardless of the treatments she received, she was not getting better.

Petitioner testified that between 7-23-09 through 10-19-09, she worked light duty, which consisted of cleaning windows and no lifting. After she returned to work in a full duty capacity, on or about 10-19-09, she was transferred from Midway Terminal to Jefferson Park. She testified that after she was released from care and back to full duty work, she still had swelling and tingling in her fingers.

Petitioner testified that currently, she has swelling in her hands and it is difficult to open jars. She denied having been previously diagnosed with right epicondylitis[2]. Petitioner testified that prior to her accident on 7-23-09, she was diagnosed with bilateral carpal tunnel syndrome but had never been recommended for release surgery[3]; she had had tingling and swelling in her hands/fingers and had used braces/splints on her hands, prior to the accident.

Evidentiary documents

An "EMPLOYEE'S REPORT OF INJURY ON DUTY" form was prepared and signed by the petitioner on 7-24-09. The reported injury occurred at 11:30 p.m. on 7-23-09 while petitioner was cleaning train car; petitioner pulled door manual release and the doors opened half way when petitioner attempted to spread the doors open but they closed abruptly smashing her right hand; the reported injury/body part effected was "right hand". RX1.

A "SUPERVISOR'S REPORT OF EMPLOYEE INJURY ON DUTY" form completed recorded the history of petitioner's accident noting that claimed injury was a right-hand crush injury. The report goes on to state ... "Actual testing showed the door and its safety systems operating properly-maintenance testing confirmed this." The "FIRST AID LOG" recorded a right-hand crush type injury. RXs 2-3.

Respondent's exhibit 7 entitled "HEALTH CARE PROVIDER CERTIFICATION FAMILY AND MEDICAL LEAVE ACT" dated 6-18-09, pre-dates either of petitioner's claimed work injuries and in relevant part documents her medical condition as follows: "pt.in office-related stress to jts (joints), symptoms include sciatic pain, numbness tingling bl (bilateral) hands, R (right) shoulder pain....."The pt. has informed me that the only aspect of her job that is painful and difficult to do is

[2] VA records offered as P Ex.3, pg. 2770, notes the pre-existing diagnosis of right lateral epicondylitis.

[3] Contrary to petitioner's testimony she was recommended to have release surgery but decline to have procedure(s). (P Ex. 3, pg. 2761)

stair climbing. Questioning the pt. following several treatments. She admitted improvement w/stair climbing." [4]

Concentra medical records

On 7-24-09, Petitioner presented to Concentra complaining that ... "I was trying to hold the train door opened but the door closed on me and smashed my right hand". Petitioner complained of pain located at the dorsum aspect (the back or posterior surface) of the right hand; described the pain as moderate and throbbing; and there was associated redness, swelling and stiffness. Upon physical examination, it was noted that Petitioner was right hand dominant and had tenderness, mild swelling and erythema of the dorsum; and decreased grip strength. An x-ray of the right hand was negative. Petitioner was diagnosed with a crush injury to the hand and given modified work activities of limited use of the right hand, avoiding repetitive grasping. A follow-up was scheduled for 7-28-09. The last time petitioner was seen at Concentra; she was diagnosed with a contusion to the right hand and was to be reassessed on 8-3-09. RX4.

Jackson Park Medical Associates

Petitioner sought treatment with Dr. Michael Foreman from 7-31-09 through 10-14-09. (RX6)[5]. The petitioner complained of injuries to both hands after they were slammed between the car doors; and when she removed the left hand, the doors again shut on her right hand. Petitioner was diagnosed with acute bilateral hand sprain/contusions.[6]

Dr. Srdjan Andrei Ostric

Petitioner treated with Dr. Ostric for injuries sustained in the 7-23-09 accident, from 8-31-09 through 10-19-09, a total of 4 visits. Dr. Ostric's recorded history of the accident was that petitioner's hands (at the base of the metacarpals/wrist area) were smashed as "she had both hands slammed in a machine". Petitioner reported a previous diagnosis of lateral epicondylitis and on physical exam, she was noted to have pain at bilateral lateral epicondyles. Petitioner was diagnosed with bilateral hand contusions and aggravation of her lateral epicondylitis. On 9-17-09, the diagnosis remained bilateral wrist contusions. RX5.

IME –Dr. Michael Vender

On 11-6-09, the petitioner was seen by Dr. Michael Vender, at the request of Respondent, regarding the 7-23-09 accident. The history given was that while petitioner was using her upper extremities to push apart the train doors, the doors snapped onto her hand. She pulled the left hand out and the door then caught her right hand. At the time petitioner presented for the evaluation, she complained of pain in both hands, difficulty with flexion and pain in the lateral elbows. Upon physical examination, the left elbow had pain with firm grip but no pain in the right elbow; no tenderness to palpation in the elbows. X-rays showed degenerative arthritis changes in the right thumb; crepitation was noted bilaterally in the thumb CMC joints. RX8.

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[4] The Arbitrator interprets this chart entry to mean that the provider is questioning the veracity of petitioner's complaints.

[5] The last date billed is for the preparation of narrative report/records on 10-22-09.

[6] The Arbitrator is referencing the narrative report dated 10-15-09 as the actual hand written chart notes are difficult to read.

Dr. Vender diagnosed Petitioner with possible bilateral lateral epicondylitis, right flexor carpi radialis tendinitis; and possible left thumb CMC synovitis. Dr. Vender opined that Petitioner's elbow complaints and the diagnosed condition in the thumb carpometacarpal joints would not be related to her injury of 7-23-09; however, an injury to the area of the flexor carpi radialis at palm of the right wrist could be more consistent with the described nature of the injury. Dr. Vender further opined that the petitioner could continue performing her normal work activities.

Petitioner was seen at the VA on 8-26-09 for the first time after the 7-23-09 reported work accident. She was following-up with the VA to get new night splints for her diagnosed CTS and gave a history of being injured at work when train doors slammed on her hands. She complained of bilateral hand pain and decreased range of motion in her wrists. She did not want to treat at the VA for these complaints. By December, 2009 when Petitioner presented, she did not voice any complaints regarding her hands/wrists and upon physical exam, there were no complaints regarding her upper extremities.

10 WC 202554

On 2-4-10, three (3) weeks before the petitioner's second claimed work injury, she was seen at the VA by Karen Davis, FNP-BC, a board-certified, family nurse practitioner, who had last seen her in May, 2009; approximately two months before the 7-23-09 reported accident. At that time petitioner discussed her desire to take disability pension retirement but due to financial concerns ... "I would like to try to last another two years but I don't know if I can physically do it."

Jesse Brown VAMC records, service dates after the 2-25-10 claimed work injury

Petitioner's exhibit No. 3 is medical records from the VA hospital where she has treated for various medical conditions, within service dates of 8-29-09 through 5-26-16. (PX3)[7] The records show that Petitioner had pre-existing upper extremity conditions diagnosed as: (1) bilateral carpal tunnel syndrome (CTS), with a surgical recommendation and use of night splints; (2) and right lateral epicondylitis treated with cortisone steroid injection. *id* at 2759-2763, 2770-2771.

On 2-26-10, the day after Petitioner claimed an injury to her right upper extremity/elbow after climbing up and boarding a train, she was seen by FNP Davis. At that time, she wanted a "note to stay off work because of worsening right elbow pain. Has very physically demanding job. Persistent right elbow pain." Upon examination, she was noted to have right elbow tenderness to palpation over medial and lateral epicondyle areas. She was referred to the orthopedic department wherein she was found to be diffusely tender and very painful with all forearm and wrist motion; she was released to return to light duty, i.e., no lifting greater than 5 pounds or push/pull with right arm. *id* at 2759-2760. Petitioner was referred to physical therapy and issued a strap for the right elbow.

[7] The exhibit of records is broken down by the provider in sectioned headings- review of same shows that section **"Progress Notes"** starts with the service date of 8-29-09 on pages 2770-2771 and ends with the service date of 5-26-16 on page 793. The exhibit only records services rendered after petitioner's 7-23-09 accident but the exhibit does contain to some extent petitioner's pre-existing medical history relevant to her claimed injuries; other diagnosed conditions petitioner received treatment for include her spine, degenerative arthritis, right shoulder, right knee, left ankle/foot (surgery in May, 2010), right leg/hip, fibromyalgia, pulmonary embolisms and PTSD.

On 3-10-10, Petitioner was seen at the VA's pain management and rehabilitation (PMR) department for consultation. *id* at 2755-2757. Her recorded history was that she presented for an evaluation for her right elbow and hand pain; she had a history of trauma ... "to her right hand when she got it caught in a bus door while on the job..."[8].... "She had an acute exacerbation of pain last month related to pulling her body weight into a train." The assessment was acute, chronic inflammation of right elbow and wrist secondary to trauma soft tissue injury. On 5-25-10, it was noted in the chart note that Petitioner was complaining of bilateral shoulder complaints, with minimal to moderate loss on motion depending on pain level.[9] PX3, pp. 2740-2742.

On 6-11-10, Petitioner had a follow-up appointment with the orthopedic department where she was referred for an MRI of the right elbow and an EMG. PX3, pp. 2738-2740. The records reflect that Petitioner had an MRI of the right elbow on 7-12-10. *id* at 2733—2736.

On 7-15-10, Petitioner presented to the VA's ER with left shoulder complaints after having a right upper extremity MRI wherein she ... "had to lie in an awkward position on table due to weight. Pt. states the machine "accidently fell on her left shoulder" she felt a "crushing pain", and then had them pull her out. She was diagnosed with possible muscular strain/contusion but no hematoma was identified. The MRI was indicative of medial epicondylitis and a cortisone steroid injection was given, *id* at 759-760. As to the claimed left shoulder injury, Petitioner followed-up in VA's orthopedic department on 7-23-10, where she reported that the machine came down and hit her left shoulder during the exam. The left shoulder was assessed as a muscular strain with no resulting restrictions from an orthopedic standpoint. *id* at 2733-2734.[10]

On 11-1-10, Petitioner followed-up in the orthopedic department for her right elbow and newly claimed left shoulder injury. The clinical history indicated that her left shoulder was injured because she got stuck in the MRI imaging machine. The examination of her left upper extremity suggested it was limited secondary, by the petitioner's efforts; and the severity of her reported pain could not be objectively explained, based on clinical examination and diagnostic findings. PX3, pp. 2669-2670.

On 11-4-10, Petitioner presented to FNP Davis to have her complete paperwork for disability. ... "I am just hurting all over. My knees are killing me. There is no way I can go back and do what I was doing at work. Pt states there is no light duty for her and they are not going to put her in any other position." Accordingly, Davis authored a letter on 11-4-10 stating that Petitioner was ... "unable to return to her job at CTA due to her inability to perform any job that requires physical labor. Her chronic polyarthropathy with significant elbow, shoulder and knee pain significantly limit her ability to perform physical labor." PX3, pg. 2667.

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[8] It is noted that the reference is again related to an injury occurring only to the right hand in the 7-23-09 accident.

[9] This is a reference to pre-existing left shoulder complaints and deficits even before the alleged injury to the left shoulder during the right elbow MRI.

[10] After the initial history given days as to how the left shoulder was injured, the subsequent records go on to recite a history of the petitioner being manhandled in order to extract her from the MRI machine which caused the claimed left shoulder injury. Also of note is that petitioner mentioned that her left elbow was hurting her as well at that time without giving any further history.

On 11-19-10, Petitioner underwent a rheumatology consult, inclusive of her upper extremities, for multiple joint pain. The left shoulder film was reviewed as essentially normal except for minimal degenerative spurring; the right elbow film was reviewed as showing a large effusion seen-edematous changes noted, overlying the medial collateral ligament likely representing epicondylitis. Physical examination revealed reduced abduction and tenderness, with internal rotation of the shoulders bilaterally; reduced extension of elbows bilaterally, as well as bilateral deficits of the wrists and knees. The assessment was that the petitioner had multiple joint pain of unclear etiology reminiscent of fibromyalgia as she had diffuse pain; the right elbow MRI ... "shows an elbow effusion meaning there is some kind of arthropathy in the elbow joint. they suggest epicondylitis on the MRI but there is such diffuse pain and dramatic response to palpation everywhere we would be hard pressed to make that diagnosis on physical exam." PX3, pp. 2663-2667.

In follow-up with pain management rehabilitation on 12-14-10, Dr. Panchal assessed Petitioner's left shoulder pain as likely related to a more metabolic cause, given her generalized discomfort versus anything affecting the structural integrity of the shoulder. (PX3, pg. 2657). Thereafter the VA records reflect a diagnosis of fibromyalgia for the aforesaid areas of her upper and lower extremities, bilaterally, even though her alleged injuries were never to her bilateral elbows or shoulders. *id.* at 483; 735-744;2420-2421; 2461-2463; 2560-2562; 2567-2570; 2583-2587.

Petitioner was hospitalized in October, 2015 for diagnosed fibromyalgia. *id.* at 403- 404. Also, the records reflect other claimed injuries in June, 2011 when she was in a stampede of people and fell. *id* at 2612; or when she fell in the shower in July, 2012. *id.* at 2461.

CONCLUSIONS OF LAW

09 WC 38167

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v. Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. *Id.* The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much

his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); *see also Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor v. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see also, Seiber v. Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v. Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

The Arbitrator finds Petitioner's current condition of ill-being regarding her bilateral hand/wrist, is not causally related to the 7-23-09 accident. The Arbitrator questions whether Petitioner even injured her left hand/wrist on the aforesaid date as the initial report of injury on duty references the right hand only, as does the initial medical chart note from Concentra for the service date of 7-24-09.[11] As for the right hand/wrist there was tenderness, mild swelling and redness of the dorsum of the hand but no bruising or sensory loss. The diagnosis was a contusion with a recommendation to limit activities of the right hand and avoid repetitive grasping. There was no recommendation for therapy of further work-up and Petitioner was to return for follow-up on 7-28-09 and again on 8-3-09.

The petitioner thereafter sought additional treatment with Dr. Foreman at Jackson Park Medical that she testified did not relieve her symptoms and for which she never received billing. She was also seen by Dr. Ostric, who diagnosed her with bilateral wrist contusions and bilateral epicondylitis, even though that was not what she complained was injured at work.

The VA records establish a pre-existing diagnosis of bilateral carpal tunnel syndrome, severe to the degree that surgery was recommended but declined by the petitioner. Also, evident from the VA records is a history of the right hand being involved in an accident on 7-23-09; and other events where both of Petitioner's hands were smashed. But what is not contradictory is that Petitioner had ongoing complaints of multiple joint pain in her upper and lower extremities and was diagnosed with fibromyalgia; having the same symptoms initially complained of regarding her claimed work injuries.

[11] Neither complaints of the left hand nor any physical examination findings were recorded.

Regardless of which hand was involved in the accident, it is apparent that Petitioner sustained a contusion to the right hand and that it resolved shortly after the accident. This is supported by Petitioner's testimony that she continued to work and missed no time; transitioned from light duty to full duty as of 10-19-09. Also, the medical records, inclusive of the VA records show that any complaints as to the hands resolved to the point where she was only symptomatic consistent with her pre-existing CTS and fibromyalgia. There is no evidence of sequela at present, from the diagnosed hand contusion.

Were the medical services that were provided to Petitioner reasonable and necessary?
For the reasons set forth above, the Arbitrator finds that the bill in the amount $5,946.00 for services rendered at Jackson Park Medical Center is not reasonable, necessary or related to the to the 7-23-09 accident.

What is the nature and extent of the injury?
For the reasons set forth hereinabove the Arbitrator finds that petitioner did not sustain a permanent partial disability for any accidental injury sustained on 7-23-09.

Aletha Washington
10 WC 20254

FINDINGS OF FACTS
The parties agree that on February 25, 2010, the petitioner and the respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. They further agree that in the year preceding the injuries, the Petitioner earned $50,648.00 and that her average weekly wage was $974.00. Lastly, the parties agree that Petitioner received one week of full salary pay after 2-25-10 in addition to receiving $5,200.00 in other benefits for which Respondent asserts an 8(j) credit if determined Petitioner is due and owed any temporary total disability benefits.

The parties disagree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute. The parties further disagree that petitioner's current condition of ill-being is resulting from the alleged and disputed accident and thus accordingly Respondent disputes petitioner is due and owed any temporary total disability benefits.
At issue in this hearing is as follows: (1) did Petitioner sustain accidental injuries arising out of and in the course of her employment with Respondent; (2) did Petitioner give notice of a work injury to Respondent; (3) is the Petitioner's current condition of ill-being causally connected to the injury alleged; (4) is Petitioner entitled to temporary total disability benefits and if so what 8(j) credit is Respondent entitled to; and (5) the nature and extent of the injury.

Petitioner's testimony regarding the claimed accident of 2-25-10

Petitioner testified that she was hired by Respondent ("CTA") as of October, 1999. In 2009 her position was that of a full-time train car servicer, assigned from Midway station; her job duties were cleaning entire trains, including but not limited to, windows and doors.

Petitioner testified that on 2-25-10, she was being observed by her supervisor as to how she performed her duties. She was in the process of boarding a train car from the track level, which was accomplished by holding onto a grab bar, placing her left foot up on a stirrup then lifting herself to place her right foot up in a stirrup, bringing her right foot up into the train and reaching around the train door to place her arm into the train to complete the process of hoisting herself up from the left stirrup and into the train. Petitioner testified the distance from ground/track level and into the train was approximately three and one-half feet (3.5').

Petitioner testified that she injured her right arm/elbow on 2-25-20, when she reached her right arm around the train door. It felt as if her right elbow was pulling out of her arm. Petitioner testified that her supervisor, who was present, helped her back down off the train and let her go home for the remainder of the day.

Petitioner testified that after that accident, she never completed the mandatory injury on duty forms, nor was her claimed injury memorialized because when she went to do so, the supervisor who was present, no longer worked at that location. Petitioner testified that she did call in to report the accident but because her supervisor was no longer there, nothing was documented. When Petitioner was cross-examined as to whether she presented to location to complete the mandatory report of injury form, as she did in the 2009 accident, she testified that she did not.

Petitioner testified that she sought treatment for her right elbow injury at the VA hospital. She testified that her right arm hurt from the elbow down to the wrist area. She was referred to physical therapy and eventually was sent for an MRI of the right elbow on 7-12-10. Petitioner testified that her left shoulder was injured during the process of taking her MRI, which was difficult due to her size. Petitioner described being forced into the machine with her left shoulder pushed in and upwards, causing pain. Petitioner testified that after that failed MRI attempt she was manually taken to the other side of the VA hospital to have the MRI taken in another machine. Petitioner completed an "incident report" describing this occurrence. PXs 3 & 4.

Petitioner testified that she continued to treat at the VA hospital for her work injury to the right elbow for approximately six (6) months, during which time she observed her swelling in the right elbow diminish.

Petitioner further testified that effective 1-5-11, she was on disability pension from CTA and that after her 2-25-10 accident, she never returned to work. She testified that there was no light duty for her to perform. However, on cross-examination petitioner did concede that she never presented herself nor made herself available for light duty work during the period of 2-25-10 through 1-5-11.

Petitioner testified that she received 26 weeks of short term disability benefits, for a total of $5,200.00, plus 1 week of salary. Petitioner testified that as a result of her work injuries, she was permanently disabled from returning to work at CTA and was provided with a letter to that affect, authored by Karen Davis, FNP-BC. Petitioner testified that during her work-up for her work injuries she also had other multiple health conditions that contributed to her permanent disability. PX3, pp. 2667-2668.

Petitioner further testified that before the 2-25-10 accident, she had not been diagnosed with right epicondylitis and had never received any therapeutic injection(s) for same; nor did she have any treatment for any shoulder complaints.

Evidentiary documents

Respondent's exhibit 7 entitled "HEALTH CARE PROVIDER CERTIFICATION FAMILY AND MEDICAL LEAVE ACT" dated 6-18-09, pre-dates either of petitioner's claimed work injuries and in relevant part documents her medical condition as follows: "pt.in office-related stress to jts (joints), symptoms include sciatic pain, numbness tingling bl (bilateral) hands, R (right) shoulder pain"....."The pt. has informed me that the only aspect of her job that is painful and difficult to do is stair climbing. Questioning the pt. following several treatments. She admitted improvement w/stair climbing." [12]

Dr. Srdjan Andrei Ostric

Petitioner treated with Dr. Ostric for injuries sustained on 7-23-09. Petitioner reported a previous diagnosis of lateral epicondylitis and on physical exam she was noted to have pain at bilateral lateral epicondyles. Petitioner was diagnosed with bilateral hand contusions and aggravation of her lateral epicondylitis. RX5.

IME –Dr. Michael Vender

On 11-6-09 petitioner presented to Dr. Michael Vender, by request of Respondent, regarding the 7-23-09 accident. At the time petitioner presented for the evaluation she complained of pain in both hands, difficulty with flexion and pain in the lateral elbows. Upon physical examination, the left elbow had pain with firm grip but no pain in the right elbow; no tenderness to palpation in the elbows. X-rays showed degenerative arthritis changes in the right thumb; crepitation noted in the right and left thumb CMC joint. RX8.

Dr. Vender diagnosed the petitioner with possible bilateral lateral epicondylitis, right flexor carpi radialis tendinitis and possible left thumb CMC synovitis. Dr. Vender opined that petitioner's elbow complaints and the diagnosed condition in the thumb carpometacarpal joints would not be related to the injury of 7-23-09.

Jesse Brown VAMC records- service dates after the 2-25-10 claimed work injury

Petitioner's exhibit No. 3 is medical records from the VA hospital showing that the petitioner has treated for various and numerous medical conditions, within service dates of 8-29-09 through 5-26-

[12] The Arbitrator interprets this chart entry to mean that the provider is questioning the veracity of petitioner's complaints.

16. PX3.[13] The records show that Petitioner had pre-existing upper extremity conditions diagnosed as: (1) bilateral carpal tunnel syndrome (CTS), with a surgical recommendation and use of night splints; and (2) right lateral epicondylitis, treated with cortisone steroid injection. *id* at 2759-2761, 2770-2771.

Petitioner was seen at the VA on 8-26-09 for the first time after the 7-23-09 reported work accident. She was following-up with the VA to get new night splints for her diagnosed CTS when she gave a history of being at work when injured by the train doors slamming on her hands; she complained of bilateral hand pain and decreased range of motion in her wrists; she did not want to treat at the VA for these complaints. By December, 2009, when the petitioner is seen, she does not voice any complaints regarding her hands/wrists; and upon physical exam, there are no complaints as to her upper extremities. *id* at 2768-2763.

On 2-4-10, three weeks before the petitioner's second claimed 2-25-10 work injury, she was seen at the VA by Karen Davis, FNP-BC, a board certified, family nurse practitioner, who had last seen her in May, 2009; approximately two months before the 7-23-09 reported accident. At that time, the petitioner discussed her desire to take disability pension retirement but due to financial concerns ... "Would like to try to last another two years but I don't know if I can physically do it."

On 2-26-10, the day after Petitioner claimed an injury to her right upper extremity/elbow after climbing and boarding a train, she was seen by FNP Davis. She wanted a "note to stay off work because of worsening right elbow pain. Has very physically demanding job. Persistent right elbow pain." PX3, pg. 2761.

Upon examination, she was noted to have right elbow tenderness to palpation over medial and lateral epicondyle areas. She was referred to the orthopedic department wherein on 3-5-10 she was found to be diffusely tender and very painful with all forearm and wrist motion; she was released to return to light duty, i.e., no lifting greater than 5 pounds or push/pull with the right arm, *id* at 2759-2760. Petitioner was referred to physical therapy and issued a right elbow strap, *id* at 2758.

On 3-10-10 petitioner was seen at the VA's pain management and rehabilitation (PMR) department for consultation. *id* at 2755-2757. At that time her recorded history was that she presented for an evaluation for her right elbow and hand pain; she had a history of trauma ... "to her right hand when she got it caught in a bus door while on the job..."[14].... "She had an acute exacerbation of pain last month related to pulling her body weight into a train." The assessment was acute, chronic inflammation of right elbow and wrist secondary to trauma soft tissue injury. On 5-25-10 it was noted

[13] The exhibits of records are broken down by the provider in sectioned headings- review of same shows that section "Progress Notes" starts with the service date of 8-29-09 on pages 2770-2771 and ends with the service date of 5-26-16 on page 793. The exhibit only records services rendered after petitioner's 7-23-09 accident but the exhibit does contain to some extent petitioner's pre-existing medical history relevant to her claimed injuries; other diagnosed conditions petitioner received treatment for include her spine, degenerative arthritis, right shoulder, right knee, left ankle/foot (surgery in May, 2010), right leg/hip, fibromyalgia, pulmonary embolisms and PTSD.

[14] It is noted that the reference is again related to an injury occurring only to the right hand in the 7-23-09 accident.

in the chart note that the petitioner was complaining of bilateral shoulder complaints with minimal to moderate loss on motion depending on pain level.[15] PX3, pp. 2740-2742.

On 6-11-10, Petitioner had a follow-up with the orthopedic department where she was referred for an MRI of the right elbow and an EMG. PX3, pp. 2738-2740. The records reflect that the petitioner had an EMG on 7-9-10 and an MRI of the right elbow on 7-12-10. *id* at 775-776; 2733—2735.

On 7-15-10, Petitioner presented to the VA's ER with left shoulder complaints, after having a right upper extremity MRI wherein she ... "had to lie in an awkward position on table due to weight. Pt. states the machine "accidently fell on her left shoulder" she felt a "crushing pain", and then called for them to pull her out. She was diagnosed with possible muscular strain/contusion but no hematoma was identified. The MRI was indicative medial epicondylitis and a cortisone steroid injection was recommended and given. id at 759-760. As to the claimed left shoulder injury, Petitioner followed-up in VA's orthopedic department on 7-23-10, where she reported that the machine came down and hit her left shoulder during the exam; the left shoulder was assessed as a muscular strain with no resulting restrictions from an orthopedic standpoint, *id* at 2733-2736.[16]

On 11-1-10, Petitioner followed-up in the orthopedic department for her right elbow and newly claimed left shoulder injury. The clinical history indicated that her left shoulder was injured because she got stuck in the MRI imaging machine; her examination of the left upper extremity suggested it was limited secondary to the petitioner's efforts; and the severity of her reported pain could not be fully explained based on clinical examination and diagnostic findings. PX3, pp. 2669-2670.

On 11-4-10, Petitioner presented to FNP Davis to have her complete paperwork for disability ..... "I am just hurting all over. My knees are killing me. There is no way I can go back and do what I was doing at work. Pt states there is no light duty for her and they are not going to put her in any other position." Accordingly, Davis authored a letter on 11-4-10 stating that petitioner was ... "unable to return to her job at CTA due to her inability to perform any job that requires physical labor. Her chronic polyarthropathy with significant elbow, shoulder and knee pain significantly limit her ability to perform physical labor." PX3, pp. 2667-2669.

On 11-19-10, Petitioner underwent a rheumatology consult for multiple joint pains inclusive of her upper extremities complaints. At that time the left shoulder film findings were recorded as essentially normal except for minimal degenerative spur; right elbow film findings were recorded as large effusion seen-edematous changes noted overlying the medial collateral ligament likely representing epicondylitis; physical exam revealed reduced abduction and tenderness with internal rotation of the shoulders bilaterally, reduced extension of elbows bilaterally as well as bilateral deficits of the wrists

[15] This is a reference to pre-existing left shoulder complaints and deficits even before the alleged injury to the left shoulder during the right elbow MRI.

[16] After the history given days after the MRI was taken as to how the left shoulder was injured, the subsequent records go on to recite a history of the petitioner being manhandled in order to extract her from the MRI machine which caused the claimed left shoulder injury. Also of note is that petitioner mentioned that her left elbow was hurting her as well at that time without giving any further history.

and knees. The assessment was that Petitioner had multiple joint pains of unclear etiology reminiscent of fibromyalgia as she had diffuse pain; the right elbow MRI ... "shows an elbow effusion meaning there is some kind of arthropathy in the elbow joint. They suggest epicondylitis on the MRI but there is such diffuse pain and dramatic response to palpation everywhere we would be hard pressed to make that diagnosis on physical exam." PX3, pp. 2663-2667.

In follow-up with pain management rehabilitation on 12-14-10, Dr. Panchal assessed Petitioner's left shoulder pain as likely related to a more metabolic cause given her generalized discomfort versus anything affecting the structural integrity of the shoulder. PX3, pg. 2657. Thereafter the VA records reflect Petitioner's diagnosis to be fibromyalgia for the aforesaid areas of her upper and lower extremities, bilaterally. The Arbitrator notes that her alleged injuries were never to her bilateral elbows or shoulders, *id* at 483; 735-744; 2420-2421; 2461-2463; 2560-2562; 2567-2570; 2583-2587. Petitioner was hospitalized in October, 2015 for her diagnosed fibromyalgia. *id* at 403- 404. Also, the records reflect other claimed injuries in June, 2011, when she fell in a stampede of people, *id* at 2612; or when she fell in the shower in July, 2012, *id* at 2461.

CONCLUSIONS OF LAW

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

To be compensable under the Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." Ill.Rev.Stat.1991, ch. 48, par. 138.2. The claimant has the burden of establishing both requirements. (*Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.) An injury " 'arises out of' one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12. "An injury is received in the course of employment where it occurs within a period of employment, at a place where the worker may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto". *Scheffler Greenhouses, Inc. v. Industrial Comm'n* (1977), 66 Ill.2d 361, 367, 5 Ill.Dec. 854, 362 N.E.2d 325.

When determining the above issues the Arbitrator must carefully weigh all evidence presented, including the credibility and testimony of the petitioner. The weight of a witness's testimony depends upon that witness's personal credibility. Once the petitioner's credibility is questioned, the concept of truthfulness becomes critical. It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require than an award be entered or

affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E.2d 307 (1956). The Arbitrator relies on the medical records and evidence presented into evidence.

The Arbitrator finds that Petitioner has not proven, by a preponderance of the evidence, that she sustained an accidental injury arising out of and in the course of her employment on 2-25-10. The Petitioner testified that she was climbing onto the train as she ordinarily did time and time again but felt pain in her right elbow, when doing so. Petitioner has a pre-existing diagnosis of right elbow epicondylitis, with complaints of her right elbow within the month of the alleged accident, which she denied during her testimony. Petitioner becoming symptomatic on 2-25-10, does not automatically establish that she aggravated or exacerbated her pre-existing condition.

The Arbitrator notes that even though all the medical records offered into evident are for dates of service after the two claimed accidents, there is enough in those records to conclude that Petitioner had ongoing complaints of right epicondylitis prior to the claimed work injuries; had received treatment for that condition; and that she was still symptomatic. The Arbitrator notes that on 2-4-10, three (3) weeks before the claimed 2-25-10 alleged accident, Petitioner was seen by Karen Davis, FNP-BC, and voiced her ongoing difficulty in doing her work activities and how she would like to retire due to same, but for financial concerns.

The petitioner testified that she never filled out an Injury on Duty form or any other documentation that is requisite for a CTA employee when claiming an injury on duty. Her explanation was that on the day of the accident she was with a supervisor who knew of her accident and just let her go home without any documentation as to the event. Petitioner also testified that when she called in the following day to the location, she was not able to report anything because the supervisor was no longer there. It is evident that the petitioner was aware of the procedures to be followed regarding a work accident, as evidenced by the Report of Injury on Duty form that she completed after her claimed accident on 7-23-09.

Petitioner has failed to prove that she sustained a compensable accidental injury upon review of the medical evidence presented. The initial chart notes regarding complaints of right elbow pain on 2-26-10, refer to persistent right elbow pain with no history of a 2-25-10 work injury. The petitioner was voicing the same complaints of right elbow pain she was experiencing as noted in the 2-4-10 chart note and going back to May, 2009.

The medical records also state that Petitioner had multiple joint complaints regarding her upper and lower extremities bilaterally, which was diagnosed as fibromyalgia. The Arbitrator relies on the rheumatologist's consult that concluded that the petitioner had multiple joint pains of unclear etiology reminiscent of fibromyalgia as she had diffuse pain; the right elbow MRI ... "shows an elbow effusion meaning there is some kind of arthropathy in the elbow joint. they suggest epicondylitis on the MRI but there is such diffuse pain and dramatic response to palpation everywhere we would be hard pressed to make that diagnosis on physical exam."

The Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment by Respondent therefore, no benefits are awarded, pursuant to the Act. In that an accident has not been proven, all other disputed issues are moot and will not be addressed.

ARBITRATION DECISION
09WC 38167 & 10WC20254
SIGNATURE PAGE

18IWCC0774

Signature of Arbitrator

July 5, 2017
Date of Decision

JUL 5 - 2017

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

Aletha Washington,
Petitioner,

vs.

Chicago Transit Authority,
Respondent.

18IWCC0775

NO: 10 WC 20254

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, accident, causal connection, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2017, is hereby affirmed and adopted.

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

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

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

DATED: DEC 14 2018
o11/15/18
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 ARBITRATOR DECISION

18IWCC0775

WASHINGTON, ALETHA
Employee/Petitioner

Case# **10WC020254**

09WC038167

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 7/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1702 GRAZIAN & VOLPE PC
VOLPE, RICHARD S
5722 W 63RD ST
CHICAGO, IL 60638

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

Aletha Washington
Employee/Petitioner

Case # **10** WC **20254**

v.

Consolidated cases: **09 WC 38167**

Chicago Transit Authority
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **May 12, 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

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

FINDINGS

On **February 25, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this incident ***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 **$50,648.00**; the average weekly wage was **$974.00**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$5,200.00** under Section 8(j) of the Act.

ORDER

Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of her employment by 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.

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

Kelly Hobbs,
Petitioner,

vs.

City of Chicago,
Respondent.

18IWCC0776

NO: 06 WC 53619

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 4, 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: DEC 14 2018
o11/15/18
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 ARBITRATOR DECISION

18IWCC0776

HOBBS, KELLY
Employee/Petitioner

Case# **06WC053619**

CITY OF CHICAGO
Employer/Respondent

On 8/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0494 JOSEPH J SPINGOLA
ATTORNEY AT LAW
1314 KENSINGTON SUITE 3843
OAK BROOK, IL 60522-7133

0766 HENNESSY & ROACH PC
CHRISTOPHER JARKOW
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

18IWCC0776

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

Kelly Hobbs
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **06 WC 53619**

An *Application for Adjustment 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 **July 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 8, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**60,632.21**; the average weekly wage was $**1,166.00**.

On the date of accident, Petitioner was **43** years of age, ***single*** 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 $**238,644.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**8,768.15** for other benefits, for a total credit of $**247,412.87**.

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

ORDER

Respondent shall pay Petitioner maintenance benefits of $777.33/week for 146 6/77^{ths} weeks, commencing September 30, 2014 through July 20, 2017, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner $600.00 for the functional capacity evaluation of June 14, 2014.

Respondent shall pay Petitioner of $619.97/week for a period of 125 weeks because the injury caused the 25% loss of the person as a whole as provided in Section 8(d)(2) of the Act.

Petitioner's claims for penalties are denied.

Respondent shall receive a credit of $8,768.15 for an advance made for permanency.

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

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

Milton Black

Signature of Arbitrator

August 4, 2017
Date

AUG 4 - 2017

PROCEDURAL HISTORY

This is the third hearing before this Arbitrator.

The first arbitration hearing occurred on January 27, 2009. In a March 16, 2009 decision, this Arbitrator made a finding of causation, awarded temporary total disability benefits through the hearing date, and awarded prospective medical treatment consisting of prescribed epidural injections. There were no appeals.

The second arbitration hearing occurred on May 21, 2013. In a July 8, 2013 decision, this Arbitrator made a finding of causation, awarded additional temporary total disability benefits through January 13, 2013, the date of Dr. Graf's Section 12 report, denied prospective medical treatment, and denied penalties and attorneys' fees. There were no appeals.

Both of those decisions are the law of the case.

This matter proceeded to a third arbitration hearing on July 20, 2017. The issues in dispute are causal connection, an unpaid medical bill, maintenance, penalties and attorneys' fees, and the nature and extent of the injury.

FACTS

Petitioner testified is was currently employed with the City of Chicago as a motor truck driver and that has not worked since November 8, 2006, the accident date. Petitioner testified that her primary job duties involved driving a dump truck, mainly used for transporting asphalt. Petitioner testified that her job duties as a motor truck driver included transporting loads of asphalt to various sites around the City and performing various maintenance tasks including checking the oil and other fluids and rolling and unrolling a tarp located in the bed of the truck. Petitioner testified that a tarp was rolled over hot asphalt to preserve heat. Petitioner testified that she would need to climb on sections of the truck to perform those duties, and she referred to specific truck photographs (PX1A through PX1F).

Petitioner testified she has difficulty walking with one leg being stronger than the other. Petitioner testified that she was taking ibuprofen for pain symptoms. Petitioner testified she could perform activities of daily living. Petitioner testified she can use a computer.

Petitioner testified that she reported for full duty work on September 30, 2014 but was a not permitted to do so, because she did not have a medical release. She was placed on "ordinary disability leave of absence" as explained in a letter to her from Respondent (PX16). Petitioner now argues that Respondent's failure to return Petitioner to work contradicts Dr. Graf's opinions, upon which Respondent relies.

On June 14, 2014, Petitioner underwent a functional capacity evaluation (FCE) at Chicago Rehabilitation Services. Petitioner did so at her at her own expense of $600.00. The FCE evaluator concluded that Petitioner could return to work within the light physical demand category with lifting below the waist to 17 pounds, lifting shoulder height up to 20 pounds, and 20 pounds overhead (PX7).

The evaluator concluded that the FCE was a valid representation of Petitioner's physical capabilities. However, the FCE specifically documents signs showing an inconsistency of effort. The following items were deemed to be inconsistent during the assessment: right five span grip inconsistencies; biomechanical

inconsistencies between floor to waist and shoulder height lifting; biomechanical inconsistencies between floor to waist and overhead lifting and biomechanical inconsistencies between floor to waist in job specific lifting (PX7, Page 9 of 16).

Additionally, the FCE evaluator noted that Petitioner had a Waddell score of 3 out of 5, which was noted to suggest a positive Waddell sign and the potential for unreliable pain reports during functional testing (PX7, Page 10 of 16).

Additionally, the FCE evaluator noted a score of 48% on the Oswestry Low Back Disability Questionnaire, which may suggest the potential for unreliable pain reports during functional testing (PX7, Page 10 of 16).

Additionally, the FCE evaluator noted that the reliability of Petitioner's pain and showed the following factors to be determined to represent unreliable pain reports: positive Waddell signs; poor psychodynamics during McGill Pain Questionnaire and Oswestry Low Back Disability Questionnaire; pinch testing; gross motor coordination (PX7, Page 10 of 16).

Petitioner's treating physician, Dr. Slack, opined that Petitioner is unable to return to work as a truck driver. Dr. Slack referenced the functional capacity evaluation. (PX2).

Petitioner's examining physician, Dr. Chmell, opined that Petitioner is unable to return to work as a truck driver. At his evidence deposition Dr. Chmell testified regarding the functional capacity evaluation (PX11).

Respondent's examining physician, Dr. Graf, persists in his opinion that Petitioner is able to return to full duty work. At his evidence deposition Dr. Graf testified regarding the functional capacity evaluation (RX1).

On December 15, 2014, Petitioner retained Mr. Steven Blumenthal, a vocational rehabilitation specialist. In his report, Mr. Blumenthal stated that Petitioner had reported that she began working for the City of Chicago, Department of Transportation since 1988 as a truck driver. He further stated that Petitioner reported that in 1995, she was "taken off the truck and was placed in an office as a 'Lot Supervisor' although her official title was 'Foreman of Motor Truck Drivers'" (PX10, p5).

Petitioner testified that she never worked in the supervisory capacity described by Mr. Blumenthal. Petitioner denied telling Mr. Blumenthal she ever worked in the capacity described in his report. Petitioner testified that Mr. Blumenthal's summary was an inaccurate description of her job duties.

Mr. Blumenthal ultimately concluded that Petitioner could work in generalized positions including, usher, cashier, clerk, receptionist, information clerk, or general office clerk. Mr. Blumenthal concluded that these wages would be approximately $8.75 per hour to $10.30 per hour (PX10, pp11-12).

Petitioner testified that she had applied to a number of employers but that she was unable to recall accurate details.

Respondent offered a Vocational Rehabilitation File Review and Labor Market Survey authored by Ms. Jacqueline Bethell and Jamie Anderson dated April 19, 2017.

Ms. Bethel ultimately concluded that Petitioner could earn $10.25 per hour to $26.25 per hour with a median entry-level wage provided $17.12 per hour (RX8. Pp 2-3).

CAUSATION

The Arbitrator finds that Petitioner's current condition of ill being remains causally related to the injury of November 8, 2006.

Petitioner has had continuing complaints, although embellished, since her work accident. Petitioner's current condition of ill being is well-documented in the medical treatment records as well as in Dr. Chmell's medical testimony.

MEDICAL

Petitioner claims for reimbursement for her $600.00 out of pocket payment for the functional capacity evaluation and report (PX7).

Respondent disputes this medical claim and argues that pursuant to the law of the case Petitioner was at maximum medical improvement as of July 13, 2013.

Respondent's dispute does not take into consideration that maximum medical improvement can be a changing condition. By way of example, Section 19(h) specifically states that an agreement or award for benefits may be reviewed if there is a recurrence, increase, diminishment, or ending of a disability.

The Arbitrator notes that the functional capacity evaluation has been relied upon by the parties, the physicians, and the attorneys in this case.

Based upon the foregoing, the Arbitrator finds that the Petitioner's claim for reimbursement is allowed.

MAINTENANCE

Petitioner reported to full duty work on September 30, 2014. Petitioner reported back to full duty work after Respondents physician, Dr. Graf, found that she could return to work. Petitioner reported back to full duty work, because this Arbitrator so found in the second Arbitration Decision in this matter.

When Petitioner attempted to return to work she was told she could not do so, because she did not have a medical release from her physician.

Respondent created an inconsistent position and placed Petitioner in the middle. Respondent compounded its position by placing Petitioner in non-Worker's Compensation disability status, despite the fact that Dr. Graf had stated Petitioner could return to work. Respondent could have, but did not, rely on its own physician's report. Respondent could have, but did not, rely on that Decision of this Arbitrator, which it sought and obtained.

The Arbitrator notes that both Petitioner and Respondent have obtained vocational rehabilitation assessments.

Based upon the foregoing, Petitioner is entitled to maintenance with a commencement date of September 30, 2014 when she attempted to return to work. Petitioner is to be paid maintenance at the temporary total disability rate.

NATURE AND EXTENT

Petitioner has made a claim for wage differential benefits. However, she has embellished her symptoms, as evidenced by the functional capacity evaluation. Furthermore, she disagrees with her own retained vocational rehabilitation expert. Her actual physical limitations and her actual job duties cannot be the determined in the absence of objective and reliable evidence.

Therefore, the Arbitrator finds that Petitioner's claim for wage differential benefits are denied.

The Arbitrator further finds that Petitioner has sustained serious and permanent injuries. Her injuries are corroborated in the medical records. The parties are aware of the medical facts as well as the previous Decisions in this case.

Considering the totality of the medical evidence, the Arbitrator finds that Petitioner has sustained the 25% loss of use of the person as a whole.

PENALTIES AND ATTORNEYS' FEES

While Respondent did create an inconsistent position, the payment of non-Worker's Compensation disability benefits was a mitigating factor. Additionally, Petitioner has not been completely forthcoming with the facts.

Based upon the foregoing, Petitioner's claims for penalties and attorneys' fees are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CINDI MICELI,

Petitioner,

vs. NO: 15 WC 00047

BERNARD ZELL
ANSHE EMET DAY SCHOOL,

Respondent.

18IWCC0777

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 55-year-old employee of Respondent, who described her job as senior accountant. Petitioner was working for Respondent at that time for about 7 years. Petitioner worked 7:00am to 4:00pm; she did not punch a time clock. Petitioner stated at that time there were about 9 people working in that building; a 2-story brick building with offices on both floors. Petitioner stated that the building looked like a house; basically, they worked in a remodeled type of house. On the date of accident, November 20, 2014 (Thursday), Petitioner testified that as she was leaving the building, at 4:00pm, she walked

down the stairs, and at the bottom of the stairs stepped on something. Petitioner testified that her left foot turned inwards, her ankle outwards. Petitioner stated that when you came down the stairs of the building there was a landing and then there was like 3-steps down. Petitioner stated that the accident occurred on the sidewalk at the bottom of the 3rd step. Petitioner stated that it was dry, but it was covered with rock salt. Petitioner believed that the maintenance crew who worked for the school placed the rock salt there. Petitioner viewed RX 2 (2 photos) and identified it as the entrance to the building where she worked and where the incident happened that day. Petitioner indicated on the photo the area where the accident happened (marked the photo). Petitioner testified that it was not a public sidewalk there; it was still on Respondent's property. There was a shadow of a fence which was also on Respondent's property; not public property. Petitioner believed the sidewalk there was maintained by Respondent's maintenance crew. Petitioner knew that the stairs were painted and repaired by an outside company at some point. Petitioner testified that after she twisted her ankle she looked to see what she stepped on and that was when she realized that it was rock salt. Petitioner stated she was experiencing some pain in her left ankle and foot. Petitioner stated that she stood there for a minute waiting to see if it would subside enough for her to be able to walk to the school's parking lot. Petitioner had been leaving work to walk to the area set aside for employee parking by the school; just west of the building about a half block west and a half block south. Petitioner testified that the costs of parking in the lot was split between the school and the employee; she was required to park in the same location/lot every day. Petitioner testified that the lot was a private lot owned by the apartment building there; it was not a public lot. Petitioner testified that when she got home she called Dr. Eernisse, a podiatrist at Michigan Avenue Podiatry (Michigan and Washington). Petitioner and her husband had previously seen Dr. Eernisse. Petitioner had seen Dr. Eernisse about 4 times for a prior right foot injury about 2013. Petitioner first saw Dr. Eernisse regarding her left foot on November 26, 2014. Petitioner testified she gave the doctor a history of the accident and she believed the doctor recorded that. Petitioner testified that the doctor examined her left foot, took x-rays of it and placed Petitioner in a boot. Petitioner stated that the doctor told her that she would probably need surgery to repair the Achilles tendon; the doctor wanted to first see if it would heal on its own. Petitioner did not recall if surgery was scheduled then, but eventually the doctor said surgery was necessary and it was scheduled. Petitioner had outpatient left foot surgery on December 17, 2014 at the downtown surgical center off Washington.

- Petitioner testified that she had been working from November 20 through December 12, 2014. Petitioner stated that after the surgery the doctor said Petitioner would be off work for 6 weeks. During that time Petitioner continued to see Dr. Eernisse and last saw her about March 19, 2015. Petitioner did not return to work as she had been laid off from Respondent on December 12, 2014

- Petitioner testified that prior to seeing Dr. Eernisse in November 2014 she noticed considerable swelling of her left foot/ankle and a considerable amount of pain. Petitioner testified that it was very difficult for her to walk and that she had the same conditions just

prior to the December 2014 surgery. Petitioner stated after the surgery there was still quite a bit of pain, some surgically related. Petitioner was told, after surgery, not to put any weight on that foot/leg at all. Petitioner stated that she had seen the doctor 5-6 times after the surgery. Petitioner had seen no other doctors for treatment regarding her left foot/ankle injury. Petitioner testified to being examined by Dr. Lee at Respondent's request. Petitioner testified that Dr. Lee did not offer any type of treatment or care and did not prescribe anything for her.

- Petitioner testified that after her 6-week recovery and December 2014 layoff from Respondent she obtained some temporary jobs. She worked as a senior accountant for a nursing home, an interim business manager for a school, and as a senior accountant for a chemical company. Petitioner stated that she eventually did obtain full time employment (senior accountant, for 2.5 years) with Keshet, a private Jewish school in Northbrook for people with developmental disabilities. Petitioner testified that during the time she worked there she noticed she continued to experience pain in her left foot, tightness behind her heel and periodic numbness to her toes.

- Petitioner viewed PX 1 and testified that it was a list of her bills and the payments BCBS made. Petitioner stated all those bills were incurred for her left ankle/foot treatment and nothing else. Petitioner stated that some of the bills had been paid via BCBS, she paid part and the Respondent school had paid part of it. Petitioner testified that she had some out of pocket expenses that were not reimbursed and there were outstanding balances. Petitioner further stated that her claimed TTD did not overlap with any jobs she had worked.

The Commission notes that Petitioner had a prior right Achilles tendon issue and had MRI's bilaterally. The February 5, 2013 MRI for left side ankle pain, showed a normal Achilles tendon, no tear, Moderate effusion. Dr. Eernisse noted a history that on Thursday, November 26, 2014 Petitioner stepped on a curb and thought she tore her Achilles tendon. The doctor noted a little swelling, and the objective findings indicated a partial rupture of the Achilles; an acute tear. The First report of injury form 45 dated December 17, 2015, noted a history of leaving the building at the end of day on November 20, 2014, and twisting her ankle; unsure if Achilles tendon was affected. Dr. Lee questioned Petitioner waiting the few days before seeing Dr. Eernisse, as the pain from an Achilles tendon tear is very bad. Petitioner had been working and clearly, based on that medical opinion, did not have a left Achilles tear between the 2013 MRI and this event or she would have been in pain. Dr. Lee also noted the mechanism of injury described could potentially result in an Achilles tendon tear. The treating medical records show the history of accident and the acute findings that resulted in repair of the ruptured Achilles tendon. The history of a mechanism of injury in the most contemporaneous medical records is not, however, consistent with the IME history and Petitioner's testimony. Petitioner was reportedly doing a normal activity of daily living by walking down the steps (or curb), but Petitioner testified of the condition of the surface being slippery and covered with salt and stepping and twisting which was not a history in the records immediately after the alleged accident as there was no indication of iciness or salt on the pavement.

18IWCC0777

Respondent's maintenance people took care of the premises, so they could have applied salt on an icy surface and that may have increased Petitioner's risk beyond the general public. However, the history of accident in Petitioner's medical records history was that of stepping off the curb; a normal activity, the same risk as the general public. Petitioner's testimony is rebutted and not supported in the most contemporaneous medical records. The later IME report of Dr. Lee indicated a mechanism of injury of stepping down from the steps and stepping on salt or an icy/slick surface and twisting her left ankle/foot. Petitioner failed to meet her burden of proof that she sustained an accident that arose out of and in the course of her employment given her differing histories. Further, Petitioner failed to meet her burden of proving a causal relationship between the accident and her condition of ill-being. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses to find Petitioner failed to meet the burden of proving she sustained an accident that arose out of and in the course of her employment, and further, failed to meet her burden of proving a causal connection between the accident and her condition of ill-being. The finding of no accident and no causal connection renders all other issues moot to deny any and all benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is herein reversed to find that Petitioner failed to meet the burden of proving accident that arose out of and in the course of employment and further failed to meet the burden of proving any causal connection to any such accident/incident, thereby rendering all remaining issues moot.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-0-. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 18 2018
o-10/25/18
DLG/jsf

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MICELI, CINDI
Employee/Petitioner

Case# **15WC000047**

BERNARD ZELL ANSHE EMET
Employer/Respondent

18IWCC0777

On 3/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1596 MEACHUM BOYLE & TRAFMAN
JATASA TIMOTIJEVIC
25 W WASHINGTON ST SUITE 500
HICAGO, 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

CINDI MICELI,
Employee/Petitioner

v.

BERNARD ZELL ANSHE EMET,
Employer/Respondent

Case # 15 WC 00047

Consolidated cases: NONE

18IWCC0777

An *Application for Adjustment 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 **January 22, 2018 and February 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 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 **$78,786.24**; the average weekly wage was **$1,515.12**.

On the date of accident, Petitioner was **55** 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 **$0.00** 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 **$16,639.00** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent on November 20, 2014.

Respondent shall pay Petitioner temporary total disability benefits of **$1,010.08**/week for **8-5/7** weeks, commencing **December 17, 2014** through **February 16, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$3,181.39**, as provided in Sections 8(a) and 8.2 of the Act, representing the balances not paid by Respondent's group health insurance that are allowable pursuant to the medical fee schedule of the Act. Total medical bills incurred were $33,697.89.

Respondent shall be given a credit of **$16,639.00** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that an opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence through the testimony of Dr. Lee. The Arbitrator has further considered the treating physician's and evaluating physician's comments along with the testimony of Petitioner as a factor in the evaluation of Petitioner's permanent partial disability as required by §8.1b(b)(i). The doctor noted a 12% impairment rating to the left lower extremity. Because of the failure of Dr. Lee to review the operative report, which indicates an overly lengthened left Achilles tendon, the Arbitrator therefore gives *lesser* weight to this factor which is an omission.

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 **senior accountant** at the time of the accident and that she ***is*** able to return to work in her prior capacity as a result of said injury. The Arbitrator notes Petitioner's testimony in agreement and her subsequent work history. Because of this employment history, the Arbitrator therefore gives *no additional* weight to this factor.

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 her age, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no real loss of earnings resulting from this injury. Because of this, 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 Dr. Lee and Dr. Eerinesse both agree as to the course of treatment and ultimate treatment results. Because of such agreement, 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 **20%** loss of use of **left foot** pursuant to **§8(e)** of the Act.

Respondent shall pay Petitioner the further sum of **$735.37**/week (Maximum Rate) for a period of 33.4 **weeks**, as the injuries sustained caused the complete and permanent loss of use of the left foot to the extent of **20%** thereof under section **8(e)** of the Act.

Penalties and fees are denied (see attached).

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

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

David A. Kane
Signature of Arbitrator

March 7, 2018
Date

ICArbDec p. 2

MAR 7 - 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CINDI MICELI, Petitioner,	)	
vs.	)	NO: 15 WC 00047
BERNARD ZELL ANSHE EMET, Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW BY THE ARBITRATOR

Petitioner testified that on November 20, 2014, she was employed by respondent as a Senior Accountant. At that time she worked in that position for respondent a little over seven years. She would work from 7:00 a.m. to 4:00 p.m. on weekdays and was not required to punch a time clock. She did payroll, handled benefits, bank reconciliations, recorded journal entries, or basic accounting duties. She described the job as being mostly desk work but it did involve walking. Petitioner testified that she worked in a two-story brick building with offices on both floors. A total of nine employees worked in that particular building, which was previously a private home.

On Thursday, November 20, 2014, as she was leaving the building, she walked down the outside stairs and stepped on something, causing her to twist her left foot. This occurred at 4:00 p.m. Petitioner identified photographs of the staircase which lead to the entrance of the building where she worked. She described the weather as being

dry, but the stairs were covered with rock salt, which was put down by the maintenance crew that worked for the school. The stairs and sidewalk depicted in the photographs were on school property. A fence appears at the end of the sidewalk which is also owned by the school. The sidewalk is also maintained by the maintenance crew. The stairs are painted and were repaired by an outside company at one point in time.

After twisting her ankle, petitioner looked to see what she stepped on and realized that it was the rock salt. She was experiencing some pain in her left foot and ankle, which she described as being a "seven" and waited to see if it would subside so that she could walk to the school's parking lot. She was in the process of walking towards the area set aside for employee parking by the school. The parking area is west of the school entrance, around a half block west and half a block south. The costs for the parking were split between the school and petitioner, and she was required to use the same lot daily. It was not a city lot but a private lot.

After arriving home, petitioner called Dr. Eernisse, a podiatrist, who she had used in the past as well as her husband. Petitioner previously saw Dr. Eernisse for a right foot injury.

The next day petitioner went to work and reported the injury. An accident report was filled out shortly thereafter by Cheron McNeal who was doing benefits and HR functions at the time.

Petitioner saw Dr. Eernisse on November 26, 2014. She testified that her pain had increased to a "nine" at that time. The day before, petitioner noticed considerable swelling and pain to her left foot and found it difficult to walk. Dr. Eernisse took x-rays and put her left foot in a boot and felt the injury would require surgery to repair the Achilles tendon. Out-patient surgery was eventually scheduled and performed on December 17, 2014 at the 25 East Surgery Center in Chicago. The day prior to

surgery, petitioner was still experiencing a lot of pain and swelling to her left foot and ankle.

Petitioner prior to surgery continued to work for Respondent until she was laid off on December 12, 2014. She last saw Dr. Eernisse on March 19, 2015.

Following her release to return to work, petitioner did obtain a couple of temporary jobs, working as a senior accountant for a nursing home and as an interim business manager for a school, along with working as a senior accountant for a chemical company.

Petitioner eventually found regular employment at Keshet School, a private Jewish school for the developmentally disabled. She worked at that school for two and a half years, noticing pain in her left foot and tightness behind the heel. She also noticed that her toes get numb periodically and are starting curl under.

Rebecca Brown testified that she is the chief financial officer for respondent. She held that same position on November 20, 2014. She oversaw accounting, human resources, technology, contracts.

She spoke with petitioner about her injury after Ms. Brown returned from vacation on December 1, 2014. She was on vacation from approximately November 18, 2014 through December 1st. At that time she saw petitioner with her left leg in a boot and propped up on a stool. I asked her what happened and she said she had taken a step and something happened to her ankle. She mentioned it was her ACL and the doctor was urging surgery.

Ms. Brown testified that she never saw any of petitioner's medical records. The business building where she and petitioner worked was across the street from the school building. Ms. Brown testified the photographs depicted the front door of the

building, the staircase and sidewalk, all of which were on school property, and all of which were maintained by the maintenance staff of the school. Some paint was missing from the painted stairs.

Dr. Simon Lee testified by evidence deposition on July 18, 2017. Dr. Lee is a board certified orthopedic surgeon. Dr. Lee testified he performed an AMA rating on May 12, 2016. He reviewed and summarized medical records provided to him. He recorded a history that on November 20, 2014, she was leaving work and was coming down the back stairs, there was salt and a slippery surface, and she fell injuring her left ankle. She stated she had immediate pain, swelling and difficulty with weight bearing. Following an MRI, she underwent surgery for the Achilles on December 17, 2014.

Dr. Lee evaluated petitioner's gait entering the examining room, noted the surgical incision and some atrophy of the left calf without malalignment. She had an overall decreased resting tension to the left lower extremity, and to the Achilles to direct palpation. Palpation produced tenderness with good plantar flexion strength against resistance.

Dr. Lee diagnosed status post left Achilles rupture and status post-surgical repair. He felt she was at maximum medical improvement at the time of examination. He used the AMA Guide to the Evaluation of Permanent Disability. At page 501 the diagnosis of Achilles tendon rupture is discussed. Using the grade modifiers and determining the class the patient was in, including use of modifiers for functional history, physical exam, clinical studies arrives at a lower extremity impairment rating. She was considered a "Class 1" or mild with a range of 7 to 13 percent based on other grade modifiers. Functional history appears at Page 16.6, which he described as a moderate degree of symptoms and complaints, between mild and moderate.

Dr. Lee noted no instability or malalignment, but she did have increased range of motion due to an over lengthened tendon along with evidence of muscle atrophy. The

ultimate sum total of the grade modifiers was Plus 1. With the starting point of C Plus 1 would give her a Grade D. Within that range, she would be considered a 12 percent lower extremity impairment, or using Table 16-10, translate to a five percent whole person impairment.

Based upon his review of records, Dr. Lee felt the mechanism of injury is not particularly occupationally related in any way and felt it no different than any activity of daily living for most individuals. When asked how an Achilles tendon ruptures, he felt the proposed mechanism was a sudden eccentric load, meaning the muscle is trying to pull and get the ankle or heel to come up while it is dropping down. Typically, a normal Achilles tendon does not rupture, there is some level of weakness or disease state that seems to propagate a catastrophic failure.

Dr. Lee did admit that slipping on salt on stairs located outdoors could or might have been the cause of a ruptured Achilles tendon. He also admitted that during his initial AMA rating examination, he was not asked to render an opinion on causation. He admitted that a standard AMA impairment rating is based on the specific diagnosis. He admitted that an MRI report of the left and right ankles was performed on February 5, 2013 and there was no indication that she had a ruptured left Achilles tendon prior to the slip on the stairs. Dr. Lee did not have access to the left Achilles tendon surgical report.

When comparing the left and right legs, atrophy was noted only on the left, with less range of motion to the left with the exception of increased dorsiflexion of the operated tendon, which Dr. Lee described as lengthening. He noted no symptom modification or exaggeration during his exam.

The Form 45 First Report of Injury is dated December 17, 2015 and was filled out by Cheron McNeal. The date of injury was typed in along with the school address, the rest was handwritten by Mr. McNeal.

Records of treating physician Dr. Eernisse were admitted into evidence. An MRI performed February 5, 2013 showed a normal appearance of the left Achilles tendon and heel pad without evidence of a tear, and mild peroneal tenosynovitis. She was diagnosed with moderate effusion of the right ankle joint along the extensor retinaculam and lateral aspect of the sinus tarsai, and mild peroneal tenosynovitis. All treatment in 2012-2013 appears to be to the right foot with the last visit being February 18, 2013. Some complaints were made to the left foot at that time which was diagnosed as bursitis.

Medical bills introduced include those from Michigan Avenue Podiatry (Dr. Eernisse), Beach Anesthesia, LabCorp, Athletico Physical Therapy, and 25 East Surgery Center, along with pharmacy bills and medical supplies that total $33,697.89. The medical fee schedule of the Act allows for $19,820.39 of those charges, of which Petitioner paid out of pocket $98.89. Respondent's group health insurance paid $16,639.00 of those charges, leaving balances of $3,181.39.

Based upon the above findings of fact, the Arbitrator finds as follows:

1. That Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent on November 20, 2014. The common themes between the testimony elicited and the documentary evidence is a slip on a set of outdoor steps. Petitioner testified that she was exiting the building to go towards her automobile, which she was instructed to park at a lot a half block west and half block south. Respondent paid for the parking at a private lot. It appears to this Arbitrator that the normal defenses of an employee leaving work at the end of the day do not appear in the facts of this case, and respondent still had ample direction and control over her activities at the time of the injury.

Petitioner testified she stepped on some rock salt towards the bottom of the company stairs, which were maintained by respondent's maintenance crews. She was in the process of stepping on a company sidewalk to walk to the public sidewalk, where she would then walk to her automobile, which she was instructed to park at a certain parking lot. Respondent paid for half of the parking fees.

2. Dr. Lee testified that the act of slipping or twisting the left ankle would be sufficient to cause a ruptured Achilles tendon, or what he described as a sudden eccentric event. This testimony along with petitioner's testimony establishes causation and negates his attempts to testify that any exertion would have caused this injury.

3. The records of Dr. Eernisse establish that as a result of this accidental injury, petitioner was excused from work commencing December 17, 2014 through February 16, 2015, or a period of 8-5/7 weeks, and is entitled to receive temporary total disability from respondent for that period of time. Petitioner testified that following the injury she continued working until December 12, 2014, when laid off. Petitioner resumed working on a temporary employment type of basis after February 16, 2015, and eventually found new permanent employment at a new school.

4. The Arbitrator finds the medical bills introduced include those from Michigan Avenue Podiatry (Dr. Eernisse), Beach Anesthesia, LabCorp, Athletico Physical Therapy, and 25 East Surgery Center, along with pharmacy bills and medical supplies that total $33,697.89. The medical fee schedule of the Act allows for $19,820.39 of those charges, of which Petitioner paid out of pocket $98.89. Respondent's group health insurance paid $16,639.00 of those charges, leaving balances of $3,181.39. Dr. Lee testified that the treatment rendered was reasonable and necessary to cure or relieve the condition of ill-being created by

this accident and did admit that causation existed based on the facts as presented to him. The Arbitrator awards the medical balances to petitioner and allows respondent a credit under Section 8(j) of the Act for payments of $16,639.00 of the allowable charges based on the medical fee schedule.

5. Based upon the testimony of petitioner as to her current complaints, along with the AMA guideline examination as performed by Dr. Lee, the Arbitrator finds the disability to the left foot to be 20% under the Act. This is based on the five factors of the Act along with Dr. Lee's findings, which did not include a review of the operative report which established an overly lengthened Achilles tendon being symptomatic post-surgery, which he did find during his examination.

6. The Arbitrator finds that penalties and attorney fees may not be warranted in this matter. This finding is based upon a less than clean history of injury given to the treating physician which could be reasonably relied upon in a denial of the claim.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATY QUINLAN,

Petitioner,

vs. NO: 13 WC 25294

CITY OF ELGIN POLICE DEPARTMENT,

18IWCC0778

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, temporary total disability, medical, prospective medical, nature and extent of permanent disability, and clerical errors, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's Decision with respect to all issues except the nature and extent of Petitioner's injury.

After consideration of the five factors set forth in Section 8.1b(b) of the Act, and the record as a whole, the Commission views the Petitioner's permanent partial disability for the cervical and left arm ulnar nerve injuries different from the Arbitrator.

Findings of Fact and Conclusions of Law

The Petitioner's cervical spine injury was surgically repaired by Dr. John Brayton consisting of a one level fusion on May 12, 2014. Dr. Brayton also performed a left ulnar nerve decompression and transposition surgery on Petitioner on July 7, 2015. Dr. Brayton declared Petitioner at maximum medical improvement (MMI) on January 4, 2016. At that time Dr. Brayton noted Petitioner's range of motion had returned to normal and her atrophy and paresis were resolved. (Px2)

18IWCC0778

Cervical Spine Injury

The Petitioner testified she still has pain in her neck and she continues to see Dr. Wilson for pain management after she was found to be at maximum medical improvement and released by Dr. Brayton. Petitioner underwent a Section 12 evaluation by Dr. Sean Salehi at Respondent's request on July 30, 2013. Dr. Salehi authored a contemporaneous opinion report and nine subsequent letters and opinion reports in response to Respondent's requests for review of various medical records, additional treatment recommendations and AMA impairment ratings.

On January 26, 2015, Dr. Salehi opined "it is medically appropriate the patient be referred to pain management for non-narcotic pain management. This treatment would be by way of non-narcotic pain medications for three months." (Rx2) On October 25, 2016, Dr. Salehi opined that the overall goal of seeing the pain management physician, Dr. Wilson, would be to taper off narcotics given the well-established issues with chronic narcotic use including sensitization to pain, tolerance and dependence. Dr. Salehi deferred to Dr. Wilson for the time course to be tapered off such drugs. (Rx4, p. 6)

Dr. Salehi also assigned a 7% AMA impairment rating for the Petitioner's cervical condition. *Id.*

While the Commission agrees with the Arbitrator that the other statutory factors support a higher permanent partial disability award than the AMA impairment rating, the Commission disagrees with Arbitrator's analysis under Section 8.1b(b)(i), one of the five factors set forth in Section 8.1b(b) of the Act required to determine permanent partial disability. Under Section 8.1b(b)(i), the Arbitrator considered the AMA ratings furnished by Dr. Salehi and wrote the following: "While the Arbitrator has carefully considered the AMA ratings she believes the other statutory factors support a more significant permanent partial disability for the injuries she sustained." (Arb. Dec. p. 6)

The Commission finds the Arbitrator failed to assign any weight to the unrebutted AMA impairment ratings offered by Respondent's examiner, Dr. Salehi, or assigned minimal weight to the unrebutted AMA impairment ratings, in favor of the other statutory factors. The Commission gives Dr. Salehi's unrebutted cervical AMA impairment rating moderate weight and in favor of a reduction of the Arbitrator's permanent partial disability award.

The Commission agrees with the Arbitrator's evaluation of three of the four other factors under Sections 8.1b(b)(ii), (iii), and (iv), as it relates to Petitioner's cervical spine. With respect to the treating medical records as corroborative of Petitioner's disability under Section 8.1b(b)(v), the Commission finds the Petitioner's condition after the surgery to be of greater weight, and more indicative of Petitioner's disability, than the Arbitrator.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying §8.1b of the Act, the Commission finds the Petitioner has sustained cervical injuries that caused 22-1/2% loss of use of the person as a whole under Section 8(d)2 as the result of the March 26, 2013 work-related accident.

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Left ulnar nerve Injury

Dr. Brayton declared Petitioner at MMI on January 4, 2016. At that time Dr. Brayton noted Petitioner's range of motion had returned to normal and her atrophy and paresis were resolved. (Px2) On March 24, 2016, Dr. Brayton testified: "...I would expect that within a year Petitioner would achieve full recovery." Dr. Brayton clarified: "A year from the ulnar nerve transposition surgery..." (Px3, p. 44)

The Petitioner testified "...my left arm is much, much, better post-surgery than pre-surgery. I will still have some pain that's related mostly towards weather...extreme cold or extreme rain, but I don't have any symptoms or any pain into my hand. It's essentially a feeling of tendonitis in the forearm which my surgeon told me was a normal result of that surgery & basically the scar still hurts." (T, pp. 39-40) Petitioner planned no additional treatment. (T, p. 42)

Dr. Salehi assigned a -0-% AMA impairment rating for the ulnar nerve injury on November 29, 2016, more than one year after the surgery. Dr. Salehi noted a lack of any objective sensory or motor deficits on physical examination. While the Commission agrees with the Arbitrator that the other statutory factors support a higher permanent partial disability award than the -0-% AMA impairment rating, the Commission finds the Arbitrator failed to assign any weight to the unrebutted AMA impairment ratings offered by Respondent's examiner, Dr. Salehi, or assigned minimal weight to the unrebutted AMA impairment ratings, in favor of the other statutory factors.

The Commission gives Dr. Salehi's unrebutted left ulnar nerve AMA impairment rating moderate weight under Section 8.1b(b)(i) and in favor of a reduction of the Arbitrator's permanent partial disability award.

The Commission also considered the most recent treating medical records in evidence under Section 8.1b(b)(v) and the Commission finds Dr. Brayton's opinion regarding Petitioner's prognosis for her left ulnar nerve condition and Dr. Salehi's findings upon physical examination warrant substantial weight when assessing permanent partial disability for Petitioner's ulnar nerve condition.

The Commission disagrees with the Arbitrator regarding the evidence of disability in Petitioner's left arm noted in the medical records under Section 8.1b(b)(v) noting Dr. Brayton's testimony comports with Dr. Salehi's physical examination findings, all of which favor a reduction of the permanent partial disability award.

The Commission agrees with the Arbitrator's considerations under the remaining three factors of Section 8.1b(b)(ii), (iii), and (iv) as it relates to Petitioner's left arm.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying §8.1b of the Act, the Commission finds the Petitioner has sustained left ulnar nerve injuries that caused 15% loss of use of the left arm under Section 8(e) as the result of the March 26, 2013 work-related accident.

The Commission further finds that the Arbitrator's Decision on page six, under the section "TTD," entitles the Petitioner to temporary total disability benefits for the period of time that she

18IWCC0778

was kept off work by Dr. Brayton following the left arm surgery. The Commission agrees with the Arbitrator that the ulnar nerve condition was causally related to the accident and that the surgery was reasonable and necessary, therefore, the Respondent owes Petitioner temporary total disability benefits for the Petitioner's lost time beginning July 15, 2015 through August 5, 2015, a period of 3-1/7 weeks. The Commission finds that the calculation of four weeks lost time by the Arbitrator was erroneous and the Arbitrator's omission of the additional TTD from the Order was merely a scrivener's error.

The Commission also corrects other scrivener's errors in the Arbitrator's Decision. On the unnumbered pages of the Arbitrator's Decision, in the Findings section, the Commission strikes the fifth paragraph and substitutes "Petitioner's current conditions of ill-being regarding the cervical spine and the left elbow ulnar nerve are causally related to the accident." This language is consistent with that in the Addendum to the Decision of the Arbitrator.

The Commission also strikes "July 15, 2015" and substitutes "July 17, 2015" as the date of the left ulnar nerve surgery, under the "Conclusions of Law" sections of the Arbitrator's Decision as follows: 1) in the "Causal connection" section on page four, in the fifth paragraph; 2) in the "Medical Bills" section page five in the second paragraph; and 3) in the "TTD" section on page six.

The Commission modifies the Arbitrator's Decision as stated herein and otherwise affirms and adopts the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $786.87 per week for a period of 85 weeks, representing the sum of weeks for the periods April 11, 2013 through November 4, 2014 and July 15, 2015 through August 5, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 26, 2013 through December 20, 2016, and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $64,612.86 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $708.18 per week for a period of 112.5 weeks, as provided in §8(d)2 of the Act, for the reason that the cervical injury sustained caused the Petitioner 22-1/2% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $708.18 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the left ulnar nerve injury sustained caused the Petitioner 15% loss of use of the left arm.

18IWCC0778

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the following charges for all reasonable and necessary medical services under §8(a) and §8.2 of the Act, pursuant to the medical fee schedule, with a credit for any amounts paid by Respondent provided health insurance under Section 8(j) of the Act:

1. Pain management services related to her cervical condition instituted May 31, 2016 through the hearing date;

2. Left ulnar nerve entrapment and neuropathy treatment Petitioner received, specifically the surgery of July 15, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is to be held harmless for any subrogation claim by her group health insurer.

IT IS FURTHER ORDERED BY THE COMMISSION that the following corrections be made to the Arbitrator's Decision and incorporated herein:

1) On the unnumbered pages of the Arbitrator's Decision, in the Findings section, the Commission strikes the fifth paragraph and substitutes "Petitioner's current conditions of ill-being regarding the cervical spine and the left elbow ulnar nerve are causally related to the accident."

2) The Commission strikes "July 15, 2015" and substitutes July 17, 2015, the correct date of the left ulnar nerve surgery, under the "Conclusions of Law" sections of the Arbitrator's Decision as follows: 1) in the "Causal connection" section on page four, in the fifth paragraph; 2) in the "Medical Bills" section page five in the second paragraph; and 3) in the "TTD" section on page six.

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: DEC 19 2018
KWL/bsd
O: 10/23/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUINLAN, KATY
Employee/Petitioner

Case# **13WC025294**

15WC039567

CITY OF ELGIN POLICE DEPARTMENT
Employer/Respondent

18IWCC0778

On 3/21/2017, 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:

1228 KINNALLY FLAHERTY KRENTZ LORAN
JOSEPH C LORAN
2114 DEERPATH RD
AURORA, IL 60506

5541 FRED J BEER LAW OFFICES
2295 VALLEY CREEK DR
SUITE K
ELGIN, IL 60123

18IWCC0778

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

Katy Quinlan
Employee/Petitioner

v.

City of Elgin Police Department
Employer/Respondent

Case # **13** WC **25294**

Consolidated cases: **15 WC 39567**

An *Application for Adjustment 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 **12/20/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below **with respect to 13 WC 25294** and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of 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 **3/26/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident regarding the cervical spine, but benefits are denied regarding the left elbow ulnar nerve and lumbar spine.

In the year preceding the injury, Petitioner earned **$61,376.12 over 52 weeks**; the average weekly wage was **$1,180.31**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$64,612.86** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of **$$4,169.68 per RX15** under Section 8(j) of the Act.

The parties stipulated that in regard to medical bills, in the event that the Commission's final decision awards medical bills to Petitioner, Respondent agrees to pay for said medical bills and or resolve any personal health insurance medical bill subrogation claim pursuant to the medical fee schedule under the Illinois Workers' Compensation Act. (hereinafter "Act").

ORDER

- Respondent *shall pay* Petitioner temporary total disability benefits of $786.87/week for 81-6/7 weeks, commencing 4/11/13 through 11/4/14, as provided in Section 8(b) of the Act.

- Respondent *shall pay* Petitioner the temporary total disability benefits that have accrued from 3/26/13 through 12/20/16, and shall pay the remainder of the award, if any, in weekly payments.

- Respondent shall be given a credit of $64,612.86 for temporary total disability benefits that have been paid.

- Respondent *shall pay* the following charges for all reasonable and necessary medical services pursuant to the medical fee schedule with a credit for any amounts paid by Respondent provided health insurance under Section 8(j) of the Act:

    1. Pain management services related to her cervical condition instituted May 31, 2016 through the hearing date;

    2. Left ulnar nerve entrapment and neuropathy treatment Petitioner received, specifically the surgery of July 15, 2015;

- Petitioner is to be held harmless for any subrogation claim by her group health insurer.

- **The Arbitrator finds that the permanent partial disability sustained by Petitioner as the result of the March 26, 2013, work related accident to be 30% loss of use man as a whole**

as to the cervical injury and 20% loss of use of her left arm as a result of her ulnar nerve neuropathy. With respect to the statutory factors utilized by the Arbitrator in arriving at her decision with respect to PPD, see the attached addendum.

- The finding as to the lumbar injury is deferred to companion case 15 WC 39567.

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

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

Susan C. Mizusty

Signature of Arbitrator

3/13/17
Date

MAR 21 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATY QUINLAN, Petitioner, v. **CITY OF ELGIN AND ELGIN POLICE DEPT.** Respondents.	)	**13 WC 25294** *consolidated with* 15 395676

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing on December 20, 2016 in Wheaton, Illinois. (Arb. 1).

Petitioner has two claims that were consolidated for the purposes of the hearing. A separate decision will be issued for each claim.

Petitioner testified that prior to March 26, 2013, she had not sustained any injuries to her neck or left elbow although in the sixth grade, she fractured her upper left arm. In 2003, she had a mid-back injury that resolved with a cortisone shot. She has no prior low back injuries or treatment.

On March 26, 2013, Petitioner was involved in an accident while on duty as a community service officer for the Elgin Police Department (Respondent). According to her testimony, she was dispatched to an Elgin residence concerning the presence of a flying bat. Petitioner entered the residence equipped with a net, attached to a five-foot-long metal pole, that she held in both hands. As the bat flew in her direction, Petitioner swung the pole and net in the air to the right and downwards and, in doing so, felt immediate sharp, shooting pain in her neck and back.

Petitioner presented a few hours after the accident to Sherman Hospital with complaints of pain to the right side of her neck. She reported answering a house call for a bat in an apartment and, upon encountering the creature, turned her head quickly, straining her neck in the process. (Rx 8). She was diagnosed with a neck strain, discharged with pain prescriptions and released to full duty work with instructions to follow up with her primary care provider. (Id.).

On April 3, 2013, Petitioner followed up at Sherman Health with Dr. Kevin Thompson who noted a history of persistent right sided neck pain. (Id.). Petitioner was advised to begin physical therapy, prescribed more pain medication and released to work without restriction. (Id.). When she again presented to Dr. Thompson on April 10, 2013 with persistent complaints, a cervical MRI was ordered which, on April 15, 2013, revealed C5-C6 minimal

bilateral foraminal disc bulging, a small left foraminal disc herniation at C6-T1 levels with mildly compromised left exiting foramen at C7-T1, and C6-C7 mild right foraminal disc bulging. (Px 2). Her primary care physician, Dr. Neubauer provided a neurosurgical referral.

On May 6, 2013, Petitioner presented to Dr. John Brayton, of Neurosurgery & Spine Surgery, S.C. reporting a history of a March 26, 2013 work related injury while attempting to capture a bat. Petitioner told Dr. Brayton that she was holding a net with her right arm extended overhead while leaning forward to the left followed by cervical stiffness and pain. The day after the accident, Petitioner noted paresthesias and dysesthesias in her right arm and hand. (PX2). On examination, the doctor noted paracervical spasm bilaterally. Spurling's maneuver incited C7 radicular symptoms primarily on the left. Hypesthesia and hypalgesia along the C6 and C7 dermatomes was noted as well as superimposed hypesthesia in the upper and lower trunk distribution of the brachial plexus and ulnar distribution in the medial aspect of the distal right upper extremity and hand. Tinel's sign to percussion at the right ulnar groove and volar wrist over the carpal tunnel was noted along with increase in symptomatology with abduction of the upper extremity at the right shoulder. (Id.).

Dr. Brayton reviewed the cervical MRI noting an annular bulge at C5-6 and a herniation at C6-7 with left C6-7 neuroforaminal fragment compressing the exiting left nerve root. Based on the accident history, physical examination, and MRI scan, the doctor opined that Petitioner had a neuropractic injury to her right plexus and peripheral nerve entrapment combined with cervical radiculopathy. He recommended a combination of epidural injections and physical therapy to include a trial of home pneumatic traction, manual traction, and a regimen to address her plexopathy and peripheral entrapment symptomatology. He advocated keeping her off work pending the outcome of injections and therapy. Dr. Brayton also referred Petitioner for pain management.

Petitioner testified on cross examination that she reported to Dr Brayton that she used both arms to swing the net at the bat and did not tell him she only used her right arm..

On May 22, 2013, Petitioner presented to Dr. Jay F. Kiokemeister, DO of Interventional Pain Specialists for an assessment for cervical and bilateral shoulder/arm pain for the past 3 months. (PX5). Pursuant to his exam, the doctor noted a diagnosis of a herniated cervical disk accompanied by radiculopathy. A cervical epidural steroid injection ("CESI") was administered that day.

On June 5, 2013, Petitioner reported to Dr. Kiokemiester that she had very little relief from the first CESI. She also reported persistent right arm pain. She was using Norco on a regular basis. The doctor recommended a right shoulder MRI to rule out shoulder impingement. (Id.).

On June 13, 2013, Petitioner underwent an MRI of her right shoulder which was unremarkable. (PX5).

On June 19, 2013, Dr. Kiokmiester re-examined Petitioner noting her complaints of cervical and left arm pain. The doctor administered 4 cervical trigger point injections and recommended physical therapy to address her cervical radiculopathy. Off work restrictions from April 11, 2013 to July 19, 2013 were issued.

On July 10, 2013, Dr. Kiokemeister re-examined Petitioner and performed another set of trigger point injections. He continued her off work restrictions and recommended that she continue physical therapy.

On August 12, 2013, Dr. Brayton re-examined Petitioner who reported that over the last several weeks her symptoms evolved to include severe dysesthesias, loss of thermal sensation in the upper right extremity, and aching pain which awakened her from her sleep at night. (PX2). On examination, Tinel's sign to percussion at the ulnar grove which was significant on the right arm inciting ulnar distribution dysesthesias that encompassed portions of the middle and lower trunk of the plexus as well as the ulnar groove was noted The doctor noted an overlap between her clinical findings of cervical disk herniation at C6-7 causing C7 radiculopathy, plexus neuropractic injury, and peripheral entrapment neuropathy on the right arm. He ordered a repeat cervical MRI and EMG/NCV to discern whether she was a candidate for surgery. She was to remain off work.

On September 19, 2013, Dr. Brayton noted the recent cervical MRI did not show much change. He interpreted the EMG/NCV as confirmation of a cervical spine injury and ulnar nerve neuropathy. On exam, right arm symptoms were nearly resolved. Her focal left-sided neck pain was persistent and severe. Radicular symptoms in the left arm and hand were noted. Paracervical spasm and tenderness to palpation over the articular facets bilaterally, more prominently on the left as well as hypesthesia and hypalgesia along the left C7 dermatome were noted by the doctor. Petitioner was referred for possible diagnostic and therapeutic facet blocks followed by radiofrequency rhizotomy.

A radiofrequency rhizotomy was performed by Dr. James Wilson of Interventional Pain Specialists on November 27, 2013. (Px 5, Px 4, p. 11). Petitioner did not obtain any significant relief from that procedure. (Px 4, p. 12).

Dr. Brayton recommended surgery which was performed on May 12, 2014 consisting of a C6-7 anterior cervical decompression and intra-body fusion with titanium anterior cervical plating and synthetic bone substitute (Px 2).

By August 18, 2014, Petitioner's continuing recovery from the cervical injury and surgery was largely as expected, however, continued and progressive ulnar nerve symptoms were noted. (Px 3, p. 18).

On November 6, 2014, Dr. Brayton saw Petitioner principally for her left ulnar nerve injury. He had ordered a repeat EMG which showed resolution of the C6-7 findings but significant decrease in conduction velocity across the ulnar groove consistent with entrapment neuropathy of the ulnar nerve. (Px 3, p. 20).

After a fourth IME by Dr. Salehi on November 4, 2014, further treatment on Petitioner's left arm was denied by Respondent. As a result, the recommended surgery, consisting of a left ulnar nerve decompression and transposition, was not performed until July 17, 2015, (Px 2, Px 3, p. 21). The surgery left a scar, approximately 5 ½ inch long and half an inch wide on Petitioner's arm.
Post-operatively, Petitioner continued treating with Dr. Brayton and was later released by Dr. Brayton and Dr. Alpert in January of 2016 (Px 2, Rx 6). While continuing to work without

restrictions, she was referred by Dr. Brayton back to Interventional Pain Specialists in May of 2016.

Petitioner treated with Dr. James Wilson for pain management from May 31, 2016, through the hearing date. (Px 5, Px 7). The source of pain managed by Dr. Wilson is located in Petitioner's neck, radiating down her right arm (Px 6, p. 15).

Petitioner's only restriction instituted by Dr. Brayton is to work no more than 8.25 hours a day. Dr. Salehi agrees this restriction is reasonable for Petitioner's chronic pain. (Rx 4). Treatment is ongoing and Dr. Wilson believes it unlikely that her neck pain will ever completely subside (Px 4, p. 17). Petitioner continues to work as a community service officer for Respondent without restriction, other than the 8.25 hour shift limitation.

CONCLUSIONS OF LAW

Causal connection

The Arbitrator found Petitioner to be a credible witness who presented at the hearing as sincere and intelligent.

As to the mechanism of injury, Petitioner testified she held a net, attached to a five-foot-long metal pole with both hands as she lunged and swung the net forward and above her head. AS mentioned above, the Arbitrator found Petitioner's testimony credible and is not persuaded that she swung a net with a five foot pole utilizing only her right hand as suggested by Respondent.

With respect to the cervical injury, Respondent agrees that all of the medical care and treatment from the date of the accident of March 26, 2013, through Petitioner's release to full time duties in January, 2016, is causally related to this work accident. All benefits including medical and wage benefits were paid during that period of time. However, the pain management treatment from May, 2016 to the present has been denied by Respondent.

The Arbitrator finds that Petitioner's ongoing need for pain management is supported by the records, reports and testimony of both Dr. Brayton and Dr. Salehi and Dr. Wilson support the ongoing need of pain management for the cervical injury Petitioner sustained in this work related event.

The Arbitrator finds Petitioner has met her burden of proof with respect to the left ulnar nerve entrapment for which she underwent surgery on July 15, 2015. The Arbitrator relies upon Dr. Brayton's opinion that the mechanism of injury and the onset of symptoms that evolved and progressed in a classic pattern regarding Petitioner's ulnar nerve entrapment. The multiple EMG's documenting progressive entrapment of the ulnar nerve support the finding of causal connection. The Arbitrator has considered Dr. Salehi's opinion, however, the Arbitrator finds the testimony and treating records of Dr. Brayton, more persuasive.

With respect to her current condition of ill-being, the Arbitrator finds that Petitioner's complaints of ongoing left arm weakness and limitation of overhead use are consistent with the records and testimony of Dr. Brayton. Further, the approximately 5 ½ inch long and ½ inch

wide scar from the surgery demonstrates the extensive repair that was occasioned by this injury. It is also noted that Petitioner had no other accidents, injuries or conditions which could be attributable to her current state of ill-being.

With respect to Petitioner's lumbar condition, Dr. Brayton and Dr. Levin have opposing views on whether the lumbar condition is related to the March 26, 2013, work accident (Px 3, pp. 24 - 26); (Rx 5). Petitioner testified to experiencing lumbar pain shortly after the incident but that pain was much less significant than her neck and upper extremity pain. She was not treated for any lumbar complaints arising out of that incident until after her cervical fusion procedure in May, 2014. She testified that her positioning during the surgical procedure aggravated her pain.

The Arbitrator noted Petitioner's lumbar symptoms increased to the point that Dr. Brayton ordered an MRI in September, 2014 which showed degenerative changes at L4-5 and L5-S1. (Px 2). She then underwent a short series of lumbar epidural injections at Interventional Pain Specialists in the fall of 2014. (Px 5).

On October 6, 2014, Dr. Jay Levin authored an IME report in which he found no causal relationship between Petitioner's lumbar complaints and the March 26, 2013, work injury.

At the time of her release to full duty for her cervical injury in January of 2015, she was already unrestricted with respect to her low back.

Given the severity of her other injuries, it is reasonable that active treatment was not sought immediately. The Petitioner credibly testified that following the May, 2014, cervical fusion surgical procedure she experienced increased back pain. The Arbitrator finds that Petitioner suffered a lumbar strain that became increasingly symptomatic following her cervical fusion, a surgery she would not have undergone if not for the work injury. Accordingly, the Arbitrator finds Petitioner's lumbar condition related to the work accident at issue.

Medical Bills

With respect to Petitioner's cervical injury the sole issue in this regard concerns pain management services instituted May 31, 2016, and continuing to the present. The Arbitrator finds that this treatment is related to the cervical injury sustained by Petitioner on March 26, 2013. Both of Petitioner's treating physicians agree on this point. In his October 25, 2016, report, Dr. Salehi concedes that pain management is not his area of specialty and that he specifically defers to Dr. Wilson. The Arbitrator finds this care and treatment is reasonable and necessary and orders the Respondent to pay for this treatment and hold Petitioner harmless for any subrogation claim by her group health insurer.

As to the left ulnar nerve entrapment and neuropathy, the Arbitrator finds the treatment Petitioner received, specifically the surgery of July 15, 2015, was reasonable and necessary. The Arbitrator has considered Dr. Salehi's opinion that surgery is not indicated for the ulnar neuropathy. However, the Arbitrator relies upon records and testimony of her treating physician, Dr. Brayton. Additionally the fact that Petitioner has obtained significant relief following the surgery buttresses this finding. Accordingly the Arbitrator orders the

Respondent to pay for such treatment and hold Petitioner harmless for any subrogation claim by her group health insurer.

TTD

The sole issue with respect to TTD concerns the four weeks immediately following the July 15, 2015, ulnar nerve transposition surgery. Petitioner utilized her vacation and sick time for the four weeks immediately following the surgery. Having found that the ulnar nerve condition was causally related to the accident and that the surgery was reasonable and necessary, the Arbitrator finds that Respondent owes Petitioner for this four week period of time that she was kept off work by Dr. Brayton.

Nature and Extent of the Injury

As a result of the March 26, 2013, work incident, Petitioner sustained a cervical injury, a left upper extremity neuropathy and a soft tissue injury to her low back. As a result of these injuries Petitioner underwent a cervical fusion in May of 2014 and a left ulnar nerve transposition surgery in July of 2015.

With respect to her cervical injury, Petitioner has an 8.25 hour per shift limitation on her work capacity. Additionally, Petitioner has the ongoing need for pain management to treat her cervical pain which radiates into her right arm. While the May, 2014, fusion provided relief, she is not and is likely never to be pain free. Petitioner also has limitations in range of motion in her cervical spine.

As to Petitioner's left ulnar nerve injury, she obtained relief as a result of the July 15, 2015, surgery. However she continues to have achiness, weakness and difficulties with overhead use of her left arm.

The Arbitrator has considered the following factors set forth in Section 8.1(b) of the Act:

The AMA ratings furnished by Respondent's IME examiner, Dr. Salehi of 7% concerning Petitioner's cervical injury and 0% impairment for her ulnar neuropathy. While the Arbitrator has carefully considered the AMA ratings she believes the other statutory factors support a more significant permanent partial disability award for the injuries she sustained.

Petitioner was a community service police officer at the time of her accident. Her duties vary from day to day. At times she may be required to subdue subjects. Despite her ongoing physical complaints she has been able to perform her job since being released in January of 2016. Her only work limitation is that she not exceed 8.25 hours in any one shift. The Arbitrator finds that the physical demands of her job will likely result in periodic flare-ups of pain in her neck and her left arm and, therefore, assigns greater weight to this factor.

The Petitioner was 35 years old at the time of the injury. A combination of the physical demands of her job and the fact that she is likely to work for many years reinforces the

Arbitrator's conclusion that she is likely to experience exacerbations of her neck and arm injury into the future, therefore, greater weight will be placed by the Arbitrator on this factor.

With respect to her future earning capacity, Petitioner has been working full-time, full-duty since January of 2016. She is limited by the length of her shift. Although her work restriction along with her ongoing need for treatment could impact her future earning capacity, she is employed by and working for Respondent and has been for some time. The Arbitrator does not find this factor to be as significant as it otherwise might be given her significant injuries.

With respect to the treating medical records, the Arbitrator notes the following as corroborative of her Petitioner's disability:

- A cervical MRI was taken a few weeks after Petitioner's accident revealed C5-C6 minimal bilateral foraminal disc bulging, a small left foraminal disc herniation at C6-T1 levels with mildly compromised left exiting foramen at C7-T1, and C6-C7 mild right foraminal disc bulging. Dr. Brayton reviewed the cervical MRI noting an annular bulge at C5-6 and a herniation at C6-7 with left C6-7 neuroforaminal fragment compressing the exiting left nerve root. Based on her accident history, physical examination, and MRI scan, the doctor opined that Petitioner had a neuropractic injury to her right plexus and peripheral nerve entrapment combined with cervical radiculopathy.

- The records of pain management specialist Dr. Jay F. Kiokemeister, DO indicate that a CESI was administered at his initial consult with Petitioner followed by 4 cervical trigger point injections on June 19, 2013, in an effort to relieve Petitioner's persistent cervical pain. On July 10, 2013, he performed another set of trigger point injections to Petitioner's neck.

- On August 12, 2013, Dr. Brayton noted Petitioner's report that over the last several weeks her symptoms evolved to include severe dysesthesias, loss of thermal sensation in the upper right extremity, and aching pain which awakened her from her sleep at night. On examination, Tinel's sign to percussion at the ulnar grove which was significant on the right arm inciting ulnar distribution dysesthesias that encompassed portions of the middle and lower trunk of the plexus as well as the ulnar groove was noted The doctor noted an overlap between her clinical findings of cervical disk herniation at C6-7 causing C7 radiculopathy, plexus neuropractic injury, and peripheral entrapment neuropathy on the right arm. He ordered a repeat cervical MRI and EMG/NCV to discern whether she was a candidate for surgery. On September 19, 2013, Dr. Brayton noted the recent cervical MRI did not show much change. He interpreted the EMG/NCV as confirmation of a cervical spine injury and ulnar nerve neuropathy. On exam, her focal left-sided neck pain was persistent and severe. Radicular symptoms in the left arm and hand were noted. Paracervical spasm and tenderness to palpation over the articular facets bilaterally, more prominently on the left as well as hypesthesia and hypalgesia along the left C7 dermatome were noted by the doctor. Petitioner was referred for possible diagnostic and therapeutic facet blocks followed by radiofrequency rhizotomy.

- A radiofrequency rhizotomy was performed on November 27, 2013 which reportedly did not provide any significant relief.

- Noting that Petitioner's conservative care options had been exhausted Dr. Brayton recommended surgery which was performed on May 12, 2014 consisting of a C6-7 anterior cervical decompression and intra-body fusion with titanium anterior cervical plating and synthetic bone substitute.

- By August 18, 2014, Petitioner's continuing recovery from the cervical injury and surgery was largely as expected, however, continued and progressive ulnar nerve symptoms were noted. On November 6, 2014, Dr. Brayton saw Petitioner principally for her left ulnar nerve injury. He had ordered a repeat EMG which showed resolution of the C6-7 findings but significant decrease in conduction velocity across the ulnar groove consistent with entrapment neuropathy of the ulnar nerve.

- Surgery, consisting of a left ulnar nerve decompression and transposition, was performed on July 17, 2015. The surgery left a scar, approximately 5 ½ inch long and half an inch wide on Petitioner's arm.

- Post-operatively, Petitioner continued treating with Dr. Brayton and was later released by Dr. Brayton and Dr. Alpert in January of 2016 (Px 2, Rx 6). While continuing to work without restrictions, she was referred by Dr. Brayton back to Interventional Pain Specialists in May of 2016.

Petitioner testified that she suffers continued nerve pain in her neck. If the nerve pain goes unchecked, the pain radiates down to her chest and arms. Petitioner treats with Dr. Wilson for pain management who prescribes pain medication that Petitioner takes every 4 hours in an effort to treat these symptoms.

Petitioner's complaints of ongoing left arm weakness and limitation of overhead use are consistent with the records and testimony of the treating medical records. Further, the approximately 5 ½ inch long and ½ inch wide scar from the surgery demonstrates the extensive repair that was occasioned by this injury.

The Arbitrator finds that the medical records in evidence corroborate Petitioner's complaints of pain. Accordingly, the Arbitrator assigns a great deal of weight to this factor when assessing PPD.

Based upon all of the above, the Arbitrator finds that the permanent partial disability sustained by Petitioner as the result of the March 26, 2013, work related accident to be 30% loss of use man as a whole as to the cervical injury and 20% loss of use of her left arm as a result of her ulnar nerve neuropathy.

The finding as to the lumbar injury is deferred to companion case 15 WC 39567.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with comment	☐ Rate Adjustment Fund (§8(g))
☒ Vacate October 2, 2017 Commission Decision	☐ Second Injury Fund (§8(e)18)
☒ Reinstate and Modify August 11, 2016 Arbitrator Decision	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Winston Robinette,

Petitioner,

vs. NO: 11 WC 19907

The American Coal Company,

18IWCC0779

Respondent.

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an order from the Circuit Court of the Fourth Judicial Circuit of Montgomery County dated June 1, 2018 wherein the court set aside the decision of the Commission dated October 2, 2017 and remanded the matter for consideration of solely Petitioner's diagnosis of coal workers' pneumoconiosis (CWP) as his claims for emphysema and asthma were barred by the statute of limitations. The Commission vacates the decision of October 2, 2017 and reinstates and modifies the August 11, 2016 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 along with Commissioner Coppoletti's dissenting opinion dated October 2, 2017.

Procedural History

This matter proceeded to hearing before Arbitrator Nowak on July 16, 2015 with the following issues in dispute: 1) accident; 2) causal relationship; 3) nature and extent of the injury; and 4) Sections 1(d)-(f) and 19(d) of the Occupational Diseases Act. On August 11, 2016, Arbitrator Nowak issued his decision finding Petitioner proved 1) he suffered from coal workers' pneumoconiosis (CWP), emphysema, and asthma which arose out and in the course of his

employment; 2) such conditions developed due to Petitioner's employment as a coal miner and his current condition of ill-being was causally related to said diseases; 3) disablement pursuant to Section 1(e) of the Occupational Diseases Act; and 4) entitlement to benefits pursuant to Section 8(d)1 of the Act of $248.91 per week for the duration of his disability.

On September 7, 2016, Respondent filed a timely Petition for Review before the Commission. On October 2, 2017, the Commission issued its decision affirming and adopting the decision of the arbitrator with Commissioner Coppoletti dissenting.

On October 25, 2017, Petitioner filed a timely review before the Circuit Court of Fourth Judicial Circuit of Montgomery County. On June 1, 2018, the circuit court entered its order finding "[t]he statute of limitations for CWP is 5 years and his claim relating to disability caused by CWP was timely filed. Any claim related to occupational disease other than CWP, such as COPD, emphysema, or asthma is subject to the three year statute of limitations and is barred." As such, the court held "the decision of the Commission is set aside and the cause is remanded to the Commission for a finding of whether Mr. Robinette suffered CWP arising out of [*sic*] the course of his employment, without considering any occupational diseases other than CWP."

Findings of Fact/Conclusions of Law

Based upon our review of the facts and law, the Commission affirms and adopts the August 11, 2016 Decision of the Arbitrator, which is attached hereto and made a part hereof with the following modification - Petitioner established he suffers from CWP and any finding regarding emphysema or asthma is hereby stricken. Commissioner Coppoletti affirms and adopts her dissenting opinion filed on October 2, 2017 which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that its decision of October 2, 2017 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2016, as modified above, is hereby affirmed and adopted along with Commissioner Coppoletti's dissenting opinion filed on October 2, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $248.91 per week commencing April 28, 2008 and continuing for the duration of his disability, as provided in §8(d)1 of the Act.

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

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

181WCC0779

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: DEC 20 2018
LEC/maw
r09/11/18
43

Joshua D. Luskin

Charles J. DeVriendt

DISSENT FILED OCTOBER 2, 2017

I respectfully dissent. I view the medical evidence in a different light than the majority as I would afford greater weight to the opinions of Dr. Selby and Dr. Meyer both of whom are certified B Readers whereas Dr. Paul is not. Further, the diagnostic x-rays performed while Petitioner was in Respondent's employ (11/02/07; 03/05/08; 12/09/08; 04/05/11) fail to evidence pneumoconiosis, and the x-rays performed previously (01/16/75; 03/28/01; 01/31/02) similarly fail to evidence the disease. I would find Petitioner failed to prove he suffered an occupational exposure leading to his development of pneumoconiosis, emphysema, and asthma and deny the matter in its entirety.

Accordingly, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINETTE, WINSTON
Employee/Petitioner

Case# **11WC019907**

THE AMERICAN COAL COMPANY
Employer/Respondent

18IWCC0779

On 8/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

0755 CULLEY & WISSORE
300 SMALL STREET
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

18IWCC0779

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

WINSTON ROBINETTE
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 11WC 19907

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **July 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **April 28, 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 occupational disease that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$48,535.24**; the average weekly wage was **$933.37**.

On the date of accident, Petitioner was 65 years of age, *married* with 0 dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, commencing 4/28/08, of $248.91/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.

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

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

Michael K. Nowak, Arbitrator

7/28/16
Date

ICArbDec p. 2

AUG 11 2016

FINDINGS OF FACT

Petitioner was 72 years old at the time of arbitration. He lives in Litchfield, Illinois. Petitioner graduated from high school and had some schooling here and there following high school. Petitioner worked 30 years in the coal mining industry, all underground. Petitioner testified that in addition to coal dust, he was exposed to silica dust, roof bolting glue fumes, diesel fumes, and trowel, which is a two-part epoxy. He was also exposed to smoke from coal fires.

Petitioner last worked a shift in the coal mine on April 28, 2008, with Respondent. Petitioner was 65 years old on that date and his job classification was frontline foreman. He testified that he was exposed to dust on that day. Petitioner testified that was the last day he worked at the mine because he got into an argument with his supervisor. He testified that the supervisor called him and two other foreman liars, and he just decided to quit.

Right after he left the coal mine, Petitioner worked for three to four months delivering false teeth from the Dental Arts Laboratory to different dentists in Springfield. In that job he worked part-time and made $7.00 per hour. He also worked delivering air conditioners and furnaces for Rogers Supply in Springfield, Illinois for five or six months. At that job he earned $14.00 per hour.

Petitioner started his mining career with Crown Coal Company in 1966. His first job was as a shooter which is the person who shoots the coal down so that it can be loaded out. He testified that was a really dusty job. He also ran a shuttle car at that mine. That job also required him to work at the face of the mine. Petitioner then worked at a motorcycle shop from 1969 to 1973 and managed a motorcycle dealership from 1973 to 1977. Petitioner went to work for Peabody in January 1975 and worked there until August 1994. He worked as a loading machine operator for three years and then went into management. He was a section foreman. He testified that he was exposed to even more dust than the miners because he had to take air readings every so often. These readings were taken at the face where the guys were working. He left Peabody when that mine shutdown in 1994. He then went to work for Amax in 1996 to 1997 as a foreman. That mine had a lot of diesel equipment, and they were running two units so Petitioner was exposed to a lot of diesel fumes in that mine. Petitioner went to work for Black Beauty Mine in 2001. He worked there through 2006 as a ram car operator. He worked at Monterey Coal from 2006 to 2007, as a frontline foreman. Petitioner then worked at Respondent from November 2007 to April 2008, as a foreman. Petitioner's job as a foreman at Respondent included taking air readings and being up at the face of the mine to make sure that everything was right before everything got rolling

Petitioner testified that he first noticed breathing problems in 1994. He noticed that he was getting shorter and shorter of breath and that when he would go outside in the high humidity and heat, he could hardly breathe. He first noticed the problems when he was a shift manager. He testified that from the time that he first noticed his breathing problems until he left the mine, the breathing problems got a lot worse. He testified that since leaving the mine his breathing problems have gotten worse. He testified that he was having a lot of problems as of the time of arbitration. He testified that he could walk half a block at most on level ground before becoming short of breath. He could climb six or seven stairs before having to rest. Petitioner testified that he does not take breathing medication. He testified that his breathing difficulties affect his daily life quite a bit because he cannot do too much. He testified that if he picks something up and tries to carry it, by the time he

gets to where he is going he has to sit down because he cannot get any air. Petitioner testified that he likes to dance and sing karaoke. He testified that he can do one dance at a time and then has to sit down for three.

Petitioner testified that his primary care physician is Dr. Roger Wujek with Litchfield Family Practice. He testified that he talked to Dr. Wujek about his breathing problems. He testified that he was honest with Dr. Wujek whenever he questioned him about any complaints or symptoms that he had. Petitioner testified that he smoked for about 10 years from 1984 to 1994. He smoked about half a pack a day. Petitioner takes medication for blood pressure and arthritis.

Petitioner signed up for Social Security when he left the mine. He also received a "small" pension from UWMA and from some of the coal mines where he worked. In his job with Rogers Supply, he worked in the warehouse. Anything that came in he would stack up with a forklift. He also made deliveries two days a week to different places in Illinois. When he made the deliveries, he would pull a little ramp out and slide the HVAC units down the ramp and tell the people here it is. He testified that these things weighed 100 to 110 pounds. He might also pick a few parts for a customer.

Petitioner testified that from time to time while he was a coal miner, he underwent chest x-ray screening for black lung by NIOSH. The last time that was done was just five months before he left Respondent. NIOSH would send him reports and tell him what the films revealed. Petitioner did not bring any of those letters to arbitration.

Petitioner testified that he saw Dr. Paul at the request of his counsel. Dr. Paul caused spirometry to be performed on him. He testified that he saw Dr. Cohen at the Coal Miners Clinic in Springfield where he also had spirometry performed. He went to see Dr. Cohen in Springfield because of an ad in the newspaper. He testified that the report from Dr. Cohen's testing was in his car at the time of arbitration. Dr. Cohen also arranged for him to undergo an analog chest x-ray in Lincoln, Illinois. Petitioner did not get a report from that chest x-ray, but he got the film back. He testified that he gave that film to his attorney.

Medical records of Litchfield Family Practice were admitted into evidence. They begin with an office visit of August 25, 1998. At that time Petitioner complained of sinus drainage. His lungs revealed some minimal expiratory wheezing. The diagnosis was upper respiratory infection, rule out pneumonia. (Respondent's Exhibit No. 5, p. 187). Petitioner was seen for upper respiratory infections and sinusitis multiple times throughout 1998 and 1999. (*Id.*, at 185-188). Petitioner was seen on May 25, 2006, to reestablish care. On that date his review of systems respiratory revealed no cough or difficulty breathing. His chest exam was normal. (*Id.*, at 181-183). Petitioner was seen on March 5, 2008, at which time he complained of cough which had been present for three days. It was characterized as both dry and productive of mucoid sputum. Review of systems revealed cough but not dyspnea. The assessment was cough. (*Id.*, at 177-178). Petitioner returned on September 11, 2008, for physical exam. Review of systems respiratory revealed no cough and no difficulty breathing. (*Id.*, at 170-172). Petitioner presented for his annual physical on December 16, 2009. He had no complaints and had a good energy level. (*Id.*, at 162-164). When seen on May 5, 2010, for blood pressure check, Petitioner denied dyspnea. (*Id.*, at 161). Petitioner was seen on September 8, 2010, with complaint of cold symptoms including sneezing, nasal congestion, scratchy throat, sore throat, productive cough, and facial pressure and pain with headache. The onset was two days prior. Petitioner did not suffer wheeze or shortness of breath. Review of systems respiratory revealed the presence of a mild cough, but no dyspnea. Physical

examination of the chest revealed breath sounds to be normal with no adventitious sounds. The assessment was pharyngitis and acute sinusitis. (*Id.*, at 159-160). Petitioner was seen on December 8, 2010, for annual physical exam. He had no current medical problems. Review of systems respiratory revealed no cough and no difficulty breathing. Physical examination of the chest revealed normal breath sounds with no adventitious sounds. (*Id.*, at 153-156). Petitioner presented for colonoscopy on September 26, 2011. Review of systems respiratory revealed no cough and no difficulty breathing. (*Id.*, at 142-144).

Dr. Paul examined Petitioner on April 24, 2012, at the request of his attorney. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). Dr. Paul is the Medical Director of St. John's Respiratory Therapy and a Clinical Assistant Professor of Medicine at SIU Medical School. He specializes in allergy and pulmonary diseases. Dr. Paul reads 15 to 20 chest x-rays per day and interprets about the same number of pulmonary function tests per day. (Petitioner's Exhibit No. 1, p. 8). Dr. Paul is board certified in internal medicine and allergy and immunology. (*Id.*, at 51). Dr. Paul is neither an A-reader nor a B-reader. Dr. Paul's diagnoses were pneumoconiosis, emphysema and asthma. He testified that the physical examination of the chest revealed wheeze that was consistent with both emphysema and asthma. (*Id.*, at 9-10). Dr. Paul testified that the fact that Petitioner had wheezing on the date that he examined him suggested that he was asthmatic. (*Id.*, at 10). Dr. Paul testified that the spirometry that he performed suggested emphysema because Petitioner had a low FEV1 and a decreased carbon monoxide diffusing capacity. He testified that it also suggested pneumoconiosis because Petitioner had a decreased total lung capacity which went along with restrictive lung disease. The testing suggested asthma because he had a 33% improvement after bronchodilators in his FEV1. (*Id.*, at 10-11).

Dr. Paul testified that in his opinion Petitioner had coal workers' pneumoconiosis (CWP) caused by coal dust and a coal mine environment. (*Id.*, at 13). Dr. Paul testified that in light of his diagnosis of coal workers' pneumoconiosis, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (*Id.*, at 15-16). Dr. Paul testified that in his opinion Petitioner had clinically significant pulmonary impairment in terms of physical examination of the chest and his complaints. He testified that Petitioner had radiographically apparent pulmonary impairment caused by coal dust. He also testified that Petitioner had physiologically significant pulmonary impairment as shown on the pulmonary function testing. Dr. Paul testified that all of these impairments were caused by the coal mine environment. (*Id.*, at 18-19). Dr. Paul testified that when Petitioner had a presentation as he did at the time of Dr. Paul's examination he would be limited to sedentary work. (*Id.*, at 20).

Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in the lungs, a tissue reaction to it. The scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. By definition, if one has coal workers' pneumoconiosis, he would necessarily have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (*Id.*, at 22-23). Dr. Paul testified that a person could have radiographically significant coal workers' pneumoconiosis and have normal pulmonary function tests, normal blood gases and normal physical examination of the chest. Dr. Paul testified that the scarring of pneumoconiosis can be both obstructive and restrictive. (*Id.*, at 26-27). Dr. Paul testified that simple coal workers' pneumoconiosis is typically asymptomatic. He testified that, more likely than not, simple pneumoconiosis will not progress once the exposure ceases. (*Id.*, at 43-44). Dr. Paul testified that the scarring of pneumoconiosis is permanent. He testified that the impairment from pneumoconiosis is permanent as well. (*Id.*, at 51).

Dr. Henry K. Smith, B-reader and board certified radiologist, interpreted chest x-ray for Petitioner dated January 31, 2002, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in the bilateral middle and lower lung zones. He made an identical interpretation of chest x-rays dated November 2, 2007, December 9, 2008, March 5, 2008, and July 5, 2012. He interpreted a chest x-ray of April 5, 2011, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the bilateral middle and lower lung zones. (Petitioner's Exhibit No. 2).

Dr. Michael Alexander, B-reader and board certified radiologist, interpreted chest x-ray of January 31, 2002, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. He made an identical interpretation of chest x-rays dated November 2, 2007, March 5, 2008, December 9, 2008, and July 5, 2012. (Petitioner's Exhibit No. 3).

Records of chest x-rays taken of Petitioner as part of the Coal Workers' Health Surveillance Program were admitted into evidence. Petitioner's chest x-ray of January 16, 1975, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. The chest x-ray of March 28, 2001, was interpreted by two B-readers as negative for pneumoconiosis. A chest x-ray of January 31, 2002, was interpreted by two B-readers as negative for pneumoconiosis. A chest x-ray of November 2, 2007, was interpreted by an A-reader and a B-reader as negative for pneumoconiosis. (Respondent's Exhibit No. 4).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner. Dr. Meyer is board certified in radiology and is a B-reader. Dr. Meyer reviewed films dated January 13, 2002, November 2, 2007, March 5, 2008, December 9, 2008, April 5, 2011, and July 5, 2012. (Respondent's Exhibit No. 2, pp. 3-4, 40). Dr. Meyer testified that the 2002 film showed the lungs to be well expanded with no radiographic findings of coal workers' pneumoconiosis. The lungs were again clear with no radiographic findings of coal workers' pneumoconiosis on the 2007 examination. (*Id.*, at 4). Dr. Meyer testified that on the chest x-rays from 2008 and 2011, the lungs were clear. He testified that there was a linear band at the left lung base. He testified that there was no evidence of emphysema. He opined that the linear parenchymal band was just an area of scarring from a previous inflammatory process and would not be related to an exposure to a coal mine. Dr. Meyer testified that often times it is an area of prior infection such as pneumonia. (Respondent's Exhibit No. 1, pp. 40-41). With regard to the 2012 examination, Dr. Meyer described the lungs as being clear with no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 1).

Dr. Jeff Selby examined Petitioner at the request of Respondent's counsel on July 5, 2012. (Respondent's Exhibit No. 3, p. 8). Dr. Selby is board certified in internal medicine and pulmonology, and is also a B-reader. (*Id.*, at 4-5). Dr. Selby's examination included an occupational and medical history, physical exam and various laboratory testing. (*Id.*, at 8). Petitioner's chief complaint was breathing; he stated that he had noticed breathing problems for 10 years or more. He reported that he did not cough or wheeze. His wife, however, stated that he wheezed at night or after an upper respiratory infection. Petitioner walked one quarter mile four times per week and also worked out four times per week. Petitioner started smoking in 1966 at a rate of less than one pack per day and stopped in 1994. (*Id.*, at 9-10). The chest exam showed clear breath sounds with good airflow. Dr. Selby found the chest x-ray of July 5, 2012 showed no parenchymal or pleural abnormalities consistent with pneumoconiosis and was negative for coal workers' pneumoconiosis. Dr. Selby also caused pulmonary function testing to be performed. That testing revealed normal spirometry, lung volumes and diffusion capacity with a significant improvement post bronchodilator. (*Id.*, at 12-13). Exercise testing was

performed. Dr. Selby testified that based upon a reasonable degree of medical certainty, Petitioner was capable of heavy manual labor. (*Id.*, at 14-15). Dr. Selby's final assessment regarding Petitioner was that he did not suffer any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. Dr. Selby concluded that Petitioner does not have coal workers' pneumoconiosis. He also concluded that Petitioner had the respiratory or pulmonary capacity to perform any and all of his previous coal mine duties including his last job working as a mine foreman. Dr. Selby testified that Petitioner had a history and pulmonary function testing consistent with asthma which was not caused by nor contributed to by coal mine dust inhalation or work in or around the coal mine. Dr. Selby testified that Petitioner's history of cigarette smoking and exposure to secondary cigarette smoke could be contributing to or entirely causative of any dyspnea he experiences. Dr. Selby also testified that Petitioner was quite obese and his large abdomen and general obesity were major contributors to any dyspnea that he experienced. (*Id.*, at 15-17).

Dr. Selby reviewed treatment records regarding Petitioner. He also reviewed chest x-rays dated January 16, 1975, March 28, 2001, January 31, 2002, November 2, 2007, March 5, 2008, December 9, 2008, and April 5, 2011. (*Id.*, at 30). Dr. Selby found the chest x-rays of January 16, 1975, and March 28, 2001, to be unreadable due to underexposure, poor contrast and poor processing. Dr. Selby found no evidence of pneumoconiosis on the chest x-rays of January 31, 2002, November 2, 2007, March 5, 2008, December 9, 2008, and April 5, 2011. (*Id.*, at Deposition Exhibit No. 3). 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. (*Id.*, at 91). Dr. Selby testified that by definition if a person has pneumoconiosis, he would necessarily have an impairment in the function of his lung at the very site of the scarring, whether that impairment could be measured by spirometry or not. (*Id.*, at 91).

The Arbitrator notes that Petitioner had an audible wheeze at the time of hearing.

CONCLUSIONS

Issue (C): Did an occupational disease 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 disease?

Petitioner's testimony that he was exposed to diesel fumes, fumes from roof bolting glue, coal dust, and silica dust, was unrebutted. The Arbitrator found Petitioner to be a forthright and credible witness.

The Arbitrator finds the testimony and/or opinions of Dr. Paul, Dr. Smith, and Dr. Alexander more persuasive than those of Dr. Meyer and Dr. Selby in this case. Dr. Paul diagnosed Petitioner with coal worker's pneumoconiosis (CWP), emphysema, and asthma. Dr. Paul found Petitioner to have clinically significant pulmonary impairment, radiographically apparent pulmonary impairment, and physiologically significant pulmonary impairment. He further testified that Petitioner's impairment and diagnoses resulted from his exposures as a coal miner and rendered him permanently precluded from working as a coal miner.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he developed occupational diseases including, CWP, emphysema, and asthma, which arose out of and in the course of his employment as a coal miner and that his current condition of ill being is causally related to said diseases.

Issue (O): Was disablement timely under the Occupational Diseases Act?

For purposes of Section 1(e) of the Occupational Diseases Act, an employee is considered disabled from earning full wages at the work in which he was engaged when last exposed to the hazards of the occupational disease or equal wages in other suitable employment where he can no longer work without endangering his life or health. *Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 999 N.E.2d 382 (5th Dist. 2013), citing *Owens-Coming Fiberglas Corp. v. Industrial Comm'n*, 362 N.E.2d 335 (1977).

Dr. Paul found Petitioner to have clinically significant pulmonary impairment, radiographically apparent pulmonary impairment, and physiologically significant pulmonary impairment. He further testified that Petitioner's impairment and diagnoses resulted from his exposures as a coal miner and rendered him permanently precluded from working as a coal miner.

Both Dr. Paul and Dr. Selby testified that asthma can result in a waxing and waning of pulmonary function that could render Petitioner capable of heavy manual labor on some days, but only sedentary labor on others. They also both testified that an asthma attack can be fatal. Dr. Selby testified that if Petitioner's asthma were caused in part or aggravated in part by his coal mine exposures, then his coal mine exposures would have been a causative factor in his dyspnea.

The Arbitrator finds that Petitioner's CWP, asthma, and emphysema cause disablement by both impairment in function and by an inability to return to the environment of a coal mine without endangering Petitioner's health.

Although Dr. Selby disputes that Petitioner suffers from CWP, both he and Dr. Paul agree that if a miner is found to have CWP at any time in his life, he would have had the disease, at least to some degree, when he left mining.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's disablement was timely under the Occupational Diseases Act.

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

Petitioner requests a wage differential award under Section 8(d)1 of the Act. That Section provides, in pertinent part:

> If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. *820 ILCS 305/8(d) 1*

In discussing awards under Section 8(d)1 the Court in *Levato v. Ill. Workers' Comp. Comm'n*, 14 N.E.3d 1195 (1st Dist. 2014) succinctly stated:

> Our supreme court has expressed a preference for wage-differential awards over scheduled awards. See *Gallianetti v. Industrial Comm'n, 315 Ill. App. 3d 721, 727, 734 N.E.2d 482, 487, 248 Ill. Dec. 554 (2000)* (citing *General Electric Co. v. Industrial Comm'n, 89 Ill.2d 432, 438, 433 N.E.2d 671, 60 Ill. Dec. 629 (1982))*. "As a general matter, *section 8(d)(2)* applies to those cases in which a claimant suffers injuries that partially incapacitate him from pursuing the usual and customary duties of his line of employment, but do not cause him to suffer an impairment of earning capacity." *Gallianetti, 315 Ill. App. 3d at 728-29. Section 8(d)(2)* may also apply in circumstances where a claimant suffers an impairment of earning capacity but waives his right to recover under *section 8(d)(1). Id.*
>
> To qualify for a wage differential award, the claimant must prove a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings.

Id., at 1200-01.

Based on the above findings, Petitioner has proven that he has impairment in the function of his lungs. Petitioner has proven an inability to work further as a coal miner without endangering his life or health.

The Petitioner has also proven what he was able to earn following the end of his coal mine employment. By his unrebutted testimony, Petitioner established that after leaving coal mining he had two positions, with his highest wage in such employment being $14 per hour. The parties stipulated that Petitioner's average weekly wage as a coal miner was $933.37. After coal mining, he was able to earn $14 an hour, or $560.00 per week. The difference between his mining wage and what he is able to earn is $373.37 per week. Sixty-six and two-thirds percent of this amount is $248.91.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 4/28/08, of $248.91/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.

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

TRACY McCORMICK,
Petitioner,

v. NO: 13 WC 10345

PROVISO TOWNSHIP HIGH SCHOOL DISTRICT #209,
Respondent.

18IWCC0780

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an order from the Circuit Court of Cook County dated February 11, 2015 wherein the court reversed the decision of the Commission dated June 17, 2014 and remanded the matter for a calculation of benefits owed Petitioner, the Commission vacates its decision of June 17, 2014 and finds Petitioner proved a causal relationship between her accident and current condition of ill-being and awards benefits accordingly as outlined below.

Procedural History

This matter proceeded to hearing before Arbitrator O'Malley on August 12, 2013 with the following issues in dispute: 1) causal relationship; 2) medical expenses; 3) prospective medical care; 4) temporary total disability benefits; and 5) credit due Respondent. On November 4, 2013 Arbitrator O'Malley issued his decision finding Petitioner failed to prove a causal relationship beyond June 28, 2013 between her left knee injury and her current condition of ill-being. Given this finding Arbitrator O'Malley awarded the following: 1) temporary total disability benefits from April 8, 2013 through June 28, 2013; 2) reasonable and necessary medical expenses through June 28, 2013; 3) credit for temporary total disability benefits paid in the amount of $5128.66; 4) credit for medical benefits paid pursuant to Section 8(j) of the Act; and 5) denial of prospective medical care.

On November 15, 2013, Petitioner filed a timely Petition for Review before the Commission. On June 17, 2014, the Commission issued its decision affirming and adopting the decision of the Arbitrator with further explanation regarding 1) Dr. Miller's opinions and 2) the video surveillance.

On July 14, 2014, Petitioner filed a timely review before the Circuit Court of Cook County. On February 11, 2015, the circuit court entered its order finding "The Decision of the Illinois Workers' Commission is reversed and remanded." In the body of its order, the court found Dr. Miller's opinions and the video surveillance unpersuasive thereby finding the Commission's decision to be against the manifest weight of the evidence. The circuit court remanded "the matter for a calculation of the benefits owed Plaintiff."

On March 11, 2015, Respondent filed a timely appeal to the Appellate Court, First District. On February 11, 2016, the Appellate Court entered its order pursuant to Supreme Court Rule 23 dismissing the appeal for lack of jurisdiction and remanding the matter to the Commission with directions. In the body of the Order, the Court states "Thus, the Commission will be required to review all the controverted and relevant facts and provide both a factual and legal basis for a finding of causation subsequent to June 28, 2013." *Proviso Township High School District #209 v. The Illinois Workers' Compensation Commission and Tracy McCormick*, 2016 IL App (1st) 150716WC-U, ¶ 12. On April 29, 2016, the Court issued its mandate.

Thereafter, the record of proceedings was transmitted to the Commission, but it was discovered the DVDs containing the video surveillance were missing. The parties subsequently obtained additional copies of the DVDs, and the record was supplemented accordingly and viewed by the Commission.

Findings of Fact

Based upon the Order of the Appellate Court, the Commission reviewed the evidence *de novo* but in doing so, the Commission is cognizant of the Court's opinion in *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC, which holds the Commission is bound to follow the mandate of the circuit court. "Its frustration notwithstanding, the Commission could not simply ignore the circuit court's order. No matter how defective the circuit court's reasoning may have been, the Commission was charged with following the court's order, reversing the Commission and ordering it to award benefits." *Noonan* at ¶ 11. As such the Commission affirms and adopts the statement of facts as set forth by the arbitrator in his decision of June 17, 2014 and incorporates such facts herein.

Conclusions of Law

With all due respect to the circuit court, it is the Commission's belief that the prior Commission panel which reviewed the arbitrator's decision neither misrepresented nor misinterpreted Dr. Miller's findings and/or conclusions. The Commission performed the function

to which it is tasked and weighed the competing evidence. See *Esquinca v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 150706WC, ¶ 48 ("In resolving questions of fact, it is within the province of the Commission to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence."). In performing its function, the Commission simply afforded greater weight to Dr. Miller's opinions over those of Petitioner's treating physicians and by inference, found Petitioner not credible regarding her ongoing complaints of knee pain based upon the video surveillance. As such, Dr. Tonino's opinions were afforded less weight as they were based, in part, on the subjective complaints of a less than credible Petitioner. These findings, though not precisely articulated, formed the basis of the Commission's June 17, 2014 decision.

Even such, based upon the circuit court's review of the evidence and thereby its directive, the Commission finds Dr. Miller's opinions unpersuasive and affords greater weight to the opinions of Dr. Tonino. As such, the Commission finds a causal relationship between Petitioner's current condition of ill-being as it relates to her left knee and her accident. Petitioner testified her lower back and left shoulder conditions, albeit causing periodic pain, had resolved.

Given the finding as to causal relationship, the Commission finds Petitioner is entitled to medical expenses in the amount of $6,142.54 which are awarded pursuant to Sections 8 and 8.2 of the Act. The parties stipulated Respondent is entitled to a credit pursuant to Section 8(j) of the Act for any amounts paid for medical expenses with the corresponding hold harmless agreement in favor of Petitioner. The Commission finds Petitioner is entitled to prospective medical care as recommended by Dr. Tonino consisting of an arthroscopic evaluation as well as the attendant follow-up care. The Commission finds Petitioner is entitled to temporary total disability benefits for the period of April 8, 2013 through August 12, 2013 representing 18 and 1/7 weeks. The parties stipulated Respondent is entitled to a credit of $5,128.66 for temporary total disability benefits previously paid.

IT IS THEREFORE ORDERED BY THE COMMISSION that its decision of June 17, 2014 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 12, 2013, is incorporated herein regarding the statement of facts as well as all undisputed issues.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,196.69 per week for a period of 18 1/7 weeks, representing April 8, 2013 through August 12, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any. Respondent shall be given a credit of $5,128.66 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $6,142.54 for the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's injuries pursuant to §§ 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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.

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DEC 20 2018

DATED:

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC

D: 7/25/18

Charles J. DeVriendt

Charles J. DeVriendt

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Joshua D. Luskin

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GINA BRETTMAN,

Petitioner,

vs. NO: 14 WC 09744

TRINITY RIVER CONSTRUCTION, LLC.,

Respondent.

18IWCC0781

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, medical, prospective medical, temporary total disability, average weekly wage/benefit rate, permanent disability and penalties, 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 Petitioner's husband, Derek Brettman, testified that he printed four e-mails that he took from his computer relating to the Respondent's e-mail account that were created and sent by Gina Brettman on the morning of March 12, 2014. (2/24/15 T, pp. 56-59) The e-mails were sent out at 7:59 a.m., 9:08 a.m., 9:15 a.m. and 9:37 a.m. (Px17)

The Petitioner's sister, Anjanette Gangloff (Gangloff) testified via evidence deposition. (Px61/Exhibit A) Gangloff testified that she called Petitioner on the subject date of accident at 9:11 a.m. or 9:12 a.m. (Px61, p. 11)

The following is the pertinent testimony exchange between Petitioner's attorney and Gangloff on direct examination thereafter:

Q. And how do you know that?"
A. Because I called her, and you and I had gone back over it refreshing.
Q. You reviewed this document?
A. Yeah, the phone record, yes.
Q. And this is an itemization of Gina's phone records it appears?
A. It appears to be, yes.
Q. And this is to confirm the approximate time of –
A. Yes.
Q. What was the approximate time and length of the conversation?
A. About 12 minutes. (Px61, pp. 11-12)

Neither Petitioner's telephone number nor her telephone records were identified during Gangloff's evidence deposition or at the arbitration hearing. Further, Gangloff's telephone number was never established thus there is no corroborating evidence of this conversation between Gangloff and Petitioner.

Assuming arguendo, based upon her testimony, Gangloff called Petitioner at 9:11 a.m. or 9:12 a.m. and the conversation lasted 12 minutes, the phone call would have ended at 9:24 a.m. Gangloff testified that she could tell where her sister was when they spoke, and her sister was in the car. Gangloff testified "I asked her what she was doing, and she said she was driving." (Px61/Exhibit B, p. 14) When asked if she could tell from her personal observation whether she was in the car, Ms. Gangloff testified: "Yes. It sounded like she was in the vehicle. I have no reason not to believe that she wasn't. She always -she doesn't lie to me....so she said she was driving to CT to drop off her waivers and pick-up her checks. *Id.* The Commission finds Gangloff's testimony regarding her phone conversation with her sister conflicts with the fact that Petitioner sent an e-mail at 9:15 a.m., the same time Gangloff testified that she and Petitioner were talking on the telephone and the same time she thought Petitioner was in the car. The Commission is not persuaded by this testimony and finds Gangloff's testimony is not credible. If Gangloff spoke with her sister for twelve minutes, Petitioner was at home and typed one email during their conversation at 9:15 a.m. and one after their conversation at 9:37 a.m.

The Petitioner's friend, Margarita Escobedo also testified via evidence deposition. (Px60/Exhibit B) Escobedo testified that she called Petitioner four times March 12, 2014. However, she did not know the exact times the telephone conversations were initiated or the duration of the calls other than that they were brief. Escobedo testified she spoke with Petitioner three times and left her a voice mail as well. Deposition Exhibit Escobedo Number 1 was identified by Petitioner's attorney as an itemization of telephone calls from Petitioner's cell phone on March 12, 2014 and was attached to the evidence deposition of Petitioner's girlfriend, Margarita Escobedo. However, the list was never offered into evidence at the time of the deposition or at the time proofs were closed at the last arbitration hearing.

The Commission notes, however, that before oral arguments, the parties discovered that there were several volumes of witness testimony erroneously omitted from the voluminous authenticated trial transcript. The parties stipulated to an agreed motion and Order on September 26, 2018 which stated: "The presented transcripts of the deposition of Anjanette Gangloff and Margarita Escobedo shall be incorporated into the record on review." The Commission granted

the motion and entered the Order and accepted the tendered documents. By including the referenced phone number list with the presented transcripts of the deposition of Margarita Escobedo, the Commission finds the list is in evidence, albeit for a limited purpose.

The list attached to the evidence deposition neither identifies the Petitioner's name and cell phone number nor includes a complete itemization of the purported Petitioner's cell phone calls. The list shows only five phone calls. The first was an unidentified telephone number beginning with an area code of 708 that occurred at 9:12 a.m. and was 12 minutes in duration. The Commission thus finds this list is unreliable except for the limited purpose of refreshing Escobedo's recollection as to the time and duration of her telephone calls. (Px60/Exhibit A)

Escobedo testified the first telephone call she had with Gina Brettman on March 12, 2014 occurred at 9:25 a.m. "and that is when Gina told me where she was, that she was out doing work for Trinity River Construction." (Px60/Exhibit B p. 12). The Commission notes this phone call was seven minutes in duration. Escobedo also testified that when she had the first conversation at 9:25 a.m. it was her impression that "she was leaving her home around that time." (Px60/Exhibit B p. 13). Based upon the fact that Petitioner sent an e-mail at 9:37 a.m., the Commission is not persuaded that Petitioner told Escobedo that she was "out doing work." Escobedo also testified she spoke with Petitioner at 9:42 and that Petitioner told her she was en route "to run her morning errands for Trinity Construction." *Id.* The Commission notes this phone call was 15 minutes in duration ending at 9:57 a.m. Even if, arguendo, Escobedo was confused regarding the first two phone calls, and Petitioner was leaving her home about the time the second phone call was placed, the Commission is not persuaded that Petitioner told Escobedo she was in route to do work errands when the evidence shows that Petitioner was en route to pick up her prescription at Walgreens and go to physical therapy.

Escobedo testified that she "had to cut our second conversation." (Px60/Exhibit B, p. 15) Escobedo called back at 10:01 and left Petitioner a voice mail. *Id.* The exhibit corroborates a phone call of about a one-minute duration. At 10:04 Escobedo called Petitioner back and spoke with her. Escobedo testified at the end of the conversation Petitioner said "I'll call you right back. I have to run in real quick." The phone itemization list confirms the 10:04 telephone call was on or about 9 minutes duration, ending at 10:13 a.m. (Px60/Exhibit B, p. 16)

Escobedo testified she thought Petitioner was at the title company at the time of the 10:04 telephone call. (Px60/Exhibit B, pp. 17) It is patently obvious to the Commission that the Petitioner was at Walgreen's at the time of the last phone call given she checked out her prescription purchase at 10:14 a.m., a fact confirmed by the Walgreens cash register receipt. (Px22) Therefore, the Commission finds Escobedo's testimony is unreliable and not credible. The Commission further finds that even without Escobedo deposition Exhibit one, the Commission would have come to the same conclusions based upon Escobedo's testimony, the e-mails generated by Petitioner on the morning of March 12, 2014 (Px17) and the Walgreen's receipt (Px22).

Finally, the Commission notes the Arbitrator's Decision with respect to Derek Brettman's testimony regarding his receipt of a duffle bag that was purported to be in Petitioner's vehicle at the time of the accident, which included a bank deposit slip, checks and lien waivers. The Commission finds the conclusion raised by Derek Brettman's testimony is not only speculative,

but his testimony is not credible. First, there is no evidence in any of Petitioner's 61 exhibits that confirm Eric Smith was at the scene of the motor vehicle accident or that corroborates that he would have access to the Petitioner's vehicle at the time of the accident or thereafter when the vehicle was in a police secured tow yard.

Second, the Commission finds Petitioner's Group Exhibit 26 (Px26), the police reports, belie Derek Brettman's testimony. Px26 contains the Illinois Traffic Crash Report, Citation and Complaint, Sergeant Hooten, Officer #352 reports from both Sherman and Condell Hospitals where the semi-driver and Petitioner were taken respectively and various other supplemental police reports which document the chain of custody for Gina Brettman's personal effects and the 2008 Ford Expedition she was driving. The Commission is not persuaded any miscellaneous items, including the duffel bag, would have eluded the police inventory at the scene of the accident or afterward when the vehicle was in police secured custody at Whitey's Towing.

Derek Brettman was interviewed at Condell Hospital on the date of accident by Sergeant Hooten. Sergeant Hooten documented that he provided Derek Brettman with as much information regarding the accident as he could and told him that Gina's personal belongings were secured at the Huntley Police Department. He (Derek) asked if a family friend, Tristan Davis, who was present (at the hospital) would be able to pick up the items. Sergeant Hooten wrote: "I advised him that was okay since I had his permission. Derek said that he thought Gina would have been coming from Dunkin Donuts when the accident occurred. He was unsure of any other errands she was taking care of." The Commission infers that at the time Derek Brettman did not think his wife, Petitioner, was heading to or from a business errand at that location. The same report confirms the day after the accident on 3/13/14 around 0800 hours, Tristan Davis came and signed for Gina's "purse and personal effects." (Px26, Supplemental Report#2)

Derek Brettman testified he received those items. Derek Brettman also testified that a friend, Candice Smith called and told him about the accident. (2/24/15 T, p. 31) Derek Brettman testified later, it was Smith's husband "who works for the Huntley fire department" that allegedly delivered a duffel bag with the son's martial art equipment and "papers including the deposit slip." No reasonable explanation was given to explain how Smith would have retrieved this duffel bag nor is it corroborated by Smith's testimony. The evidence the Commission finds most compelling is the fact that Smith is not listed as a first responder although the first responders are identified in the EMS records. (Px28, p. 1) The first responders to the scene of the accident are named as follows: Schroeder, Keith; Rittenhouse, Benjamin; Beyer, Michael; Verdonck, Scott; Sundquist, Scott; Gail, Ervin and Bianchi, Anthony. (Px28)

Supplemental Report #4 also confirms that V2, Brettman's 2008 Ford Expedition was in "Hold" at Whitey's Towing, Requested by Keane and listed "Hold for Other" The typed part of Supplemental Report #4 stated that as late as on 3/19/14, Det Keane, #356,..."went to Whitey's Tow yard to document the damage to the Unit 2 vehicle, being the 2008 Expedition...(Para. 3, p. 4) ...I then spoke with the law office of Brustin and Lundblad who are representing the driver of Unit 2. They requested that I speak with their hired accident reconstructionist in order to take photographs of the vehicle. I then spoke with David Sallmann who stated that he was hired by Brustin and Lundblad and wanted to examine the 2008 Expedition. Based on the fact that he wanted to take measurements I set up an appt to meet him at Whitey's Towing on 3/21/2014 at

11:00 AM... (Paragraph 4, page 4, PxGroupx26) On 3-21-2014 I met with David Sallmann at Whitey's Towing. David stated he would be taking photographs and measuring the vehicles. (P. 5)

Supplemental Report #7 Report dated 3/17/14 (Px26) listed the Purpose as "Tow yard. The Property Item(s) listed the number as "10"; Status: "Returned to Owner" ...Description: "misc items from SUV" The report further states:

> On 3/17/14 at 1000 hours, I went to Whitey's Tow yard in Crystal Lake and met with an insurance adjuster who wanted to take photos of Gina's vehicle. I met with Dustin Hatch and we both went into the secured garage of Whitey's with one of the drivers. Dustin took photos of the vehicle as I went through it looking for personal effects, per Derek Brettman's request.
>
> Derek stated there may be business paperwork and checks in the truck. He also said there may be a duffel bag with kid sports gear in it. With the help of the tow truck driver, we looked through the SUV and did not find the business paperwork or the duffel bag. I was able to collect a re-usable bag and put sunglasses, garage door opener, blank business deposit slips, a notarized blue piece of paper that looks like a contract, a black jacket, a Pottery Barn bag with miscellaneous paperwork, and a gray scarf inside it and brought it back to the police station. Derek also asked for the child booster seat that was in the backseat of the SUV. That also was brought back to the station.
>
> I called Derek and left a detailed message explaining there was no business paperwork or checks in the vehicle. I confirmed with officers on scene and the accident pictures that there was no paperwork seen.
>
> I filled out a property return receipt and put a copy of the drivers exchange and 10-50 form in the Sergeants Office along with the items retrieved from the SUV. Patrol was notified that either Derek or Tristan will stop by to sign for the property. Derek again gave Tristan permission to pick up the items. Nothing further at this time. (Px26)

The Commission finds it is curious that the same day the Petitioner's first Application for Adjustment of Claim was signed with Derek Brettman's signature, is also the first mention of the duffel bag. (Px3, PxA) The Commission further finds that Derek Brettman's testimony that Eric Smith gave him a duffel bag is contradicted by the police reports and the EMS records, and accordingly is not credible. (Px26, Px28)

Based upon a review of the record as a whole, the Commission concurs with the Arbitrator's Decision and concludes Petitioner has failed to prove she was engaged in a business errand March 12, 2014 and therefore finds Petitioner did not sustain accidental injuries which arose out of and in the course of her employment. The Commission modifies the Arbitrator's Decision as stated herein and otherwise affirms and adopts the Arbitrator's Decision.

18IWCC0781

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claim for compensation is denied. All other issues are rendered moot.

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: DEC 20 2018
KWL/bsd
O:10/23/18
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRETTMAN, GINA
Employee/Petitioner

Case# **14WC009744**

TRINITY RIVER CONSTRUCTION LLC
Employer/Respondent

18IWCC0781
18IWCC0781

On 1/26/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0786 BRUSTIN & LUNDBLAD LTD
MILO LUNDBLAD
10 N DEARBORN ST SUITE 700
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

18IWCC0781

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gina Brettman
Employee/Petitioner

Case # 14 WC 9744

v.
Trinity River Construction, LLC.
Employer/Respondent

Consolidated cases:

18 IWCC0781

An *Application for Adjustment 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 Falcioni, Arbitrator of the Commission, in the city of Kankakee, Illinois on 2/24/15, 7/21/15, 7/7/16, 12/19/16. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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 3-12-14, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $38,208.96; the average weekly wage was $734.79.

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

See Attached and above.

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

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

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

Robert E. Atherton

Signature of arbitrator

January 16, 2017

Date

JAN 26 2017

MEMORANDUM OF DECISION OF ARBITRATOR

In support of the Arbitrator' s decision relating to (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds the following facts:

Petitioner, Gina Brettman, was unable to testify due to injuries sustained in the accident in question. It was represented that Petitioner's husband, Derek Brettman, has been named her legal guardian. Mr. Brettman testified in this matter.

Mr. Brettman testified Petitioner was employed as an office administrator. Generally, her job duties involved office work, bookkeeping, mailings and banking. On March 12, 2014, it is alleged Petitioner sustained injuries as a result of a motor vehicle accident while engaged in a business errand. It is alleged Petitioner was traveling to Chicago Title Company in Crystal Lake, Illinois from the company business office in Marengo, Illinois at the time the accident occurred.

Petitioner's sister, Anjanette Gangloff, testified in this matter by evidence deposition. Ms. Gangloff testified to having a close relationship with her sister and talking with her on the phone often. Ms. Gangloff testified she reviewed phone records to refresh her memory and recalled speaking with Petitioner on the phone at 9:11 or 9:12 a.m. on the date of the accident, March 12, 2014. According to Ms. Gangloff, the two spoke for 10-12 minutes. Ms. Gangloff claimed that Petitioner specifically told her during their conversation that she was on her way to CT meaning Chicago Title in Crystal Lake (Deposition transcript of Ms. Gangloff of August 28, 2014, Pg. 13 and Pg. 16). Ms. Gangloff specifically testified that Petitioner stated to her in direct response to a question what are you doing that she was "I'm on my way to Chicago" meaning Chicago Title (Deposition transcript of Ms. Gangloff, Pg. 16). Despite the alleged close relationship of Ms.

Gangloff and Petitioner, Ms. Gangloff did not offer any testimony as to knowledge of personal appointments Petitioner may have been performing this date. It is noted that Petitioner did not visit Chicago Title in Crystal Lake following this conversation. It is further noted that the accident alleged occurred at least one hour after their conversation took place and Petitioner had not yet visited Chicago Title prior to its occurrence.

Margarita Escobedo also testified by evidence deposition. Ms. Escobedo testified she is best friends with Petitioner. She spoke with Petitioner three times on the morning of the accident, March 12, 2014. Ms. Escobedo acknowledged having lengthy telephone conversations with Petitioner on a regular basis during business hours, despite the contention that Petitioner worked full time during business hours. Ms. Escobedo's third conversation of the morning with Petitioner started at 10:01 a.m. Ms. Escobedo claimed she believed Petitioner was running errands for Trinity Construction the morning of the accident. She claimed that at the end of her last conversation with Petitioner after 10:00 a.m., she believed Petitioner was at a Title Company. The Arbitrator notes again that Petitioner did not visit Chicago Title in Crystal Lake on the morning of the accident. There is no evidence Petitioner visited another Title Company the morning of the accident. At the time of the last conversation with Petitioner, it appears fro the record that Petitioner was in fact at or about to arrive at the Walgreens in question herein.

Derek Brettman is Petitioner's husband and the owner of Respondent company, Trinity River Construction. The company has a workers' compensation insurance policy. The policy does not carry any deductible which the company is responsible for. Mr. Brettman testified to a conversation with Petitioner the night before the accident on March 11, 2014. Mr. Brettman claimed she was going to Chicago Title in Crystal Lake the next day to pick up more checks. In

testifying, Mr. Brettman used the term in plural checks and not a single check (T39, testimony February 24, 2015). In his direct testimony, Mr. Brettman made no mention of any personal errands or personal activities Petitioner discussed with him March 11, 2014 an if fact denied knowledge of Petitioner's treatment with Athletico Physical Therapy. Mr. Brettman acknowledged that he wanted to convince the Commission that his wife, the Petitioner, was traveling on a business errand when the March 12, 2014 accident occurred (T83, testimony February 24, 2015). Again, Mr. Brettman denied knowledge that his wife was involved in a physical therapy program for her back prior to the accident (T92-93). Mr. Brettman denied being aware his wife attended a physical therapy visit for her back condition on Friday, March 7, 2014. He denied helping his wife with exercises for her back condition over the weekend of March 8 or March 9, 2014 (T97, testimony February 24, 2015). Mr. Brettman denied his wife ever told him she had a physical therapy appointment scheduled the morning of March 12, 2014 (T99, testimony February 24, 2015). Mr. Brettman denied being aware the reason Athletico Physical Therapy may have been trying to contact his wife after March 12, 2014. He denied his wife had a scheduled appointment at Athletico Lake in the Hills at 11:00 a.m. on March 12, 2014 (T101-102, testimony February 24, 2015). He also denied knowing that his wife was taking a prescription medication to relieve her back

Susan Anderson testified she is a physical therapist employed by Athletico Lake in the Hills for the past 10 years. She stated the Petitioner, Mrs. Brettman, was a patient of hers in March of 2014. Ms. Anderson began treating Petitioner for a back problem commencing March 7, 2014 (T25-27, testimony July 7, 2016). Following the initial visit of March 7, 2014, Petitioner scheduled visits with Ms. Anderson on March 10, 2014, March 12, 2014 and March 14, 2014.

Petitioner attended a second visit with Ms. Anderson on Monday, March 10, 2014. Ms. Anderson specifically testified that on March 10, 2014, Mrs. Brettman stated she was having increased pain because her spouse was trying to assist her with stretching when he dropped her leg (T27, 32, testimony July 7, 2016). The records of Athletico Lake in the Hills Physical Therapy show that on March 7, 2014, Petitioner was given home program instruction by her therapist. Further, the records specifically show that on March 10, 2014, Petitioner stated to Ms. Anderson that her spouse was stretching her legs and accidentally let her legs fall which resulted in increased pain (RX 6). Ms. Anderson testified Petitioner had a scheduled physical therapy appointment with her at Athletico Lake in the Hills at 11:00 a.m. Petitioner was expected to attend the appointment. No one attempted to cancel the visit (T28-29, testimony July 7, 2016). The Athletico Company records show Petitioner is listed as a no-show/no-call for the March 12, 2014 visit (RX 7The Arbitrator concludes Petitioner had a scheduled physical therapy appointment at Athletico Lake in the Hills at 11:00 a.m. on March 12, 2014, the morning of the motor vehicle accident which is the subject of this claim.

The evidence of record shows Petitioner was employed as an office administrator for Respondent. No record was kept of the days or hours Petitioner actually worked for Respondent during the course of a week. There was some inconsistency whether Petitioner was paid hourly or salaried. In medical history forms written by Petitioner less than 8 months prior to the accident which is the subject of this claim, Petitioner described her occupation as a part-time secretary (RX 5). Mr. Brettman admitted that Petitioner identified her position as a part-time secretary (T19-20, testimony July 21, 2015). Mr. Brettman admitted that no record was kept of personal activities or personal time Petitioner engaged in during business hours. If Petitioner

attended to personal business during business hours, there was no record kept of it or any change in Petitioner's pay (T95-96, testimony February 24, 2015). Conversely, he testified that Petitioner had his full permission to attend to personal matters during working hours, although no specific permission was given to her to go to Walgreens or attend physical therapy, as he had no knowledge of these activities being performed by the Petitioner prior to the accident.

On the morning of March 12, 2014, Petitioner had driven to Walgreens at 12000 Princeton Drive in Huntley, Illinois. There is no evidence presented Petitioner had driven to any other place that morning. The evidence shows Petitioner purchased a prescription from Walgreens at 10:14 a.m. on March 12, 2014 (RX 1). The prescription was for Nabumetone, an antiinflammatory and pain medication she had been prescribed for her back condition (RX 2). Petitioner reported increased pain at the time of her March 10, 2014 therapy visit. Petitioner did not buy any items at Walgreens in addition to her single medication. There is no business related reason alleged for Petitioner to travel to the Walgreens in Huntley, Illinois. A map of the area shows the Walgreens in Huntley, Illinois is not on any route Petitioner would take from the Brettman home to Chicago Title in Crystal Lake, Illinois. According to Derrick Brettman, there were many different ways to get from his house to the Walgreens in question, with the most usuall route being "down the backside of Dell Webb.."This route would not take Petitioner on route that would be on the way to either Chicago Title or Golden Eagle bank. Nor is it on a route directly to Athletico.

Based on police and emergency personnel records in evidence, the motor vehicle accident in question occurred at approximately 10:20 a.m. at the intersection of Kreutzer Road and Route 47. The Walgreens Petitioner visited is located at this intersection. Petitioner offered no

explanation as to any business related reason for her to be at this intersection. Petitioner offered no evidence of any business related reason for her to be in this area of Kreutzer Road. It is apparent Petitioner had driven to this area of Kreutzer Road to visit the Walgreens store in Huntley for personal reasons. The intersection of Kreutzer and Route 47 was under construction at the time of the motor vehicle accident. There were temporary lights in place on wires which were noted by one of the police officers responding to the scene to be blowing slightly in the wind. The officer also noted intersection traffic lights were dim and a bit hard to see but the colors were visible. There was snow on the lenses of the signals. The Petitioner was making a left hand turn from Kreutzer Road on to Route 47 when the accident occurred. Petitioner had a scheduled physical therapy appointment at Athletico Lake in the Hills located at 280 North Randall Road, Lake in the Hills, Illinois at 11:00 a.m. The location of the Athletico is approximately 7 miles from the Walgreens store and Petitioner's location at the time of the accident. Pursuant to the maps admitted in evidence, Athletico lies approximately between either Chicago Title and Golden Eagle Bank and Petitioner would presumably taken northbound Rte 47 for at least a portion of the journey to any of the above locations.

CONCLUSIONS OF LAW

THE Arbitrator notes at the outset that Petitioner bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Indus. Comm'n*, 223 Ill App. 3d 706 (1992). Preponderance of the evidence means the greater weight of the evidence in merit and worth which has more evidence for it than against it. *Spankrov v. Alesky*, 45 Ill. App. 3d 432 (1st Dis. 1977). In support of the Arbitrator's decisions, the Arbitrator finds that the following conclusions of law are supported by a preponderance of the evidence:

Petitioner has not presented any definitive evidence to show she was driving on a business errand at the time of the accident. No evidence was presented Petitioner was instructed by

management to travel on the morning in question. No evidence was presented Petitioner was required to travel for any business related reason on the morning in question. No evidence was presented Petitioner had any business related appointments on the morning in question. Petitioner was not instructed by her employer to perform any business related travel this date and was not restricted by the employer from engaging in personal activities during business hours. It was alleged by witnesses that Petitioner was traveling to Chicago Title in Crystal Lake, Illinois based on conversations and an alleged telephone call Petitioner had with her sister shortly after 9:00 a.m. However, Petitioner did not visit Chicago Title at that time as alleged. No evidence ifn fact exists that Petitioner did anything business related after leaving her office after answering some emails and preparing some business documents. Mr. Brettman testified to receiving a duffle bag that was in Petitioner's vehicle at the time of the accident which included a bank deposit slip, checks and lien waivers. Based on this, it is suggested that Petitioner was engaged in a business errand the morning of the accident. However, the Arbitrator finds that such a conclusion is speculative. The only positive evidence relating to what Petitioner was doing or scheduled to do on the morning in question is that she arrived at Walgreens and filled a prescription and that she had a physical therapy appointment shortly thereafter which she did not attend presumably due to the accident she was involved in.attend a scheduled physical therapy appointment at Athletico Lake in the Hills for her back condition.

No evidence was presented of any scheduled or required visit to a bank or Title Company at or around the time of this accident. Further, actual bank and Title Company records in evidence show Petitioner did not visit the bank or Title Company with the frequency the witnesses seem to allege. Petitioner did not call any witnesses to testify from the Golden Eagle

Community Bank or Chicago Title Company to testify as to what business Petitioner would have attended to at those respective facilities. The Respondent company business account was at Golden Eagle Community Bank. Golden Eagle Community Bank records in evidence show deposits made, apparently by Mrs. Brettman into the company business account over the past several months. In reviewing deposits made over the three month period prior to the accident, the records show that in December 2013 there were 21 business days. Petitioner or a representative of Respondent made deposits on only five of those days: December 3, 2013, December 5, 2013, December 9, 2013, December 10, 2013, and December 17, 2013.

Similarly, in January 2014, there were 22 business days. Petitioner or a representative of Respondent made deposits on only six of those days: January 2, January 3, January 8, January 9, January 24, and January 31, 2014. In the month of February 2014, there were 20 business days. Petitioner or a representative of Respondent made deposits on only four of those days: February 4, February 10, February 12, and February 19, 2014. Based on these records, it was unusual for Petitioner to make deposits two days in a row. It would be highly unusual for her to visit the bank three days in a row. The Golden Eagle records show that in the week prior to the accident, there was only one deposit made on March 3, 2014. No further deposits were made the rest of the week of March 3, 2014. On March 10, 2014, a deposit was made of $73,446.00. The next day on March 11, 2014, a deposit was made of $31,430.82. Derrick Brettman testified that there were sufficient funds in the company's account to cover the payroll due the next day. It is unknown whether any checks were available to Petitioner at Chicago Title Company on March 12, 2014, particularly the morning of March 12, 2014. Chicago Title Company records in evidence show that checks dated March 4, March 10, and March 11, 2014 had all been deposited

into Golden Eagle Bank on March 11, 2014. The only check that may have been available was a single check in the amount of $5,446.00 (RX 8).

After hearing multiple witnesses and reviewing all the documentary evidence presented, the Arbitrator concludes Petitioner has failed to prove she was engaged in a business errand March 12, 2014. The Arbitrator therefore finds Petitioner did not sustain accidental injuries which arose out of and in the course of her employment. The claim for compensation is denied. All other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RANDALL RYJEWSKI,

Petitioner,

vs. NO: 09 WC 35861

SEASON'S HOUSE,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's "Petition to Compel Issuance of a Notice of Case Dismissal or Alternatively Case Reinstatement Instanter" (*Petitioner's Petition*), which was filed on October 25, 2018. A hearing was held before Commissioner DeVriendt on November 16, 2018, in Chicago, Illinois, and a record was made.

This matter was originally before Arbitrator Williams on February 18, 2015. Attorney John E. Lusak appeared for the Petitioner and Joseph Fitzpatrick for Respondent also appeared. *See* Affidavit of John E. Lusak, ¶¶6, 8, and Transcript p. 8. This matter was to be returned to the call as Petitioner was still undergoing medical care. Arbitrator Williams indicated that the case would be returned to the call, but erroneously dismissed the case without prejudice as of February 18, 2015. (T. p.6). Neither party was aware of the case dismissal and continued to negotiate a potential settlement agreement well into 2016. *See* Commissioner Ex.1, attachment A.

The Commission finds counsel for Petitioner's argument that no notice was received to be more persuasive than Respondent's counsel's argument that they were aware of the dismissal and were not required to advise Petitioner and that they will be unduly prejudiced should the case be allowed to proceed.

Respondent argues the matter was dismissed on February 18, 2015 and notices of dismissal were generated by the Commission on February 19, 2015. Therefore, Petitioner was required to file his Petition to Reinstate within 60 days thereafter. Accordingly, since Petitioner filed his Petition to Compel Issuance of a Notice of Case Dismissal or Alternatively Case Reinstatement Instanter on October 25, 2018, beyond the 60-day limit, his Petition is barred.

Petitioner asserts his Petition is timely as he never received the Notice of Dismissal to commence the 60-day clock. 50 Ill.Admin Code 9020.90(a), states in pertinent part: "When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days ***from receipt of the dismissal order*** to file a Petition to Reinstate the cause onto the Arbitration call." *Emphasis added.* Petitioner produced an affidavit in support of his argument that notice was never received. As the clock does not begin to run to file a reinstatement until the receipt of the dismissal order, Petitioner's Petition to Compel Issuance of a Notice of Case Dismissal or Alternatively Case Reinstatement Instanter was timely filed.

In advancing its argument, Respondent relies on the cases of *Conreras v. Industrial Comm'n,* 306 Ill.App.3d 1071 (1999) and *Banks v. Industrial Comm'n*, 345 Ill.App.3d 1138 (2004), and claims that the Petitioner had an obligation to keep track of this case and ensure that the Petition to Reinstate was timely presented and timely heard and that Petitioner had an affirmative duty to exercise due diligence in the prosecution of this case. Respondent's further argument that Respondent is prejudiced based on the passage of time is also not compelling. Respondent made a generalized statement that there may be witnesses gone or documents no longer available but did not provide evidence in support of this statement.

We find Respondent's citations distinguishable and not compelling in the face of evidence presented at hearing. The evidence of the actions of both counsel for Petitioner and Respondent indicate that attorney Lusak continued to operate under the impression that the case was active, and he had no knowledge that the case had been dismissed. Respondent continued to negotiate this case as though it were an active and open case for at least a year and a half after the dismissal. Respondent's claim that he did not have a duty to notify Petitioner of the dismissal and that he would let sleeping dogs lie is not persuasive.

Finally, we note that in *Conley v. Industrial Commission*, 229 Ill. App. 3d 925, 594 N.E.2d 730 (1992), the Court found that the "[t]he granting or denying of the petition to reinstate rests in the sound discretion of the Commission." *Conley* at 930.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition to Compel Issuance of a Notice of Case Dismissal or Alternatively Case Reinstatement Instanter is granted and Petitioner's case is reinstated.

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

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

DATED: DEC 2 1 2018

Charles J. DeVriendt

CJD/dmm
R: 111618
49

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM McCARTHY,

Petitioner,

18IWCC0782

vs.

NO: 14 WC 35167

CITY WATER LIGHT & POWER,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner sustained an undisputed compensable accident on February 3, 2012 and sustained an injury to his right shoulder. Subsequently, he had five surgeries on his shoulder, the last two being a total reverse shoulder arthroplasty and revision shoulder arthroplasty, respectively. The Arbitrator found that Petitioner's current condition of ill-being was causally related to his work-accident and awarded him 57&4/7 weeks of temporary total disability benefits, $151,412.30 in medical bills submitted into evidence, and determined that Petitioner was permanently and totally disabled as of August 19, 2016. The Commission agrees with the Arbitrator regarding the issues of causal connection, the award of medical expenses, the finding that Petitioner was permanently and totally disabled as of August 19, 2016, and his denial of Petitioner's Petition for Penalties and Fees. Accordingly, the Commission affirms and adopts those aspects of the Decision of the Arbitrator.

Regarding the issue of temporary total disability, the Arbitrator awarded benefits from June 23, 2015 through August 18, 2017, the day immediately before the Arbitrator determined Petitioner became permanently and totally disabled. However, the record established that Petitioner executed a resignation letter on January 22, 2017, voluntarily retiring from Respondent's employment effective February 13, 2016. In addition, Petitioner testified that he was receiving retirement benefits at the time of the arbitration hearing. The Commission finds that as of February 13, 2016, Petitioner voluntarily took himself out of the labor market, began receiving retirement benefits, and thereby became ineligible for continued temporary total disability benefits. Therefore, the Commission modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $929.39 per week for a period of 33&5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $929.29 per week for life, commencing August 19, 2016 as provided in §8(f) of the Act, for the reason that the injuries sustained caused the permanent and total disability of Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner compensation that has accrued from June 23, 2015 through October 25, 2017, and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMMISSION that Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $151,412.30 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule.

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

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

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

DATED: DEC 21 2018

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

Stephen J. Mathis

DLS/dw
O-11/1/18
46

18IWCC0782

Dissent

I am in concurrence with the majority opinion with respect to causal connection, medical expenses, permanent partial disability and the denial of the imposition of penalties and fees, however, I respectfully dissent from the majority decision with respect to temporary total disability and would affirm the Arbitrator's well reasoned decision in its entirety.

The majority decision ceases Petitioner's temporary total disability benefits as of February 13, 2016 on the basis that Petitioner voluntarily took himself out of the labor market by retiring and commencing receipt of retirement benefits as of that date. Petitioner's unrebutted testimony is that he sought accommodated duty consistent with his permanent restrictions in the fall of 2015. Respondent was unable or unwilling to accommodate those restrictions. On January 14, 2016, Petitioner received a letter from the Respondent informing him that he would be terminated effective March 16, 2016 if he could not return to work. Faced with the prospect of being terminated for not being able to return to work without restrictions, Petitioner chose to retire. Petitioner made several attempts to return to work during the course of his treatment. Petitioner sought accommodated duty when given permanent restrictions. Petitioner testified that it was his intention to work at least two more years to maximize his pension. The evidence and unrebutted, credible testimony clearly established that Petitioner did not voluntarily remove himself from the labor market but retired because of the circumstance Respondent placed him in as a result of the accident he incurred. Accordingly, I would affirm the Arbitrators well reasoned decision in its entirety.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0782

McCARTHY, WILLIAM
Employee/Petitioner

Case# **14WC035167**

14WC039420

CITY WATER LIGHT & POWER
Employer/Respondent

On 12/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)
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 McCarthy
Employee/Petitioner

Case # 14 WC 35167

v.

14 WC 39420

City, Water, Light & Power
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, Arbitrator of the Commission, in the city of Springfield, on October 25, 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On February 3, 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 $ 72,492.54 the average weekly wage was $ 1394.08 .

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 is entitled to a credit for medical bills paid by its group carrier.

The parties stipulated that Respondent paid all TTD owed to the Petitioner through 9/17/2014.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ 929.39/week for 57 4/7 weeks, commencing **June 23, 2015** through **August 18, 2016** , as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ 929.39/week for life **commencing August 19, 2016**, because the injuries sustained caused **Petitioner to become permanently and totally disabled** as provided in Section 8(f) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **June 23, 2015** through **October 25, 2017** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $ **151,412.30** for medical services, as provided in Section 8(a) of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with

regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay $ 0 in penalties, as provided in Section 19(k) of the Act.

Respondent shall pay $ 0 in penalties, as provided in Section 19(l) of the Act.

Respondent shall pay $ 0 in attorneys' fees, as provided in Section 16 of the Act.

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

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

D. Dglas McEnty

Signature of arbitrator

12/8/2017
Date

DEC 12 2017

The Arbitrator finds the following facts:

Two cases were consolidated for arbitration. The companion case is claim number 14 WC 39420. Both cases concern injuries to the same part of body, Petitioner's right shoulder.

On February 3, 2012 Petitioner was employed by Respondent as the foreman at Respondent's Lake Services division and had held that position for the five years prior to February 3, 2012. Petitioner was a working foreman and his job duties included supervising employees, mowing, cutting trees, or cleaning the lake in a boat.

Petitioner sustained an injury to his right shoulder and had three surgeries in 1991, 1992 and 1993. The surgeries were necessitated by an injury Petitioner sustained to the right shoulder working for the same Respondent. After the surgery, Petitioner returned to work for Respondent without restrictions. Petitioner stated that after returning to work for respondent he did not have any lingering issues with the right shoulder, nor did he seek any treatment for that condition between 1993 and February 3, 2012.

On February 3, 2012 Petitioner was instructed to load a dump truck bed with firewood and logs to take to one of the clubs on the lake. Petitioner stated he lifted the log with his hands above his head and felt a pop in his shoulder. Petitioner felt the immediate onset of pain and numbness going down his right arm to his hand. Petitioner stopped working and notified the acting supervisor of Lake Services. Petitioner was sent to the St. John's Hospital emergency room.

Petitioner provided the St. John's emergency room doctor with the details of his prior right shoulder surgeries and a description of the accident at work earlier that day. Petitioner complained of pain in his right shoulder, decreased sensation, or numbness and tingling, in his right ring and small finger and was unable to lift his arm above his shoulder. (PX 2) X-rays were negative. (PX2) Petitioner was discharged and advised to follow up with a workers' compensation doctor. (PX 2)

On February 6, 2012 Petitioner was seen by Midwest Occupational Health Associates (MOHA) accompanied by Cheryl Murphy, an employee representative of Respondent. (PX 3) Petitioner informed Jennifer Frank, APN of the accident and that since he had been to St. John's

Hospital emergency room he had not had an improvement. (PX 3) Petitioner complained of right shoulder pain, tingling in his last two fingers and that his shoulder "was out of place". (PX 3) Petitioner completed a pain drawing showing stabbing pains on the top of his shoulder and burning in the front of his shoulder and upper arm. He also noted "pins and needles" on the right hand. (PX 3)

Petitioner also advised APN Frank of his prior three work related surgeries and that since his last surgery in 1993 he had not had any other problems with his right shoulder. (PX 3) On examination, Petitioner was noted to have limited range of motion of his right shoulder, with abduction to 80 degrees and forward flexion to 90 degrees and limited internal and external rotation, and decreased strength in the right upper extremity of a 3/5. (PX 3) Petitioner was diagnosed with a shoulder strain and was prescribed Prednisone, on a tapering dose, and Flexeril. APN Frank also stated that Petitioner was to return and an MRI would be ordered if there was no improvement. (PX 3) Petitioner was restricted to no use of the right arm and no overhead activities. (PX 3)

Petitioner returned to MOHA on February 10, 2012 noting that he was somewhat better and had pain of a six out of ten indicating moderate to severe symptoms. Petitioner stated he felt the Prednisone was helping but he still had pain in the shoulder and biceps region. (PX 3) On examination he had pain to palpation over the bicipital groove and over the AC process. Petitioner was noted to be able to forward flex his arm to 50 degrees but over 50 degrees he had pain in the shoulder that radiated out to the biceps area. (PX 3) The MOHA practitioner that examined Petitioner stated in the record that Petitioner had no problems with his fingers, however Petitioner's pain drawing completed the same day shows that Petitioner had numbness of his right small and ring finger. (PX 3)

Petitioner was advised to finish his Prednisone taper, begin taking Norco, continue Flexeril and continue working with the current restrictions. (PX 3) Petitioner was told that if he did not improve at the next visit an MRI would be obtained. (PX 3)

On February 14, 2012 Petitioner returned to MOHA noting that he had not improved and began having difficulty sleeping and had to sleep in a chair. (PX 3) Petitioner's clinical examination findings were the same as the February 10, 2012 visit and an MRI was

recommended. (PX 3) Petitioner was accompanied by a case manager from Respondent and the case manager agreed. (PX 3) Petitioner continued to be restricted to no use of the right arm, no overhead activities and no lifting over 2 pounds. (PX 3)

An MRI was performed at the Springfield Clinic on February 16, 2012. (PX 4) The MRI was positive for severe tendinosis of the supraspinatus and infraspinatus tendinosis with a partial articular sided tear involving the supraspinatus tendon, a posterior labral tear and acromioclavicular and gleno-humeral osteoarthritis with a moderate sized gleno-humeral joint effusion and sub-deltoid bursitis. (PX4)

MOHA referred Petitioner to Dr. Christopher Wottowa for further treatment of Petitioner's shoulder. (PX 3)

Petitioner was examined by Dr. Wottowa on February 22, 2012. Dr. Wottowa recorded a complete history of Petitioner's employment and work accident, as well as his surgeries twenty years before, his more recent treatment and his current symptoms. (PX 4) Dr. Wottowa examined Petitioner and noted guarding and Dr. Wottowa stated that Petitioner had a scar over the area where a person might have a suprascapular nerve decompression. (PX 4) Dr. Wottowa reviewed the MRI and concluded that Petitioner had pre-existing problems with his shoulder including AC joint arthrosis, gleno-humeral joint arthrosis, chronic tendinosis of the supraspinatus and the accident of February 3, 2012 exacerbated these conditions. (PX 4) Dr. Wottowa felt the best way to start treating the condition was with an injection. (PX 4) Dr. Wottowa injected Petitioner's right shoulder and ordered physical therapy. Dr. Wottowa felt the Petitioner's problem would resolve in six to twelve weeks. (PX 4) Petitioner was limited to no lifting over 5 pounds. (PX 4)

Petitioner began physical therapy at Memorial Industrial Rehabilitation on February 27, 2012. (PX 5)

On February 29, 2012 Petitioner returned to Dr. Wottowa and was seen by his Assistant David Purves, PA. (PX 4) PA Purves noted Petitioner had been performing his exercises and since then had "excruciating" pain in his right shoulder and he had no relief from the injection. (PX 4) Dr. Wottowa noted Petitioner continued to complain of pain involving the interior and lateral aspect of the arm with any activity of the shoulder and only had relief when he put his arm into his sweatshirt pocket or rested on his lap. (PX 4) Petitioner was advised to continue with

physical therapy, medications and light duty work. (PX 4) Dr. Wottowa prescribed Tramadol for pain and to help Petitioner sleep. (PX 4)

Petitioner's last physical therapy visit was on April 2, 2012. Petitioner was noted to have gained some range of motion but his pain levels "remain about the same". (PX 5)

On April 4, 2012 Petitioner was examined by Dr. Wottowa noting no improvement with pain over the anterior aspect of the shoulder and AC joint. (PX 4) Petitioner was accompanied to the visit with Respondent's "workers' comp case manager" Ms. Hasselbring. (PX 4) Dr. Wottowa noted that he had received a note from Petitioner's cardiologist that suggested that Petitioner should remain on Plavix through September and that made it difficult to recommend surgery at that time due to the chance of bleeding. (PX 4) Dr. Wottowa felt that he should try very strongly to avoid surgery and recommended Petitioner continue with his home exercises, continue the same restrictions and have a second injection into the right shoulder, which Dr. Wottowa performed that day in the subacromial space and AC joint. (PX 4)

On May 16, 2012 Petitioner returned to Dr. Wottowa and noted that the injection helped his pain and was about 70 to 75% of normal that day. Dr. Wottowa released him to return to work without restrictions. (PX 4)

Petitioner returned to Dr. Wottowa on June 20, 2012 at which time Dr. Wottowa stated that petitioner was "...working full duty, which is a distinction we make only for work, because in reality, he is able to do his job and modify his job as he needs to, so he is not actually doing all of his normal activities, we just do not have him on any restrictions and he tends to restrict himself and he is able to do this". (PX 4) Dr. Wottowa noted that the second steroid injection lasted for one month and it had tapered off over the last month and he was only 45% of normal. Dr. Wottowa stated that a third injection would be the last for a while. Dr. Wottowa noted that Petitioner would be on Plavix for one year in the fall and Petitioner might be able to get off Plavix "if we have to do something in the future". (PX 4) A third injection was administered to Petitioner. (PX 4) Dr. Wottowa allowed Petitioner to continue to work since he could adjust his work activities to avoid using his right arm and if Petitioner's discomfort continued he could "choose to do something surgical". (PX 4)

On August 22, 2012 Petitioner returned to Dr. Wottowa noting continued shoulder pain over the AC joint. On examination, Dr. Wottowa noted guarding over the shoulder, crepitation and impingement signs. (PX 4) Dr. Wottowa stated that it had "been my impression through most of

his treatment that it would be unlikely that we would be able to successfully treat him conservatively". (PX 4) Dr. Wottowa recommended a shoulder arthroscopy to evaluate the biceps tendon, the labrum and rotator cuff. (PX 4) Dr. Wottowa requested cardiovascular clearance and requested workers' compensation approval for the surgery. (PX 4) The Respondent authorized the surgery through its workers' compensation insurance coverage.

On November 13, 2012 Dr. Wottowa performed a right shoulder arthroscopic surgery during which he performed a subacromial decompression, distal clavicle resection and rotator cuff repair. (PX 4) Intraoperatively, Dr. Wottowa used a shaver to trim back the labrum to normal tissue and resected a large reactive subacromial bursa and a very large anterior-inferior acromion. Dr. Wottowa then repaired the supraspinatus where it was noted Petitioner had marked, crab-meat fraying suggestive of a high grade partial if not full thickness tendon tear near the anterior portion of the tear. Dr. Wottowa repaired the supraspinatus tendon tear with four Arthrex tape or strand anchors and two Push-Lock anchors. (PX 4)

Petitioner returned to Dr. Wottowa on November 26, 2012 for his first post-operative checkup. Petitioner noted that after his surgery block wore off he had a lot of pain and was taking a lot of Vicodin. Dr. Wottowa ordered therapy and released him to light duty work with no use of the right hand. (PX 4)

Petitioner resumed physical therapy at Memorial Industrial Rehabilitation. (PX 5)

On December 12, 2012 Petitioner told Dr. Wottowa that he noticed a bump on the back of his right shoulder. (PX 4) On January 9, 2012, Dr. Wottowa noted that petitioner had less pain with doing activities at the waist level but still had discomfort when reaching his arm away from his body. (PX 5) Dr. Wottowa also noted Petitioner was having difficulty in physical therapy with pain over the anterior portion of his shoulder radiating down to his biceps. Dr. Wottowa noted that he did do a "biceps tenotomy" at the time of surgery. (PX 4) Petitioner was allowed to return to work with no lifting over 5 pounds and could drive a small pick-up. (PX 4)

On February 6, 2013 Petitioner returned to Dr. Wottowa who stated that Petitioner had "… a decided case of the slows" and his right shoulder was not getting better fast enough. (PX 4) Petitioner had continued to have severe shoulder pain about the biceps area of his shoulder and down that lateral aspect of his arm which bothered him when he reached out away from his body. (PX 4) On examination, Dr. Wottowa noted guarding and reduced range of motion and

diagnosed a "frozen shoulder". (PX 4) Dr. Wottowa administered a fourth steroid injection into the right shoulder and advised him to continue light duty and physical therapy. (PX 4)

The fourth injection did not provide Petitioner with relief and Petitioner told Dr. Wottowa that it provided no relief. Dr. Wottowa summarized the treatments that were being provided to Petitioner and noted that Petitioner was not improving despite the treatment. (PX 4) Dr. Wottowa kept Petitioner on restricted work and recommended continued physical therapy. (PX 4)

On May 8, 2013 Petitioner returned to Dr. Wottowa accompanied by the workers' compensation case manager, Lavonne Haselbring. (PX 5) Dr. Wottowa felt there had been improvement based on looking at petitioner at intervals. Dr. Wottowa asked Petitioner to return in six weeks for further assessment and possibly for a functional capacity evaluation to determine fitness for duty. (PX 4)

On June 19, 2013 Petitioner returned to Dr. Wottowa complaining of continued pain over the biceps region of his right shoulder. (PX 4) Dr. Wottowa elected to inject the biceps region. (PX 4)

On July 17, 2013 Petitioner returned to Dr. Wottowa noting that the injection gave him a few hours of relief. Dr. Wottowa recommended re-scoping the shoulder and doing a biceps tenotomy. (PX 4) Dr. Wottowa felt the surgery was medically necessary and sought workers' compensation authorization for the surgery. (PX 4)

Respondent authorized the second surgery which took place on August 27, 2013. During the procedure, Dr. Wottowa noted marked fraying of the biceps tendon with lateral tearing and splitting all the way to its insertion into the glenoid, a marked change since the pervious surgery. (PX 4) Dr. Wottowa also noted another tear or longitudinal split of the supraspinatus. (PX 4) Dr. Wottowa noted some residual spurring from the acromion that he took down, repaired the supraspinatus tear with an anchor and sutured the longitudinal split. (PX 4)

Petitioner stated that the second surgery provided no relief.

Dr. Wottowa removed Petitioner from work for four weeks for protection after his surgery. (PX 4) On October 7, 2013, Dr. Wottowa examined Petitioner and noted his motion was slightly improved but he had "quite a bit of pain". (PX 4) Dr. Wottowa also noted that Petitioner had severe right shoulder pain when he held his elbow "...in a flexed position and flexes in the plane of the scapula". (PX 4) Petitioner described the sensation as a pulling from the shoulder.

On November 18, 2013, Dr. Wottowa examined Petitioner and noted that Petitioner continued to have severe pain in his right shoulder. Petitioner began another round of physical therapy. Dr. Wottowa conceded that the pain the previous surgery was supposed to correct was still present. (PX 4) Petitioner was allowed to return to work with a 25 pound lifting restriction and advised to return in two months at which time Dr. Wottowa was going to consider ordering another MRI. (PX 4)

Petitioner noted that his pain was so great that when he attended physical therapy he would throw up due to the pain.

An MRI arthrogram of the right shoulder was performed on January 10, 2014. (PX 4) The MRI arthrogram showed that Petitioner had a full thickness tear of his right supraspinatus tendon, tendinopathy of the rotator cuff, extensive tearing of the superior, and possibly inferior, labrum and mild osteoarthritis of the glenohumeral joint. (PX 4) On the same date, Petitioner received a fluoroscopic injection into his right shoulder, his fifth injection. (PX 4) Petitioner stated the fifth injection provided no relief.

Dr. Wottowa examined Petitioner on January 13, 2014 to discuss the MRI results. Dr. Wottowa noted that the MRI showed persistent longitudinal tear of the rotator cuff which had previously been repaired. (PX 4) Dr. Wottowa advised Petitioner that he had three options: 1. to live with the shoulder in the condition it was in and move on with his life; 2. Perform a mini open rotator cuff repair and biceps tenotomy, or; 3. Go to a surgeon such as Leesa Galatz in St. Louis, Missouri. (PX 4) Dr. Wottowa recommended the second option since he felt the tear was repairable and Petitioner was accompanied by Toni McTaggart, another rehabilitation nurse for Respondent. (PX 4)

Petitioner decided to follow Dr. Wottowa's recommendation and have the third repair attempted.

On March 18, 2014, Dr. Wottowa performed a right shoulder open rotator cuff repair which was authorized by Respondent's workers' compensation carrier. (PX 4) Dr. Wottowa noted that the bicep groove had no tendon remaining and there was extensive scar tissue in the sub acromial bursa space which was debrided. (PX 4) Dr. Wottowa found the rotator cuff tears and removed the previously installed anchors, debrided the suture sites, and using sutures and Mitek triple – loaded anchor, secured the rotator cuff. (PX 4)

Petitioner reported no improvement from his third surgery.

On April 1, 2014, Petitioner returned to Dr. Wottowa's assistant David Purves in follow-up to his surgery where it was noted Petitioner had breathing problems after his latest surgery. Petitioner was released to desk work only and to begin therapy consisting of only gentle active and passive range of motion exercises. (PX 4)

On April 30, 2014 Dr. Wottowa examined Petitioner and noted Petitioner was "doing well" in that his pain was improved but he had limited strength and range of motion. (PX 4) Dr. Wottowa allowed Petitioner to return to work at "desk work" and he could drive a power steering vehicle at work. (PX 4)

On June 4, 2014 Petitioner returned to Dr. Wottowa who noted that Petitioner had done everything that he was supposed to do, yet the pain he had before surgery had returned. (PX 4) Both Petitioner and Dr. Wottowa were discouraged by the result. Dr. Wottowa recommended Petitioner continue with his therapy to concentrate on strengthening. Dr. Wottowa injected the shoulder into the biceps tendon remnant a sixth time, which provided some relief while Petitioner was in the office. (PX 4)

Also on June 4, 2014, Dr. Wottowa and Petitioner discussed that as result of the surgeries he had he may have developed a rotator cuff arthritis which meant that down the road he might be a candidate for a reverse shoulder replacement or arthroplasty. (PX 4) Dr. Wottowa also said that he was not optimistic that the Petitioner would be able to return to his normal job. (PX 4)

On July 16, 2014 Petitioner returned to Dr. Wottowa without improvement with pain, crepitation and grinding in his shoulder. Dr. Wottowa recommended a functional capacity examination (FCE). (PX 4)

A two day FCE was performed at Memorial Industrial Rehabilitation beginning on September 9, 2014 during which Petitioner gave maximal performance. (PX 7)

On September 17, 2014 Petitioner and Dr. Wottowa met to review the FCE report. Petitioner continued to complain of the same shoulder pain. Dr. Wottowa released Petitioner with permanent restrictions of no lifting over 10 pounds above his head on an occasional basis and a general 20 pound lifting restriction for all of his lifting. Dr. Wottowa also reviewed Petitioner's job description and noted that Petitioner would be required to push, pull, and lift on a regular basis, which Dr. Wottowa stated Petitioner could not do. Dr. Wottowa issued permanent restrictions consistent with above and placed Petitioner at maximum medical improvement. (PX 4)

Petitioner returned to work and the Respondent accommodated his restrictions. He remained on the job until June 23, 2015, when he underwent his fourth right shoulder surgery. The circumstances leading up to the surgery will be discussed below.

On November 3, 2014 Petitioner attended an OSHA safety meeting at work and as Petitioner was about to stand up, a co-employee, Tim Rebe, a security guard employed by Respondent and Petitioner's co-employee, came up behind Petitioner where Petitioner could not see him and slapped Petitioner's right shoulder hard in a greeting driving Petitioner to his knees. Petitioner stated that when he was struck he experienced a significant increase in the pain in his right shoulder to the point that he was not able to do anything. Tim Rebe has since been terminated from his position by Respondent.

Petitioner filled out an accident report at work and returned to Dr. Wottowa on November 17, 2014. He told Dr. Wottowa about the incident of November 3, 2014 at work and further told Dr. Wottowa that since that incident Petitioner had not been sleeping and was in "absolute agony" since the incident. (PX 4) Dr. Wottowa prescribed Elavil to help him sleep at night and prescribed a topical cream. Dr. Wottowa suggested holing off physical therapy for two weeks to see if his shoulder might "cool down". (PX 4)

Petitioner returned to Dr. Wottowa on December 1, 2014 and told Dr. Wottowa that his shoulder was "worse" and was miserable on a daily basis. Dr. Wottowa recounted the prior medical care that he provided Petitioner and noted that none of these treatments had helped him. On examination, Dr. Wottowa noted that Petitioner had a pseudo paralysis due to a lot of discomfort in the shoulder area. Dr. Wottowa further noted that his main problem was a rotator cuff deficient right shoulder. (PX 4)

He advised Petitioner that he did not have a lot more "arrows left in my quiver" to treat his problem. (PX 4) Dr. Wottowa did not think another surgery would help Petitioner unless it was a reverse shoulder arthroplasty but he felt Petitioner was too young for such a procedure and to "…wait longer and work with what he has". (PX 4) Petitioner told Dr. Wottowa that waiting was "absolutely not possible because the right shoulder [was] killing him". (PX 4) Petitioner was noted to be depressed, miserable and his life had been adversely affected by the injury. (PX 4) Dr. Wottowa recommended Petitioner see Dr. Mark Greatting, Dr. Wottowa's partner, to consult as to whether Petitioner should proceed to a total shoulder arthroplasty. (PX 4)

Dr. Greatting examined Petitioner on December 18, 2014 where Dr. Greatting was provided with a complete history of Petitioner's right shoulder injuries and medical treatment. (PX 4) Dr. Greatting examined Petitioner's right shoulder and noted that Petitioner had "significant pain" with active motion of his shoulder and when he forward flexed his shoulder it appeared that his humeral head is very prominent anteriorly. (PX 4) Passive range of motion, as well as muscle testing, of the shoulder caused significant pain and demonstrated "significant weakness". (PX 4)

Dr. Greatting felt the Petitioner had signs of a "recurrent rotator cuff tear". (PX 4) Dr. Greatting noted that it would be easier to recommend a reverse shoulder replacement if he were older but no additional surgery on his rotator cuff was likely to help. (PX 4) Dr. Greatting discussed other surgeries including a tendon transfer but this option would not provide much improvement or relief. (PX 4) Dr. Greatting advised Petitioner that a shoulder arthrodesis was an option to treat his condition though he would usually recommend waiting until the age of 65 since it would result in significant limitations of function. Petitioner advised Dr. Greatting that he had discussed the surgery options with his wife and decided that he could not live in the condition he was in and wanted to proceed with reverse arthroplasty. (PX 4)

Petitioner returned to Dr. Wottowa on January 7, 2015 to discuss Dr. Greatting's recommendations and Petitioner's decision on future medical treatment. (PX 4) Petitioner told Dr. Wottowa that his pain was "severe", and that it bothered him during the day if he moved his arm away from his body and affected his sleeping as it hurt worse at night. (PX 4) Dr. Wottowa stated that it was his opinion that the need for the surgery was related to his previous workers' compensation injury and said "...of course, yes because this is a continuation of the previous workman's comp claim". (PX 4)

Petitioner sought workers' compensation authorization for the surgery. Respondent sent Petitioner to a Section 12 exam with Dr. Brian J. Cole on March 30, 2015.. (RX 1) Dr. Cole's report indicates that he did examine Petitioner's shoulder and noted external rotation to only 45 degrees, internal rotation to L5, forward passive elevation to 135 degrees, no evidence of pseudo paralysis and no drop arm sign indicative of any full thickness rotator cuff tear. He diagnosed the Petitioner with rotator cuff tendinitis/tendinopathy resulting to mild to moderate impairment. (RX 1)

Petitioner, however, testified that Dr. Cole was two and half hours late to the appointment, and when he walked into the exam room Petitioner still had his jacket on due to the cold.

Petitioner stated that Dr. Cole never examined Petitioner's shoulder but only looked at Petitioner and told him that he did not need surgery and Petitioner could leave.

Dr. Cole stated that he did not believe the accident of November 3, 2014 changed Petitioner's shoulder "structurally or anatomically" by being slapped on the shoulder, though he did note that Petitioner's subjective complaints changed significantly according to Petitioner. (RX 1) Dr. Cole did state that he did not believe Petitioner should have a reverse shoulder arthroplasty but felt that all of Petitioner's treatment to that point had been reasonable and necessary. (RX 1)

In reliance on Dr. Cole's report, Respondent refused to authorize Petitioner's reverse shoulder arthroplasty. Petitioner proceeded to have the reverse shoulder arthroplasty, using his group health insurance, and which is addressed separately herein. Petitioner requested that Respondent authorize a right reverse shoulder replacement and Respondent refused to authorize the surgery after having Petitioner examined by Dr. Brian Cole.

Petitioner petitioned his health insurance to pay for the reverse shoulder arthroplasty performed and received authorization for same from his health insurance carrier.

Petitioner received cardiac clearance and underwent an open, reverse, right shoulder arthroplasty on June 23, 2015. (PX 4) Intraoperatively, Dr. Wottowa found that Petitioner had a "thick quantified anterior portion of the supraspinatus and a tear at the rotator interval". (PX 4, 8)

Petitioner stated that the surgery resulted in improvement in his symptoms for a while. Dr. Wottowa removed Petitioner from work after the surgery and followed his recovery.

On July 13, 2015 Dr. Wottowa examined Petitioner and noted he had a "bubble" on top of his shoulder and Dr. Wottowa prescribed antibiotic medication and physical therapy at the Springfield Clinic. (PX 4)

Physical therapy records dated July 22, 2015 indicate that Petitioner reported feeling good but that he had a "frequent catch in [his] shoulder and is able to do a stretch with slight distraction to assist with pain". The therapist did not push the Petitioner due to his pain. (PX 4) On July 24, 2015 the therapist noted that Petitioner continued to have a "frequent posterior "catch" that requires patient to release with self-traction". (PX 4) On July 30, 2015 the Petitioner reported that although he gets a catch on the back side of his arm it goes away quickly. Petitioner stated that he felt good but it seemed like he felt a pinch when he performed active or assisted flexion. (PX 4) Petitioner continued to improve with physical therapy. (PX 4)

On August 5, 2015 Petitioner returned to Dr. Wottowa and continued to show improvement, with Dr. Wottowa describing Petitioner's response as "phenomenal". Petitioner and Dr. Wottowa discussed returning to work and a possible 25 pound lifting restriction was discussed. X-rays of Petitioner's right shoulder taken on August 5, 2015 showed satisfactory alignment of the reverse arthroplasty. (PX 4) Petitioner was advised to return in two months. Dr. Wottowa continued to hold Petitioner off of work and Petitioner continued physical therapy. (PX 4)

On August 18, 2015 Petitioner's physical therapist noted that Petitioner reported frustration with pain in that no matter what he did, rest or activity, he had pain in the back of the shoulder and arm. (PX 4) The therapist stated that Petitioner continued to work hard and did well in therapy but would have increased pain after therapy. (PX 4) On August 20, 2015 Petitioner reported to his therapist that he had pain with quick movements, but while sitting at rest patient had no pain. (PX 4) Petitioner's pain continued without improvement. (PX 4)

On September 3, 2015 Petitioner's therapist noted that he continued to have sharp pain which was okay if he kept his arm by his side, but Petitioner stated that he would continue to perform the exercises and the therapist noted Petitioner had a "tendency to work through pain". Petitioner was educated regarding a new exercise plan to allow his shoulder to "calm down". (PX 4) Petitioner returned to therapy on September 9, 2015 noting that he was doing his exercises and could feel a pressure type pain and since then the Petitioner had a poor ability to move his right hand or turn his arm without a feeling as if something had shifted in his shoulder. (PX 4)

Petitioner was examined by David Purves PA-C for Dr. Wottowa on September 9, 2015. PA Purves noted that Petitioner had been doing "okay" but still had a catch, almost popping sensation involving the posterior aspect of the shoulder. PA Purves noted that Petitioner had been performing the new isometric exercises at home the previous Saturday and felt a pop in his shoulder, causing "excruciating pain and mild swelling in his shoulder. (PX 4) PA Purves noted Petitioner had difficulty with any activity or motion away from his body. (PX 4) Purves recommended a CT scan of the shoulder and provided Petitioner with a sling. (PX 4)

A CT scan of Petitioner's right shoulder performed on September 17, 2015 showed the reverse ball and socket arthroplasty without lucency or fracture. (PX 4)

Petitioner testified that while performing physical therapy he experienced a pop in his shoulder which increased his symptoms.

On October 7, 2015 Petitioner returned to Dr. Wottowa noting the increased symptoms Petitioner had since experiencing the pop in his shoulder while performing exercises. Dr. Wottowa noted the CT scan which appeared normal, but Dr. Wottowa suspected a stress fracture as a possible cause of his symptoms. (PX 4) Dr. Wottowa recommended that Petitioner wear a sling for 4 weeks. (PX 4)

On November 4, 2015 Petitioner returned to Dr. Wottowa where it was noted that after his reverse shoulder arthroplasty "all of his pain was relieved…and then in therapy, about 2 months ago, he felt a pop and since that time he has had nothing but pain over the lateral aspect of his arm. (PX 4) Dr. Wottowa noted that the pain would come on when Petitioner tried to abduct his arm causing severe pain from his deltoid firing. (PX 4) Dr. Wottowa ordered blood tests to rule out an infection and discussed Petitioner's progress with Dr. Greatting who agreed with the recommendations. (PX 4)

X-rays of the right shoulder taken on November 4, 2015 were negative. A 3 phase Bone Scan of Petitioner's right shoulder performed on November 5, 2014 showed mild periprosthetic tracer uptake which was likely a normal postoperative change. (PX 4) An indium white cell scan limited performed on November 6, 2015 revealed no "scintigraphic" evidence of acute osteomyelitis. (PX 4)

Petitioner returned to Dr. Wottowa on November 11, 2015 with the same continued pain complaints. (PX 4) Dr. Wottowa noted that the tests performed were negative. Dr. Wottowa suggested Petitioner be seen by Dr. Nicholson at Rush University. However, Petitioner had already seen Dr. Brian Cole for a Section 12 exam who is also at Rush and so Petitioner was instead referred to Dr. Aaron Chamberlain at Washington University in St. Louis, Missouri (PX 4, 9)

Petitioner was evaluated by Dr. Kimberly Bartosiak for Dr. Aaron Chamberlain on December 7, 2015. (PX 9) Dr. Chamberlain examined Petitioner and noted Petitioner had 10 degrees of forward extension limited by pain on the right while his left was normal. Passively, Petitioner could achieve 30 degrees of forward extension but limited by pain. (PX 9) Radiographs taken on December 7, 2015 showed the reverse shoulder arthroplasty well seated and in proper alignment. (PX 9) Dr. Chamberlain felt the Petitioner had a complicated surgical history to his right shoulder with persistent pain localized more over his deltoid insertion with

significant tenderness to palpation. (PX 9) Dr. Chamberlain recommended a repeat MRI and ultrasound and advised not to lift with his right arm. (PX 9)

Petitioner returned to Dr. Wottowa on January 11, 2016. (PX 4) Dr. Wottowa noted that Petitioner had seen Dr. Chamberlain who had recommended an ultrasound but Petitioner did not wish to return to Dr. Chamberlain. Petitioner told Dr. Wottowa that he was worse than he was 3 months before and felt that this was due to his arthroplasty being loose. (PX 4)

On January 11, 2016, Dr. Wottowa released Petitioner to return to work with permanent restrictions of no lifting over 1 pound with his right arm to allow him to return to work one handed and get on with his life. (PX 4, 32)

Petitioner provided this letter to Respondent. Respondent failed to prove that it made any offer of employment to Petitioner consistent with the permanent restrictions issued by Dr. Wottowa after January 11, 2016 until February of 2017.

Petitioner did return to Dr. Chamberlain on February 29, 2016 and discussed Petitioner's care with Dr. Jay Keener. (PX 9) Dr. Chamberlain and Dr. Keener felt that Petitioner might benefit from an open evaluation and possible revision of the polyethylene liner versus possible revision of the humeral stem. (PX 9) Petitioner decided to proceed with the surgery.

On March 7, 2016 Petitioner returned to Dr. Wottowa for an unscheduled visit complaining of pain of a 9 out of ten. Dr. Wottowa spoke with Dr. Chamberlain and recommended that Petitioner continue to see Dr. Chamberlain.

On April 13, 2016 Petitioner underwent a right shoulder arthroplasty with exchange of the polyethylene line and spacer as well as release and debridement of scar tissue deep into the joint and sub deltoid space. (PX 9, 12)

Petitioner resumed physical therapy at the Springfield Clinic on May 2, 2016. (PX 4)

Petitioner stated the surgery helped for a couple of weeks after the surgery.

On June 20, 2016, Dr. Chamberlain noted the Petitioner continued to have pain in the shoulder and it was difficult to understand why he was having pain at the deltoid insertion. (PX 9) Dr. Chamberlain referred Petitioner to Dr. Tang for further evaluation and did not see Petitioner any further. (PX 9)

On June 20, 2016 Dr. Chamberlain issued the very same permanent restriction as that issued by Dr. Wottowa five months earlier. (PX 26) Dr. Chamberlain permanently restricted Petitioner from lifting more than one pound with the right upper extremity. (PX 26)

Petitioner was examined by Dr. Tang on August 9, 2016 wherein it was noted that Petitioner had not received any benefit from the revision shoulder arthroplasty performed by Dr. Chamberlain. (PX 9) Dr. Tang was of the opinion that Petitioner had a right axillary nerve injury and recommended an EMG and right glenohumeral joint injection. The EMG showed a possible teres minor syndrome and possible right cubital tunnel syndrome. (PX 9) The glenohumeral joint injection was also administered on August 18, 2016 without any improvement. (PX 9) Petitioner did not return to Dr. Tang thereafter. (PX 9)

Petitioner last saw Dr. Wottowa on May 24, 2017. Dr. Wottowa summarized Petitioner's medical care through his treatment with Dr. Chamberlain and noted that despite all of the treatment Petitioner had received Petitioner's pain continued and Petitioner was "miserable". (PX 4) Dr. Wottowa noted that Petitioner wore an orthotic device around his shoulder which kept his shoulder from moving, since the smallest of movements cause pain. Dr. Wottowa discussed possible referrals to other doctors but Petitioner has not sought further care. (PX 4)

In September 2015, Petitioner enlisted his union representative, Douglas Alan Cycholl, pursuant to union rules, to inquire whether the Respondent would offer Petitioner a position as a "watchman", which is similar to a security guard. Douglas Alan Cycholl, a crew Foreman for Respondent, was the Union Representative through June of 2016. (PX 34, p. 6) Mr. Cycholl worked with Petitioner and knew him from working with him for years. (PX 34, p. 6-7) Mr. Cycholl stated that Petitioner asked him to assist Petitioner with finding other work with the Respondent in September of 2015. (PX 34, p. 8) Petitioner asked Mr. Cycholl if he could assist the Petitioner in securing a Watchman position at the Electric Department at Groth Street. (PX 34, p. 9) Mr. Cycholl explained that there were a number of Watchman positions that were covered by the union including those at the Groth Street facility and other facilities. (PX 34, p. 12) Mr. Cycholl testified that the Groth Street facility had three Watchman and a "floater" Watchman who might float between the water department and the electric department. (PX 34, p. 12)

Mr. Cycholl contacted those in charge of hiring for the Respondent and he spoke with Greg Yakel, the Superintendent of Electric Distribution, and Rick Meadows, the supervisor over that area. (PX 34, p. 8-9) Mr. Cycholl asked both if Petitioner could be moved into that position permanently and Mr. Cycholl was told that there was no interest in doing that and was provided

no explanation. (PX 34, p. 10) Mr. Cycholl added that the Respondent was in fact doing away with these positions as workers retired and or moved to other positions. (PX 34, p. 10)

Respondent advised Petitioner by letter dated January 14, 2016 that it had received Dr. Wottowa's permanent restrictions and Respondent told Petitioner in the letter that if Petitioner was unable to return to work either "...without restrictions (or restrictions that could reasonably accommodated) by March 16, 2016 then his employment would be terminated". (PX 22) There was no evidence from either party that suggested that Petitioner's permanent restrictions changed after January 11, 2016. Petitioner considered that as a result of this letter his employment with Respondent was terminated. Respondent offered no evidence to refute this belief or to suggest that Petitioner's employment was not terminated.

Petitioner submitted papers requesting retirement benefits after he was told that the respondent would not accommodate his permanent restrictions. (RX 3) Petitioner was not being paid TTD at this time nor had Respondent ever paid Petitioner temporary total disability benefits after the accident at issue here.

Petitioner's permanent restrictions remained the same after the revision procedure performed by Dr. Chamberlain. Again, Respondent offered no evidence that it ever offered Petitioner any position within his restrictions at any time after November 3, 2014 through the end of 2016.

Petitioner did not look for work within the permanent restrictions established by Dr. Wottowa on January 11, 2016 or anytime thereafter.

On October 3, 2016 Petitioner's attorney retained Certified Vocational Counselor James Ragains to perform a vocational rehabilitation evaluation. (PX 33, Dep. Ex 2) James Ragains has been a vocational counselor since 1974 and has worked continuously in the field of vocational rehabilitation since 1974. Mr. Ragains retired from his employment with Hines and Associates on November 12, 2015. Since that time, Mr. Ragains has continued to perform vocational rehabilitation for Ragains Vocational Services. (PX 33, Dep. Ex 1, p. 7) James Ragains interviewed Petitioner on October 5, 2016 and also had follow-up conversations with Petitioner on December 13, 2016. (PX 33, Dep. Ex. 2)

Mr. Ragains reviewed Petitioner's medical records and the permanent restrictions issued to Petitioner. (PX 33, p. 10) Mr. Ragains reviewed the Petitioner's prior work experience. (PX 33, p. 11) Mr. Ragains noted that Petitioner had a GED and had been employed by Respondent since

1982. (PX 33, p. 11) Ragains noted that for the last 15 years of his employment by Respondent, Petitioner had been a stock supervisor in Respondent's warehouse on the water side and his most recent position was the Lead Supervisor, or Foreman, of the Lake Services. (PX 33, p. 11-12) Mr. Ragains also noted Petitioner had been a volunteer fireman but had no training as a firefighter. (PX 33, p. 12)

Mr. Ragains was of the opinion that Petitioner's permanent restrictions negated, or neutralized, any transferable skills Petitioner might have had. (PX 33, p. 14) Mr. Ragains evaluated Petitioner before Petitioner had been evaluated by Elizabeth Skyles, which is discussed below. (PX 33, p. 14)

Mr. Ragains determined that after meeting with Petitioner, reviewing his medical records, assessing his lack of transferable skills, his permanent work restrictions, and in light of his knowledge of the Springfield, Illinois labor market, he did not believe that a stable labor market existed in which Petitioner might be employed. (PX 33, p. 16, Dep. Ex. 2) Mr. Ragains did not feel that Petitioner was a candidate for retraining. (PX 33, Dep. Ex. 2)

Mr. Ragains arrived at this conclusion even though Petitioner did not engage in any job search. (PX 33, p. 16) Mr. Ragains based his opinion in part on his knowledge of the job market based on his years of experience with the surrounding job market. (PX 33, p. 16)

On December 2, 2016 Respondent's counsel asked Petitioner's counsel to send a vocational report that was expected to be received. (PX 20)

On December 20, 2016 Petitioner's counsel forwarded James Ragains Vocational Rehabilitation report to Respondent's counsel. (PX 21)

On February 10, 2017 Respondent's counsel forwarded to Petitioner's counsel a letter that Respondent sent to Petitioner dated February 9, 2017 in which the Respondent offered employment to Petitioner as a "Watchman" in the Water Department facility. (PX 20)

Respondent retained the services of Elizabeth Skyles, CRC. Ms. Skyles met with Petitioner for the first, and only, time on January 24, 2017 at Petitioner's counsel's office. (RX 2, Dep. Ex 2) Ms. Skyles reviewed Petitioner's medical records, past employment history and educational background. (RX 2, p. 7) Ms. Skyles was of the opinion that even with Petitioner's one pound lifting restrictions he was employable. (RX 2, p. 11) Ms. Skyles was under the impression that Petitioner inquired about the Watchman position in 2016 rather than in September of 2015. (RX

2, p. 13-14) Ms. Skyles stated that Petitioner told him that he felt that he could do the job of "Watchman". (RX 2, p. 14) Ms. Skyles stated that it was her opinion that Petitioner could perform the "Watchman" positon. (RX 2, p. 15-16) Ms. Skyles did not identify any employment positions which were available in Petitioner's labor market and which were suitable to Petitioner. (RX 2, Dep. Ex. 2)

On cross examination, Ms. Skyles was evasive in her answers. (RX 2, p. 16-20) Ms. Skyles finally admitted that on the day she testified, the "Watchman" position was not available or open. (RX 2, p. 17) Ms. Skyles admitted that she was not asked to perform, and did not perform, a labor market survey of the Petitioner's labor market. (RX 2, p. 18) Ms. Skyles could not identify any open employment positions which Petitioner might be able to accept. (RX 2, p. 18) Ms. Skyles was unaware of the union rules concerning obtaining employment in the "watchman" position. (RX 2, p. 19-20) Ms. Skyles also acknowledged that when she met with Petitioner he was no longer a member of the union because he was no longer working for Respondent. (RX 2, p. 20)

Jim Ragains reviewed Ms. Skyles report and noted that she identified vague job categories which she suggested the Petitioner could perform. (PX 33, p. 17-18) Mr. Ragains stated that Ms. Skyles did not include the Dictionary of Occupational titles for any of the employment opportunities that Ms. Skyles identified Petitioner could perform. (PX 33, p. 18) The Dictionary of Occupation titles is used by vocational counselors. (PX 33, p. 18) Mr. Ragains also noted that Ms. Skyles did not identify any open employment positions in Petitioner's labor market which corresponded to the job categories she stated Petitioner could perform. (PX 2, p. 18-19)

Mr. Ragains stated that Ms. Skyles stated Petitioner could find employment as an "...attendant, information clerk, watchman, or monitor and overseer". (PX 33, p. 20) Mr. Ragains stated that the job categories outlined by Ms. Skyles were more akin to descriptions of tasks as opposed to job titles or occupations. (PX 33, p. 21) Mr. Ragains stated that the job categories identified by Ms. Skyles did not generally exist in the Dictionary of Occupation titles, except for the positions of "information clerk", and watchman, or security guard work. (PX 33, p. 18, 20-21)

Mr. Ragains noted that Ms. Skyles had stated that Petitioner could be employed as a "monitor" and Mr. Ragains stated that this occupation was last updated in the Dictionary of Occupational Titles in 1977 and was primarily used to describe the occupation in the telephone

and telegraph industry where a person monitors the conversations between telephone and telegraph operators. (PX 33, p. 22) Mr. Ragains stated that there was no such market for a monitor. (PX 33, p. 22) Mr. Ragains stated that the "overseer" job identified in Ms. Skyles report did exist in the textile or apparel manufacturing industry but not in Petitioner's labor market. (PX 33, p. 23) Mr. Ragains also stated that the job category of "overseer" was also not within Petitioner's residual functional capacity. (PX 33, p. 24) Regarding Ms. Skyles identification of the "information clerk" job category, Mr. Ragains stated that there were two codes in the Dictionary of Occupational Titles, being a travel clerk or a reception clerk. (PX 33, p. 24-25) Mr. Ragains explained that a travel clerk provides travel information to bus or train passengers and no such positions existed in Petitioner's labor market. (PX 33, p. 24) Mr. Ragains also stated that the receptionist work was defined as a person answering inquiries from persons entering a business, and that no such position existed in Petitioner's labor market. (PX 33, p. 25)

After receiving Ms. Skyles' vocational rehabilitation evaluation, Petitioner and Mr. Ragains conducted a labor market survey, performed at his request by another certified vocational counselor, Gary Wilhelm, under parameters established by Mr. Ragains. (PX 2, p. 19, 27) The labor market survey was performed between May 30, 2017 and July 10, 2017 in a 50 mile radius around Springfield, Illinois. (PX 33, Dep. Ex. 3, p. 27) Mr. Ragains stated that a labor market survey was the type of information that he reasonably relied upon in forming his professional opinions. (PX 2, p. 19)

Mr. Ragains stated that in performing the labor market survey he could not plug in all of Ms. Skyles job categories because some job categories had no identification as to what jobs Ms. Skyles was referring to. (PX 33, p. 20) Mr. Ragains did look for open Watchman and security guard type jobs since he felt the Watchman position was similar to a security guard. (PX 33, p. 25)

Mr. Ragains labor market survey indicated that when it was performed, the Respondent's "Watchman" positon was not open and applications were not being taken. (PX 33, p. 25) Mr. Ragains stated that the Respondent also told the labor market surveyor that the Respondent was in a "decision making process-about who to offer the position to". (PX 33, p. 25)

The labor market survey revealed that there were five open employment positions within the "information clerk category". (PX 33, p. 28, Dep. Ex. 3) The labor market survey showed an

open position with DXC Technologies in Jacksonville, Illinois in the information clerk category, but Mr. Ragains did not feel Petitioner could perform this because Petitioner did not have customer service or telephone related work experience and would require keyboard efficiency. (PX 33, p. 28) Mr. Ragains felt Petitioner's keyboarding ability was limited due to the impairment of his right hand and because he could only "hunt and peck" with difficulty. (PX 33, p. 29)

The labor market survey also revealed a managerial opening at Motel 6/Studio 6 which Mr. Ragains felt was not within Petitioner's residual functional capacity since the job required working at the front desk, folding laundry, towels, clean and set rooms. (PX 33, p. 29-30, Dep. Ex 3)

The third job opening identified in the labor market survey was with Staffquick in Springfield, Illinois which required "significant office computer skills" which Mr. Ragains did not believe that petitioner had. (PX 33, p. 30, Dep. Ex. 3) Staffquick also had a job opening making fishing lures and Mr. Ragains did not feel that Petitioner could perform this work because of the bimanual dexterity required of the position. (PX 33, p. 31)

The labor market survey also identified an open position at Ramada in Springfield, Illinois which required previous front desk hotel experience which the Petitioner did not have. (PX 33, p. 31) Mr. Ragains was asked if such an employer did not receive any applicants with prior front desk experience would they likely consider someone without such experience. Mr. Ragains stated that it was possible, but he would expect that such an employer would look to people with other customer services experience. (PX 33, p. 53-54)

The fifth job in the information clerk category was with Staybridge Suites which Mr. Ragains felt was not suitable for Petitioner because the employer was looking for someone with customer relations background, which petitioner did not have, and the job required that the worker lift luggage, and set up a continental breakfast and these activities would not be within Petitioner's permanent restrictions. (PX 33, p. 32) The labor market survey also identified five security guard positions. (PX 33, p. 32, Dep. Ex. 3) The first, with Allied Barton paid $11.50 per hour and was for 25 hours of work per week. (PX 33, p. 32, Dep. Ex. 3) Mr. Ragains stated that Petitioner could "potentially" find employment at Allied Barton. (PX 33, p. 33)

The second security guard position at PerMar Security was also a "potential employment situation" for Petitioner according to Mr. Ragains. (PX 33, p. 33) Mr. Ragains stated that the Per Mar position paid $12 per hour and was full time. (PX 33, p. 33)

The third security guard position was with Whelan Security and the guard would need to physically intervene in a crisis situation and Mr. Ragains did not feel that this job was suitable for Petitioner. (PX 3, p. 33)

A fourth security guard position was with G4 in Bloomington, Illinois, which required a person with a background in law enforcement or military combat experience. (PX 33, p. 34) Mr. Ragains stated that this job would also require Petitioner to become physically involved which was not suitable for Petitioner. (PX 33, p. 34)

Finally, Gary Wilhelm, Mr. Ragains' labor market surveyor, contacted the Respondent about the Watchman position and spoke with Stephanie Barton, Respondent's Labor Relations Manager. (PX 33, p. 34) Ms. Barton told Mr. Wilhelm that the "Watchman" job was not available at the time that Ms. Skyles suggested Petitioner could find employment in that position. (PX 33, p. 34) Ms. Barton also stated that the Watchman position required 20 pounds of exertion for pushing, pulling and lifting, on an occasional basis and 10 pounds of exertion or force on a frequent basis. (PX 33, p. 35) Mr. Ragains testified that he did not believe that Petitioner was capable of performing the "Watchman" position based on the permanent restrictions issued by Petitioner's two treating doctors. (PX 33, p. 35)

Mr. Ragains stated in discussing the Labor Market Survey findings that the only positions which the labor market survey identified in which Petitioner might find employment was at the two security guard positions with Allied Barton and PerMar. (PX 33, p. 36)

Mr. Ragains stated it was his opinion that Petitioner more likely than not fell into the "odd-lot" category of permanent and total disability than Petitioner would be able to apply and perform the open security guard jobs the labor market identified at Allied Barton and PerMar. (PX 33, p. 39-40

Petitioner stated that he has no movement in his shoulder, and it has affected everything that he does. Petitioner continues to wear a brace on his arm and shoulder to prevent movement of his arm as movement of his arm causes severe pain. He has learned to perform many tasks left handed. He does not sleep in bed with his wife due to constant pain, but sleeps in a recliner. Petitioner's wife helps him pack his shoulder with ice and pillows, and he averages about 3 to 4

hours of sleep per night. Petitioner stated that he did not think he could perform security guard type work because if he cannot prop his arm up he is miserable. Petitioner also notices that if his arm is not propped up his shoulder swells. Petitioner takes only Tylenol because he does not want to take narcotic medication.

Petitioner states that icing his shoulder helps most and the more he can freeze his shoulder the better it feels for a while. Petitioner states that his pain is at a level of 8 out of 10 on a regular basis.

Respondent offered the testimony of Mike Nutt, Respondent's Superintendent of Lake Service, and Petitioner's immediate supervisor. Mr. Nutt stated that the Respondent could not accommodate the Permanent restrictions issued on January 1, 2016 because he could not run equipment with his permanent restrictions arising out of the injury in case number 14 WC 35167.

Respondent's Water Division Manager, Ted Meckes, also testified. He was aware that in February of 2017 the "Watchman" position was offered to Petitioner and was involved in the discussions to offer the position to Petitioner. Mr. Meckes felt the Petitioner could perform the "Watchman" job with certain accommodations, though he did not indicate what those accommodations might be. Mr. Meckes admitted that when the Petitioner provided the Respondent with the permanent restrictions dated January 11, 2016 none of the "Watchman" positons in the water department were open. Mr. Meckes stated that when such a positon opens it is internally posted with the union for 5 days. If no union member applies in those five days, it is opened to the public. Mr. Meckes stated a "Watchman" position became "open" in July or August of 2016 and the position was filled in December of 2016. The worker hired in December lasted one day and then the position became open again, starting the hiring process again. In December of 2016 Petitioner was not a union member and no union members expressed interest in the job. Mr. Meckes stated that the "Watchman" position was offered to Petitioner in February of 2017. Mr. Meckes admitted that the Respondent had abandoned the Watchman position at the Groth Street facility due to a lack of need and by attrition.

Mr. Meckes admitted on cross examination that Respondent made no effort to offer the Petitioner the "Watchman" position when it became available in July of 2016. Mr. Meckes stated that Respondent never offered the Petitioner the open "Watchman" position through December of 2016 because the Respondent did not think about doing so.

Conclusions of Law

The Arbitrator believes the Petitioner's current condition of ill being is causally related to his accident of February 3, 2012. While he had prior shoulder injuries approximately 20 years ago, there is no evidence rebutting his testimony that he recovered soon after that treatment. In contrast, once he sustained 2012 accident, his symptoms and exam findings have consistently showed a serious injury to his shoulder. As is stated in the decision in the companion case, the Arbitrator believes the November 3, 2014 accident caused a temporary exacerbation of symptoms but did not change the underlying injuries. His right shoulder was in bad shape when Dr. Wottowa saw him on June 4, 2014 and discussed the possibility of a future shoulder replacement and remained bad when he was seen by Dr. Greatting on December 18, 2014. Dr. Wottowa in his note of January 7, 2015 relates the Petitioner's condition back to his original rotator cuff injury. (PX 4)

With respect to the reasonableness of the medical treatment, the Respondent argues the care after the date of the IME was unwarranted. As noted above Dr. Brian Cole, Respondent's Section 12 examiner, stated that he would not recommend that Petitioner have a reverse shoulder arthroplasty. Based on Dr. Cole's report, Respondent refused to authorize Petitioner's surgery.

The Arbitrator is not persuaded by Dr. Cole. The opinions of Drs. Wottowa and Greatting recommending the procedure are based upon their knowledge of the Petitioner's treatment history dating back to his accident. It is clear from the three prior operative reports that the Petitioner had a serious disruption of his shoulder joint which was not amenable to ordinary repairs. The biceps tendon was noted to be gone in the third operative report and the surgery represented the third attempt to repair the supraspinatus. The histories of ongoing symptoms and positive exam findings from both doctors in late 2014 prove that the shoulder replacement offered was a reasonable treatment option. Once completed, the subsequent treatment has been related as well. The fifth surgery was reasonable as the humeral component had loosened.

Respondent is to pay Petitioner the medical expenses submitted on Petitioner's Group Exhibit 16 as follows:

St. John's Hospital, 6/23/15-6/25/15	$ 63,445.00
Springfield Clinic, 11/17/14-5/24/17	$ 31,664.75
Sangamon Associated Anesthesiologists, 6/23/15	$ 5,083.00

Washington University Physicians, 12/7/15-8/18/16	$ 17,009.00
Barnes Jewish Hospital, 12/7/15	$ 510.00
Barnes Jewish Hospital, 2/29/16	$ 1,301.00
Barnes Jewish Hospital, 4/5/16	$ 1,303.00
Barnes Jewish Hospital, 4/13/16-4/14/16	$ 27,708.85
Barnes Jewish Hospital, 4/25/16	$ 459.00
Barnes Jewish Hospital, 5/23/16	$ 459.00
Barnes Jewish Hospital, 6/20/16	$ 459.00
Barnes Jewish Hospital, 8/18/16	$ 1,928.50
Central IL Radiological Associates, 6/23/15	$ 51.00
APL Clinical Pathologists, 6/23/15-6/24/15	$ 31.20
Total:	**$151,412.30**

The above represent the medical bills listed in Petitioner's Exhibit 16 after deducting the medical expenses for treatment to the Petitioner's cervical spine as the parties stipulated that the treatment is not related to the accident.

Respondent is to have credit for the medical expenses it has paid as listed in Respondent's Exhibit 16. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. 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.

With respect to temporary total disability, Arbitrator makes the following conclusions.

Petitioner and Respondent stipulated that Petitioner was temporarily and totally disabled from June 23, 2015 through the date of arbitration, a period of 122 and 5/7 weeks of disability.

Petitioner reached maximum medical improvement as of August 18, 2016, when he underwent the nerve studies ordered by Dr. Tang. It appears to the Arbitrator that the Petitioner's condition has not changed materially since then. He's seen both Dr. Wottowa and Dr. Lewis, his family physician, but only has been treated with medications. Accordingly, the Respondent owes TTD through August 18, 2016.

Petitioner is claiming entitlement to permanent and total disability under the "odd lot" theory, and the Arbitrator believes the evidence supports such a finding.

If the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is on the claimant to prove by a preponderance of the evidence that he fits into the "odd-lot" category–one who, though not altogether incapacitated to work, is so disabled that he will not be employed regularly in any well-known branch of the labor market. *Westin Hotel v. Indus. Comm'n, 372 Ill.App. 3d 527, 544 (200, citing Valley Mould & Iron Co. V. Indus'l Comm'n 84 Il2d 538, 546-7 (1981)*

An injured worker may carry his burden of proving that he falls into the 'odd-lot' category by either of two separate methods of evidentiary proof: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Bob Red Remodeling, Inc. Ill. Workers' Comp. Comm'n, 23 N.E.3d 1248, 1256 (2014), Westin Hotel v. Indus. Comm'n, 372 Ill.App. 3d 527, 544 (2007)* [emphasis added]

While the Petitioner has not performed a job search, he has proven entitlement under the second standard, above. The Arbitrator finds the testimony of James Ragains persuasive on the issue.

The Arbitrator notes that the Respondent's Job Description for the "Watchman" position offered to Petitioner states the "Watchman" position requires the employee be able to work in the light physical demand category, and able to exert up to 20 pounds of force occasionally and up to 10 pounds of force frequently. (RX 4) Respondent offered no medical evidence that Petitioner could perform such work. Petitioner had not been evaluated by Dr. Cole since before he had undergone a reverse right shoulder arthroplasty and a revision of same. Consequently, there is no medical evidence offered by Respondent which would establish that Petitioner can perform the duties of a Watchman.

The Arbitrator notes that Respondent indicates that it now could accommodate Petitioner's permanent restrictions yet did not offer any evidence as to how the position could be so accommodated.

The Arbitrator also notes the timing of the "Watchman" job offer. While Petitioner was recovering, and before he reached maximum medical improvement or knew what his permanent restrictions would be, the Petitioner attempted to transfer his employment to a Watchman for Respondent as early as September of 2015. Respondent rebuffed Petitioner's efforts. The facts

also demonstrate that the Respondent had "Watchman" job openings in July of 2016 and through December of 2016 but never offered the Petitioner the "Watchman" job.

The facts also demonstrate that the Respondent did not offer Petitioner employment in the "Watchman" position until Petitioner obtained, and forwarded to Respondent's counsel, a vocational rehabilitation evaluation which concluded Petitioner was not employable due to his restrictions and that he fell into the "odd-lot" category of permanent and total disability.

In light of the circumstances of the job offer openings, and the timing of same, the Arbitrator concludes that the Respondent's offer of employment in the Watchman position was a "sham" job offer. (See *Reliance Elevator Company v. The Indus'l Comm'n, 309 Ill.App.3d 987, 993 (1999*)

The Arbitrator also notes that while the Petitioner instituted efforts to obtain the job in early September 2015, his symptoms have worsened since that time. Dr. Wottowa's progress notes show that after the first shoulder replacement surgery on June 23, 2015, the Petitioner was reporting symptom improvement. On August 5, he reported to the doctor he was doing very well. His conduct from the accident date forward shows that he was interested in returning to work, so it is entirely reasonable that he would enlist the help of his union while hoping for ongoing improvement. Unfortunately, it appears that his symptoms worsened during therapy. (See PX 4; 10/7/2015) Eventually it was determined that his prosthetic humeral head had loosened and he underwent his fifth operation. Since then, all of the medical reports show that he has very little shoulder function. The evidence shows that it is very unlikely that the Petitioner could perform any type of watchman position at the present time, regardless of whether one actually exists.

The Arbitrator has also considered the labor market survey evidence concerning the availability of two security guard positions which were technically within the permanent restrictions of Petitioner's treating physicians. The Arbitrator notes the Petitioner's credible testimony that he did not think he could carry out the duties of a security guard due to his complaints of pain and need to immobilize his shoulder. The Arbitrator further adopts the opinions of Jim Ragains and finds that it is more likely true than not that Petitioner would not be able to be hired for, and perform, the duties of either security guard position based on the Petitioner's credible testimony and the medical records documenting Petitioner's continued severe subjective complaints of constant pain of which is significantly exacerbated by movement.

The Arbitrator further finds that the testimony and reports of James Ragains, and the labor market survey he obtained, established that suitable, continuous work does not exist in Petitioner's labor market within which Petitioner might find gainful employment. This evidence shifted the burden of proving that continuous suitable employment existed within Petitioner's labor market. Respondent failed to offer any evidence that suitable work was consistently available in Petitioner's labor market since Ms. Skyles failed to identify any open employment positions apart from the "Watchman" job.

Once the claimant establishes that he falls into the "odd-lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Bob Red Remodeling, Inc. Ill. Workers' Comp. Comm'n, 23 N.E.3d 1248, 1256 (2014), Westin Hotel v. Indus. Comm'n, 372 Ill.App. 3d 527, 544 (2007).* Respondent has failed to make such a showing.

The Arbitrator therefore finds that Petitioner has carried his burden of proving that he falls into the odd-lot category of permanent and total disability pursuant to Section 8(f) of the Act as Amended.

Petitioner filed a Penalty Petition alleging that Respondent's conduct in withholding temporary total disability benefits was unreasonable, vexatious, and in bad faith. (PX 27)

As is stated in the fact statement, Respondent paid all of the TTD owed the Petitioner until June 23, 2015 when he was taken off work for his first shoulder replacement surgery. Respondent refused to pay benefits at that time in reliance on Dr. Cole's report which concluded that the surgery was unnecessary. Dr. Cole based his opinion on his physical exam of the Petitioner and his conclusions that he suffered a mild to moderate impairment. He felt the Petitioner could continue to work in the modified job based upon the earlier FCE.

While the Arbitrator disagrees with the doctor on the issue of the reasonableness of the treatment, he does believe the Respondent could have relied upon the opinions of the doctor in denying benefits. The Arbitrator also notes the hesitation of both Dr. Wottowa and Greatting in performing the surgery on the Petitioner.

Petitioner argues that language in the Act contained in Section 8.7, which deals with Utilization Review, requires the Respondent to pay for the treatment. The Arbitrator disagrees. The Section cited, 8.7 (i) (3), does not apply unless the Respondent has elected to conduct a utilization review of the proposed treatment. Here, the Respondent did not elect to use a UR.

Nothing in the Act mandates that they do so. They are free under the Act to question the reasonably necessity of proposed treatment through the use of an IME, and that is what they did.

Based upon the above, penalties are 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CATHLEEN GORDILS,

Petitioner,

18IWCC0783

vs.

NO: 16 WC 12810

BURLINGTON COAT FACTORY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, 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 further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact & Conclusions of Law

1. Petitioner was employed by Respondent as a pricing associate, but frequently worked in the receiving department. Her job duties included, but were not limited to, unloading trucks and boxes, pricing and preparing merchandise, retrieving highly stacked boxes and pushing carts of merchandise. Such tasks required Petitioner to move heavy and high items.

2. On October 19, 2017, Petitioner filed an Amended Application, alleging injury to both shoulders from repetitive trauma on March 15, 2016. At hearing, in addition to claiming repetitive trauma, Petitioner alleged a specific lifting incident occurred on March 15, 2016. Petitioner testified she went to grab a pack of 12 jeans, which were wet and heavy, from a bin that did not have a riser lifting the merchandise up. As Petitioner went to grab the pack, it fell onto her and she felt her right shoulder pop. Petitioner testified she then tried to grab the same pack with her left arm, causing her left arm to begin hurting also.

   On cross examination, Petitioner clarified that although she was alleging a specific incident occurred from lifting the jeans, she had problems the entire time she worked for Respondent, as she had never lifted boxes before. Petitioner testified lifting the jeans made her condition worse.

3. Petitioner first sought treatment from Dr. Sharon Rosenberg on March 19, 2016, complaining of right shoulder and arm pain. Dr. Rosenberg's initial diagnosis was shoulder pain. Petitioner did not report any specific accident at this visit.

4. Petitioner did not complain of left shoulder pain until her April 8, 2016 visit to Dr. Steven Sclamberg. Petitioner then reported working repetitive overhead duty unloading trucks and filled out a medical history questionnaire indicating her problem began last year. She also reported suffering from lupus and fibromyalgia. After obtaining a MRI, Dr. Sclamberg diagnosed Petitioner with a right shoulder near full thickness rotator cuff tear and impingement syndrome of both shoulders.

5. In addition to physical therapy, work restrictions and prescription medication, Petitioner thereafter underwent the following surgeries:

   On April 20, 2016, Petitioner underwent a right shoulder arthroscopy with rotator cuff repair, subacromial decompression, synovectomy and debridement. On June 17, 2016, Dr. Sclamberg diagnosed Petitioner with right shoulder postoperative pericapsulitis.

   Then, on August 3, 2016, Petitioner underwent a right shoulder manipulation with bilateral injections.

   Shortly thereafter, on October 12, 2016, Petitioner underwent a left shoulder arthroscopy with rotator cuff repair, synovectomy and debridement as well as a second right shoulder manipulation with injection. The postoperative diagnoses were left shoulder impingement syndrome with rotator cuff tearing and right shoulder pericapsulitis.

   Lastly, on July 26, 2017, Petitioner underwent another left shoulder arthroscopy with subacromial decompression, synovectomy and debridement. Her postoperative diagnosis was impingement syndrome with hypertrophic synovitis and mild pericapsulitis.

6. The parties deposed Dr. Sclamberg on May 1, 2017. Dr. Sclamberg opined that Petitioner's repetitive duty work unloading trucks above an overhead height caused her right shoulder condition. He testified the repetitive lifting and lowering of one's arm grinds the tendon against the bone spur, and like a rope rubbing against a rock, frays and eventually tears the rotator cuff. Dr. Sclamberg further testified that although frozen shoulder is most commonly idiopathic, Petitioner was predisposed to frozen shoulder due to her rotator cuff surgery. He thus found that Petitioner's repetitive work injury necessitated her rotator cuff surgery, and that surgery, along with Petitioner's genetic makeup, made her shoulder stiff.

   Dr. Sclamberg acknowledged Petitioner had some degree of natural shoulder degeneration, given her age. As such, he testified Petitioner's overhead work would have at least aggravated any preexisting condition. Additionally, Dr. Sclamberg testified that when he first saw Petitioner on April 8, 2016, she advised him that her shoulder pain had been ongoing since October 2015.

   Lastly, Dr. Sclamberg testified Petitioner did not report any specific accident to him. Dr. Sclamberg also did not review a job description, and Petitioner did not convey her job duties to him, except for when she initially described unloading garments. Dr. Sclamberg acknowledged he did not know exactly how often Petitioner unloaded trucks, how much of Petitioner's work was overhead, nor the weight of any items Petitioner lifted.

7. Dr. Karlsson performed an independent medical examination on Petitioner's bilateral shoulders on August 22, 2016, and the parties thereafter deposed Dr. Karlsson on June 5, 2017. Unlike Dr. Sclamberg, Dr. Karlsson was told by Petitioner of the specific alleged lifting accident that occurred from lifting the pack of jeans on March 15, 2016. Dr. Karlsson opined that the current conditions of Petitioner's shoulders were not caused nor aggravated by any work accident. He testified it would take a significant injury to cause a rotator cuff tear, and the March 15, 2016 accident did not create a large enough trauma.

   Dr. Karlsson also pointed out that Petitioner listed different accident dates on her initial injury report, which stated April 8, 2016 was the accident date, and Dr. Sclamberg's records, where Petitioner claimed the pain was present for a year. Dr. Karlsson found Petitioner's accident history for March 15, 2016 contradicted multiple records that suggested there was no specific right shoulder injury and Petitioner's problem began in October 2015. He further noted there was no mention of left shoulder problems in early records, and as such, found no relationship between the left shoulder and alleged accident.

   Lastly, Dr. Karlsson found there to be no repetitive overhead use in Petitioner's job description that put her at risk for rotator cuff tears. Dr. Karlsson stated that whether overhead work makes an already-worn rotator cuff susceptible to tearing depends on its frequency and the lifter's position. He did not consider overhead lifting a couple times an hour to be highly repetitive, stressful for the shoulder or a high risk for shoulder problems.

In consideration of the entire record before us, the Commission concludes that Petitioner suffered a temporary aggravation of preexisting shoulder problems that had resolved by the time of Dr. Karlsson's independent medical examination on August 22, 2016. Petitioner testified she had shoulder problems the entire time she worked for Respondent but lifting the pack of jeans on March 15, 2016 worsened her condition. Dr. Sclamberg further testified that Petitioner's shoulder pain began in October 2015. This is corroborated by the medical history questionnaire filled out by Petitioner on April 8, 2016 that indicated her shoulder problem began the year before. As such, the record shows Petitioner suffered from shoulder pain predating the accident.

Nevertheless, treatment records show an increase in Petitioner's pain complaints following the March 15, 2016 specific lifting accident, which lends itself to an aggravation. At the August 22, 2016 independent medical examination, Dr. Karlsson diagnosed Petitioner with a right shoulder full-thickness rotator cuff tear and AC joint arthropathy as well as left shoulder rotator cuff syndrome. However, Dr. Karlsson opined that these conditions were not causally related to the alleged specific lifting accident nor any repetitive overhead work activities.

The Commission finds Dr. Karlsson's opinion to be more persuasive than Dr. Sclamberg's finding of current causation. Dr. Sclamberg did not review a job description nor did Petitioner convey to him her specific job duties, except for initially stating she unloaded garments. Dr. Sclamberg did not know how much of Petitioner's work was overhead nor the weight of any items she lifted. He also was not informed of any specific lifting accident. As Dr. Sclamberg did not appear to have knowledge of Petitioners' actual duties, the Commission is not persuaded by his opinion that her job duties caused the rotator cuff conditions.

Therefore, the Commission concludes that at the very most, Petitioner suffered an aggravation of her preexisting shoulder problems that was temporary and resolved as of the August 22, 2016 independent medical examination. Petitioner's claim for medical expenses and temporary total disability compensation after August 22, 2016 is therefore denied. Prospective medical care is likewise denied.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated December 14, 2017 is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $202.50 per week for 19 3/7 weeks, commencing 4/9/2016 through 8/22/2016, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services that relate only to treatment regarding Petitioner's bilateral shoulder conditions before 8/22/2016, as provided in Sections 8(a) and 8.2 of the Act. All medical treatment after 8/22/2016 is denied.

18IWCC0783

IT IS FURTHER ORDERED that Respondent is not liable for Petitioner's prospective medical care, including but not limited to, Petitioner's 12/8/2017 treatment visit with Dr. Steven Sclamberg.

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

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

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

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

DATED: DEC 21 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/met
O-
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

18IWCC0783

GORDILS, CATHLEEN
Employee/Petitioner

Case# **16WC012810**

BURLINGTON COAT FACTORY
Employer/Respondent

On 12/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CATHLEEN GORDILS
Employee/Petitioner

v.

BURLINGTON COAT FACTORY
Employer/Respondent

Case # 16 WC 12810

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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3/15/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$10,530.00**; the average weekly wage was **$202.50**.

On the date of accident, Petitioner was **52** years of age, ***married,*** with **no** dependent children.

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

Respondent claims no credit under Section 8(j) of the Act. Arb Exh 1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $202.50/week for 73 2/7 weeks, commencing 4/9/2016 through 9/3/17, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the fee schedule, of $105.00 to Orthopaedics of the North Shore, and $300.00 to Presence St. Francis Hospital as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall hold Petitioner harmless with regard to payments made by her husband's health insurance to Presence St. Francis Hospital in the amount of $122,731.20 and Orthopaedics of the North Shore in the amount of $ 3,403.34.

Respondent shall also reimburse Petitioner for the payments totaling $50.00 she made to Orthopaedics of the North Shore. PX 3.

Prospective Medical benefits

Respondent shall authorize and pay for Petitioner's return visit to Dr. Sclamberg. As of the hearing, this visit was scheduled for December 8, 2017.

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

12/13/17
Date

ICArbDec19(b)

DEC 14 2017

Cathleen Gordils v. Burlington Coat Factory
16 WC 12810

Summary of Disputed Issues

Petitioner claims bilateral shoulder injuries secondary to repetitive trauma and a lifting incident of March 15, 2016. The disputed issues include accident, causal connection, medical expenses, temporary total disability and prospective care, with Petitioner seeking a post-operative visit to her surgeon, Dr. Sclamberg. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she began working for Respondent on September 1, 2014. Her hours varied, depending on the season. During the slow months, she worked 2 to 3 days per week. During busier months, she worked 4 to 6 days per week. As of March 15, 2016, she was classified as a pricing associate. Pricing involved using a hand-held gun to mark prices on clothing, hanging clothing on racks and transferring multiple items to clearance racks.

Petitioner testified that, while she was classified as a pricing associate, Respondent scheduled her to work in receiving almost every day. She performed pricing "one or no days" per month. Her receiving duties included unloading trucks and pallets that were stacked high with boxes and pushing and unloading wheeled bins and carts full of clothing items.

Petitioner testified she is 4 feet, 9 inches tall. She had to reach overhead to grab boxes that were at the top of the stacks on the pallets. After she removed a box from the top of a pallet, she had to reach over the box to cut it open and "prep" the contents. She also had to push 4-tiered carts that were stuffed with various items. These carts were 5 ½ to 6 feet tall.

Petitioner testified that, at some point prior to March 15, 2016, she took photographs of her work area. She took these photographs on a scheduled workday, to prove to her boss that her work area was neat when she finished her shift. She testified that the photograph on page 2 of PX 5 shows one of the 4-tiered carts she pushed while working in receiving. She had to reach up to the top tier of the shelf about 30 times per hour. The photograph on page 3 of PX 5 shows a "track" that came to her waist level. The photograph on page 4 of PX 5 shows a "blue bin." These bins had interior risers (see pages 10 and 12 of PX 5) that facilitated unloading. When a bin was full, the riser was at the bottom. The riser moved up as items were unloaded. Items inside the bins had to be removed, placed on hangers and hung on "Z" racks and "roll" racks. These racks are shown on page 6 of PX 5. Petitioner testified she had to reach overhead to hang items on these racks.

Petitioner denied injuring either of her shoulders prior to March 15, 2016. On that date, she was removing items from a "blue bin" that lacked a riser. She went to grab a 12-pack of jeans. She testified the jeans were wet and thus heavier than usual. As she tried to lift the 12-pack out of the bin, she felt a "pop" in her right shoulder. She then tried using her left arm to

grab the 12-pack. As she did this, she felt pain in her left shoulder. She informed her boss, Rich, of her injury. He advised her to "take it easy." [Respondent disputed this account but stipulated to receiving timely notice of the claimed accident. Arb Exh 1.]

Petitioner testified she first sought treatment on March 19, 2016. On that date, she saw her primary care physician, Dr. Rosenberg. The doctor's electronic records reflect that Petitioner complained of right arm and shoulder pain and was also seen for hypertension and anxiety. The records contain no mention of work activities or an injury. On right upper extremity examination, Dr. Rosenberg noted mild tenderness along the supraspinatus and a decreased ability to lift the arm above shoulder height secondary to pain. She prescribed an MRI. PX 1, pp.

Dr. Rosenberg's records (PX 1) contain two different MRI reports dated March 26, 2016. One reflects Petitioner underwent a left shoulder MRI. The other contains an addendum indicating that the reference to "left" was incorrect and that Petitioner actually underwent a right shoulder MRI. The interpreting radiologist, Dr. Chaves, noted a "small, at least high grade, partial thickness articular surface tear of the anterior infraspinatus/posterior-most supraspinatus tendon, query full-thickness ulceration," a separate small high grade partial-thickness , likely articular surface, tear of the anterior supraspinatus tendon, a small amount of fluid within the subacromial-subdeltoid bursa and mild tendinosis of the intra-articular long head of the biceps. Dr. Chaves indicated an MR arthrogram might help to delineate the extent of the tearing. He described the superior labrum as degenerated. He saw no discrete labral tearing. PX 1, pp. 13-16.

On April 1, 2016, Dr. Rosenberg issued a note referring Petitioner to Dr. Sclamberg. The note describes Petitioner's diagnosis as "torn rotator cuff." PX 1, p. 37.

Petitioner testified she first saw Dr. Sclamberg on April 8, 2016. The doctor's subpoenaed records (PX 3) include a four-page "patient medical history" form dated April 8, 2016. This form contains various handwritten entries and appears to have been signed by Petitioner. On the first page, Petitioner indicated she was seeking care for "shoulder/arm pain" that had begun "last year." No writing appears in response to a question asking whether the problem stemmed from an injury. The word "no" is circled in response to a question asking whether the problem is "covered under workers' compensation." On the third page, Petitioner mentioned a history of lupus and fibromyalgia. PX 3, pp. 11-14.

Dr. Sclamberg's typed note of April 8, 2016 reflects a referral from Dr. Rosenberg. The doctor described Petitioner as "work[ing] repetitive duty unloading trucks at an overhead height" and complaining of bilateral shoulder pain, right worse than left, along with some "weakness secondary to pain." It appears the doctor described the pain as "going on since October." The doctor interpreted the MRI as showing a near full-thickness tear of the rotator cuff, supraspinatus distribution.

Dr. Sclamberg described Petitioner as 4 feet, 9 inches tall. On shoulder examination, he noted 4/5 strength testing and positive impingement signs. He diagnosed right and left shoulder impingement syndrome and a right full-thickness rotator cuff tear. He indicated he discussed various treatment options, with Petitioner opting for arthroscopic repair. PX 2, pp. 9-10. He took Petitioner off work pending surgery. PX 3, p. 8.

Dr. Sclamberg operated on Petitioner's right shoulder on April 20, 2016, performing an arthroscopy with rotator cuff repair, subacromial decompression and debridement. In his operative report (PX 3, pp. 16-17), he documented a high-grade, partial thickness supraspinatus rotator cuff tear, diminished biceps and supraspinatus interval, anterior fraying of the labrum and Grade I-II chondromalacia.

On April 22, 2016, Petitioner filed an Application for Adjustment of Claim alleging a right shoulder repetitive trauma injury of March 15, 2016.

At the first post-operative visit, on May 5, 2016, Dr. Sclamberg described Petitioner as doing well with respect to the operated right shoulder and "having a little bit of pain in the left shoulder." He removed the sutures from the right shoulder and noted a good passive range of motion. On left shoulder examination, he noted 160/45 L1 motion and a positive impingement sign. He offered Petitioner a left shoulder injection but she declined. He prescribed physical therapy and directed Petitioner to return to him in six weeks. PX 3, pp. 20, 24.

Petitioner began a course of physical therapy at Presence St. Francis Hospital on May 24, 2016. On that date, the evaluating therapist, Cynthia M. Weinstein, PT, DPT, noted that Petitioner performs "receiving for Burlington." She indicated this job involved lifting and moving garments and cutting plastic on pallets. PX 2, p. 156

Petitioner returned to Dr. Sclamberg on June 17, 2016 and complained of pain in both shoulders. The doctor noted she was eight weeks out from surgery and undergoing therapy for the operated right shoulder. He also noted she had not yet undergone any advanced left shoulder imaging. On right shoulder examination, he noted 90 degrees of active and passive forward elevation, external rotation to 15 degrees and internal rotation to the side. On left shoulder examination, he noted 160/45 L1 of motion, 4/5 strength testing and positive impingement signs. He diagnosed right shoulder post-operative pericapsulitis and left shoulder impingement syndrome. He prescribed home exercises for the right shoulder and a left shoulder MRI. PX 3, p. 26.

The left shoulder MRI, performed without contrast on June 29, 2016, showed some degree of hypertrophic AC joint arthropathy, a few tiny degenerative subchondral cystic geodes in the posterior lateral aspect of the left humeral head and mild signal changes in the supraspinatus tendon, "suggest[ing] tendinitis and peritendinitis." The interpreting radiologist noted no evidence of rotator cuff tearing and no evidence of signal alteration in the glenoid labrum. PX 3, pp. 72-73.

On July 1, 2016, Dr. Sclamberg reviewed the left shoulder MRI. His examination findings were unchanged. He recommended manipulation of the right shoulder under anesthesia along with bilateral shoulder injections. PX 3, p. 27. He continued to keep Petitioner off work. PX 3, pp. 27, 47.

On August 3, 2016, Dr. Sclamberg operated again, performing manipulation under anesthesia and an injection of the right shoulder and an injection into the left shoulder subacromial space. PX 3, pp. 28-29. On August 4, 2016, he prescribed six weeks of therapy. PX 3, p. 77.

Petitioner participated in therapy thereafter. PX 2. On August 16, 2016, she returned to Dr. Sclamberg, with the doctor noting an improved range of motion in both shoulders. The doctor recommended that Petitioner continue therapy, stay off work and return to him in six weeks. PX 3, pp. 44-46, 76.

At Respondent's request, Petitioner submitted to a Section 12 examination by Dr. Karlsson on August 22, 2016. In his lengthy report of that date, the doctor recorded the following history:

> "Ms. Gordils is a 52-year-old, right-hand-dominant female who reports injuring both shoulders on March 15, 2016. She says at that time she was working in Burlington Coat Factory in receiving. She was lifting a bag of jeans from a bin. She says the bag of jeans had 8 to 12 pairs of jeans and the bin was directly in front of her. She leaned into a bin to pull out the jeans and they were damp so somewhat heavier than she expected. She was lifting them primarily with her right arm and felt a snapping in the right shoulder. Then, she used both arms to try to pull the bag up and she felt pain in the left as well but not as bad as the right. I have asked her about her height and the height of the bin. She says that she is 4 feet, 9 inches and that the bin is about 4 feet high. However, she then indicated that the height of the top of the bin on her body came to just below breast level. She is indicating less than halfway between her waist and shoulders. I have told her that she is indicating she is 4 feet, 9 inches and the bin is 4 feet high but she is indicating it is below breast level and again confirmed it is below breast level and slightly above the waist. She told her boss on the date of injury. He told her to slow down a little bit and take it easy."

Dr. Karlsson noted that Petitioner acknowledged a history of lupus and fibromyalgia and denied any prior history of problems with either shoulder. He indicated she reported taking Norco for

pain along with medication for hypertension and high cholesterol. He further indicated he reviewed Dr. Rosenberg's note of March 19, 2016 along with the right shoulder MRI report, Dr. Sclamberg's office notes and operative note of April 20, 2016, two job descriptions (for markdown team associate and receiving associate positions), a First Report of Injury dated April 26, 2016 (listing a date of injury of April 8, 2016) and an employee "accident alert" referencing a "repetitive work injury claimed by associate." The Arbitrator notes that the receiving associate position job description, along with the First Report of Injury and employee "accident alert", are not in evidence. Dr. Karlsson described the receiving associate job description as 3 pages long. He indicated that the duties for this job included unloading trucks, breaking down pallets, feeding cartons onto equipment and operating hand trucks, "among other things." He also indicated the job required the ability to "lift up to 40 pounds or more" and "move and handle merchandise which entails lifting." RX 4, p. 5 of 8.

Dr. Karlsson diagnosed Petitioner as having a full-thickness right rotator cuff tear and AC joint arthropathy, status post surgery and manipulation, and left rotator cuff syndrome for which she had had no diagnostic studies. He did not find either of these conditions to be related to any work accident or work activity. He noted that the first report of injury referenced an accident date of April 8, 2016 and that Petitioner had consulted Dr. Rosenberg due to right shoulder pain nearly a month before this date, with the doctor making no mention of any injury. He also noted that, when Petitioner first saw Dr. Sclamberg, on April 8, 2016, she completed a form indicating her pain had "been going on for a year" and was "not related to workers' compensation."

Dr. Karlsson indicated that neither of the job descriptions he reviewed mentioned any repetitive overhead use or other activity that would place Petitioner at high risk for rotator cuff tears.

Dr. Karlsson characterized the treatment to date as reasonable and necessary but "not related to any accident or work activities." He opined that Petitioner required physical therapy for her right shoulder and that it would be reasonable to proceed with a left shoulder injection, followed by an MRI and possible surgery if the injection provided no relief. He opined that the need for this care did not stem from any work accident or work activity. He found Petitioner capable of full duty with respect to her left shoulder. With respect to the right shoulder, he recommended that Petitioner avoid working overhead or lifting more than 10 pounds, noting her limited motion and her history of a recent manipulation. He clarified that Petitioner's need for right-sided restrictions did not stem from any work accident or work activity.

Dr. Karlsson clarified that, while Petitioner reported injuring both of her shoulders on March 15, 2016, her early records did not document any specific right shoulder injury and contained no mention of any left shoulder complaints. RX 4.

On September 30, 2016, Petitioner reported right shoulder improvement to Dr. Sclamberg but complained of left shoulder pain "down the deltoid." The doctor noted that she wanted to discuss surgery "as the injection did not help." On right shoulder examination, he

noted 160 degrees of active forward elevation, 40 degrees of external rotation with the arm at the side and internal rotation near the sacrum. On left shoulder examination, he again noted 160/45 L1 of motion, 4/5 strength testing and a positive impingement sign. He discussed a left shoulder arthroscopy and possible rotator cuff repair, with Petitioner agreeing to this intervention. PX 3, pp. 42-43.

Dr. Sclamberg operated again on October 12, 2016, performing a left shoulder arthroscopy and rotator cuff repair and a manipulation under anesthesia and injection of the right shoulder. In his operative report, he documented labral fraying at the biceps attachment, high-grade, near full-thickness tearing of the rotator cuff and Grade I chondromalacia of the left shoulder. PX 3, pp. 64-65. At the first post-operative visit, on October 25, 2016, he removed the sutures, obtained left shoulder X-rays and prescribed physical therapy along with a 15-day course of Hydrocodone. PX 3, pp. 39-41.

Petitioner returned to Dr. Sclamberg on December 6, 2016. Petitioner reported right shoulder improvement but indicated her left shoulder still hurt. The doctor recommended additional therapy and directed Petitioner to stay off work and return in six weeks. PX 3, pp. 35-37.

At the next visit, on January 17, 2017, Dr. Sclamberg noted overall improvement but indicated Petitioner experienced pain when she raised her arms overhead. He prescribed additional therapy and continued to keep Petitioner off work. PX 3, pp. 31-33.

On February 22, 2017, Petitioner's therapist informed Dr. Sclamberg that Petitioner had run out of Norco and was still experiencing a lot of pain and difficulty sleeping, dressing and washing/styling her hair. PX 3, pp. 147-150.

On February 28, 2017, Dr. Sclamberg noted that Petitioner reported being "unable to sleep on the left shoulder due to pain." He also noted ongoing right shoulder complaints. He directed Petitioner to continue therapy and remain off work. PX 3, pp. 172-175.

On April 28, 2017, Dr. Sclamberg noted ongoing complaints, worse on the left. He prescribed a Medrol Dose-Pak, Tramadol and additional therapy. He continued to keep Petitioner off work. PX 3, pp. 168-171.

Dr. Sclamberg testified by way of evidence deposition on May 1, 2017. PX 4. He is a board certified orthopedic surgeon who sub-specializes in sports medicine, specifically knees and shoulders. PX 4, p. 5. He was recertified in 2014. PX 4, p. 6. Sclamberg Dep Exh 1. He sees about 120 patients per week. About half of these patients have shoulder problems. PX 4, pp. 6-7. He performs every type of shoulder surgery, from arthroscopies to reverse shoulder replacements. PX 4, p. 7.

Dr. Sclamberg testified he recalls treating Petitioner but would need to rely on his records to testify. PX 4, p. 7. He first saw Petitioner on April 8, 2016, at Dr. Rosenberg's

referral. Petitioner complained of bilateral shoulder pain, right greater than left, which she attributed to repetitive work duties, specifically unloading trucks at and above overhead height. PX 4, pp. 8-9. As of that date, Petitioner had undergone a right shoulder MRI, which he interpreted as showing a high-grade, partial thickness rotator cuff tear. PX 4, p. 9.

Dr. Sclamberg found a causal connection between the unloading duties Petitioner described and the MRI findings. Petitioner had "nearly worn all the way through her right rotator cuff." PX 4, pp. 9-10. He recalls that Petitioner unloaded garments but, in his view, the size or weight of the items Petitioner unloaded does not matter, causation-wise. In his opinion, "it doesn't actually take any weight" to cause a rotator cuff problem. Instead, it is the "act of lifting and lowering your arm over and over again that brings the rotator cuff like a rope up against a rock under a bone spur." The repetitive action "just grinds the tendon up against the spur," causing fraying of the cuff to the point where it tears. PX 4, pp. 10-11. Anyone who performs repetitive overhead work is at risk for this. PX 4, p. 11. When he uses the term "repetitive," he refers to people who reach overhead "several times an hour." PX 4, pp. 11-12.

Dr. Sclamberg testified that, with respect to the right shoulder, he recommended an arthroscopic rotator cuff repair. He recommended conservative care, i.e., therapy, for the left shoulder. He took Petitioner off work on April 8, 2016, pending surgery, and operated on her right shoulder on April 20, 2016. Petitioner remains under his care. He last saw her the week before the deposition. PX 4, p. 13. Along the way, he addressed a complication of "frozen shoulder" on the right as well as pain in the left shoulder. PX 4, p. 14. "Frozen shoulder" is a condition in which the lining of the shoulder joint gets inflamed and, effectively, "shrinks the volume of" the joint. It is a typically idiopathic condition, meaning it "just happens." PX 4, p. 15. It happens more commonly in diabetic patients and patients who have endocrine or thyroid problems. It also happens in patients who have rotator cuff problems and are post-operative. PX 4, p. 15. Because Petitioner underwent rotator cuff surgery, she is predisposed to the condition. PX 4, p. 15. Her "frozen shoulder" was a consequence of the work accident since the surgery was also a consequence of the accident. PX 4, p. 15. "Mainstay" treatment for a frozen shoulder is initially therapy, injection(s), time and medication. If conservative care fails, the patient can undergo a manipulation under anesthesia. During this procedure, the surgeon manually breaks through scar tissue while the patient is asleep. PX 4, p. 16. After the procedure, the patient "immediately" starts therapy. As of Petitioner's last visit, on April 28, 2017, her right shoulder range of motion had improved but forward flexion and external/internal rotation were still short of normal. Petitioner still had some weakness, graded 4/5. He believes he continued to impose restrictions as of that date, probably no lifting over 5 to 10 pounds and no overhead or repetitive work. PX 4, p. 17. The work accident created the need for those restrictions. PX 4, pp. 17-18.

Dr. Sclamberg testified that Petitioner, at age 53, has some degree of natural degeneration in her shoulder. All patients are different but most people develop degeneration in the shoulder as they get older. PX 4, pp. 18-19.

Under cross-examination, Dr. Sclamberg testified that Petitioner did not mention any specific accident to him. He does not believe he reviewed Dr. Rosenberg's records. He based his initial history solely on what Petitioner told him. PX 4, p. 19. Petitioner did not mention any pre-existing conditions. Specifically, she did not mention having lupus, fibromyalgia or diabetes. All of these conditions can cause a "frozen shoulder." PX 4, p. 20. He never reviewed any job description. Petitioner did not describe any job duties other than unloading garments. PX 4, p. 20. She indicated she performed this unloading repetitively. He does not know how often she performed it. He has no idea how much of Petitioner's work was overhead. PX 4, p. 21. For him, the weight being lifted is not material. In terms of frequency, "it would be lifting at or above shoulder height several times an hour." PX 4, p. 21. Petitioner told him she had been experiencing shoulder pain since October 2015. PX 4, p. 22. Petitioner is still undergoing therapy for both shoulders, at his recommendation. PX 4, p. 23.

Dr. Sclamberg acknowledged it is possible for a woman of Petitioner's age to develop rotator cuff tears as a result of the natural aging process, absent any particular work activity. PX 4, p. 24. At this time, he does not believe she needs more surgery. PX 4, p. 24. He anticipates she will reach maximum medical improvement by the next office visit, and then potentially undergo a functional capacity evaluation. PX 4, p. 24.

On redirect, Dr. Sclamberg testified that rotator cuff surgery, superimposed on the conditions of diabetes, lupus and fibromyalgia, would make "frozen shoulder" more likely. PX 4, pp. 24-25.

Dr. Karlsson testified by way of evidence deposition on June 5, 2017. RX 2. He is a board certified orthopedic surgeon who most commonly treats knee, shoulder and hip disorders. RX 2, p. 5.

Dr. Karlsson testified he "minimally" recalls examining Petitioner on August 22, 2016. He relied on his notes while testifying. RX 2, p. 6. When he conducts an examination, his assistant obtains an initial history. He then reviews the history with the examinee. RX 2, pp. 6-7. Petitioner provided him with a history of injuring both shoulders at work on March 15, 2016, while attempting to lift a pack of wet jeans out of a bin. Petitioner told him she is 4 feet, 9 inches tall. RX 2, p. 7. She described the bin as 4 feet tall but then indicated that the top of the bin was at a level just below her chest. RX 2, pp. 7-8. She described undergoing a right rotator cuff surgery, a subsequent right shoulder manipulation and a left shoulder injection. She indicated she had not yet undergone any radiographic studies of her left shoulder. RX 2, p. 9. She complained of bilateral shoulder pain, worse on the right, and decreased motion. RX 2, p. 10. Her history of lupus and fibromyalgia was "potentially" contributory in that both of these conditions can cause shoulder pain. Neither condition can cause a rotator cuff tear, however. RX 2, pp. 10-11.

Dr. Karlsson testified that, on examination, he noted good motion of the left shoulder but significant loss of motion of the right shoulder. Petitioner also had some weakness to external rotation of both shoulders. RX 2, p. 11.

Dr. Karlsson testified he reviewed some records, including imaging reports and the right shoulder MRI images. Those images showed severe arthritis with some spurring and "high signal throughout the full thickness of the rotator cuff, which was consistent with either a near full-thickness tear or a full-thickness tear through the rotator cuff." The biceps tendon was intact. RX 2, p. 12. He obtained left shoulder X-rays in his office. The films did not show any arthritis. RX 2, p. 12.

Dr. Karlsson testified that, while Dr. Rosenberg documented a complaint of right shoulder pain on March 19, 2016, she did not mention any injury. RX 2, p. 13.

Dr. Karlsson testified he diagnosed Petitioner with a full-thickness right rotator cuff tear and AC joint arthropathy, for which she had already undergone surgery, and left rotator cuff syndrome. Without a left shoulder MRI, it was not possible to determine whether Petitioner simply had left rotator cuff tendinitis or a tear. RX 2, p. 14.

Dr. Karlsson found no causal relationship between the incident Petitioner described and the right rotator cuff tear. Petitioner did not describe any large trauma to her right shoulder. Her first medical provider did not describe her pain as stemming from an injury or work activity. RX 2, p. 14. Working below shoulder height can cause a rotator cuff tear "if there is a large trauma." For example, if a person is working with a wrench below shoulder height and the wrench is suddenly and forcefully jerked, a rotator cuff tear could occur. Such tears are "much more likely" if a person is working overhead, however. Rotator cuff tears can also result from repetitive overhead work, "especially if someone is lifting heavy weights or having to apply a great deal of force, especially far away from the body and overhead." RX 2, p. 15.

Dr. Karlsson conceded that the term "repetitive" is subject to interpretation. In his mind, it refers to work being done "a significant portion of the time, 30 percent or more." RX 2, p. 15. Working close to the body and barely overhead creates much less stress than working at a full arm's distance overhead or having to apply significant force, to turn a stuck bolt or something far out from the body. RX 2, pp. 15-16. If a task is performed several times per hour, he would not consider it highly repetitive or creating a risk of a repetitive trauma. RX 2, p. 16. The mechanism Petitioner described, i.e., lifting a bag of wet clothes below shoulder height, could cause "temporary symptoms" in a person who already has arthritis or a tear but he would not expect it to cause a tear. RX 2, p. 16. Along the same lines, he does not view the right shoulder surgery and manipulation to be causally related to the incident Petitioner described. RX 2, p. 17.

Dr. Karlsson testified that, as of his examination, Petitioner required more shoulder care and restrictions, but not due to the incident she described. She should not be working overhead or lifting over 10 pounds. RX 2, p. 18. He would not place any restrictions on her with respect to the work incident. RX 2, p. 18.

Under cross-examination, Dr. Karlsson testified he finds Dr. Sclamberg's repetitive trauma analogy (a rope passing over a rock over and over again) reasonable. RX 2, pp. 18-19. Most women who are 51 or 52 years old will have some degree of rotator cuff degeneration. It would be "unusual" for a 52-year-old woman to experience a rotator cuff tear solely due to degeneration, however. The rotator cuff of someone that age is more susceptible to any trauma, whether specific or repetitive. RX 2, p. 19. It is also more susceptible to degenerative tearing. RX 2, p. 20. In a 52-year-old, "just about any weight overhead" could aggravate a degenerated rotator cuff, if the movement is "highly repetitive." He would not consider an activity performed a few times per hour to be "highly repetitive." Certainly, even without a weight, constantly lifting overhead, i.e., to put a note into a pigeonhole that is high up and away from the body, "could be a factor." RX 2, p. 21. A person who has to make this kind of movement "a significant portion of the time" will experience "pinching" of the tendon. The pinching may cause a little bit of disruption of the blood supply. An activity performed ten or fewer times per hour would not be considered causative, however. RX 2, p. 22.

Dr. Karlsson reiterated that lupus and fibromyalgia would not put a person at a high risk of a rotator cuff tear, unless the person has been on high-dose steroids for months at a time. RX 2, pp. 22-23.

On redirect, Dr. Karlsson testified that causation is contingent on arm position, frequency and the type of weight involved. Lifting a very light weight overhead with the elbow close to the body puts "a much different stress" on the shoulder than trying to lift 10 pounds two feet in front of the body and a foot overhead. RX 2, pp. 23-24. Working below shoulder level changes the position of the rope, to use Dr. Sclamberg's analogy. The rope is being pulled fully above the rock and is not being rubbed by the bones above it. If anything, lifting below shoulder level distracts the rotator cuff somewhat and unloads it. RX 2, p. 24.

On June 9, 2017, Dr. Sclamberg noted that Petitioner's right shoulder was better and "only hurts when she raises her arm." He also noted that Petitioner's left shoulder was "not improving" and that she reported having a lot of difficulty lifting her left arm. He indicated that Petitioner "is still off work and she does not think that she is well enough to return because she cannot hold her arms up above her head for long periods of time." On right shoulder examination, he noted forward flexion of 160 degrees, external rotation of 45 degrees and internal rotation to S1. He also noted 4/5 strength testing. On left shoulder examination, he noted forward flexion of 150 degrees, external rotation of 45 degrees and internal rotation to L1. He further noted tenderness of the deltoid and subacromial space and positive supraspinatus testing. He prescribed an MR arthrogram of the left shoulder and directed Petitioner to remain off work pending the results of this study. PX 3, pp. 85-88.

Petitioner underwent a conventional left shoulder MRI on June 19, 2017. The interpreting radiologist indicated he used the previous MRI of June 29, 2016 for comparison purposes. He noted evidence of the prior rotator cuff repair, no full thickness fluid gap, a small amount of subacromial-subdeltoid fluid "which may be reactive/bursitis," obliteration of the normal fat within the rotator interval, which "may represent adhesive capsulitis" and increased

fluid signal around the biceps sheath, representative of either adhesive capsulitis or tenosynovitis. PX 3, pp. 304-305.

On July 26, 2017, Dr. Sclamberg performed a left shoulder arthroscopy with subacromial decompression, synovectomy and debridement. In his operative report, he documented no rotator cuff tearing on the articular side, a normal biceps and "mild leading edge subscapularis partial tearing with hypertrophic synovitis." PX 3, pp. 209-210.

On August 8, 2017, Dr. Sclamberg removed the surgical sutures and prescribed physical therapy. He continued to keep Petitioner off work. PX 3, pp. 241-243.

Petitioner testified she began working for Kohl's on September 4, 2017. She was still performing this job as of the hearing. She works in customer service, handling merchandise returns. She testified she is not required to lift or transfer returned merchandise.

On September 22, 2017, Petitioner informed Dr. Sclamberg that her left shoulder was feeling better and that she was doing home exercises but had not yet started formal therapy. The doctor prescribed Norco and home exercises. PX 3, pp. 354-356. In a separate note bearing the same date, he released Petitioner to light duty as of September 1, 2017 and directed her to return to him on November 3, 2017. PX 3, p. 353. PX 7.

On October 19, 2017, Petitioner filed an Amended Application for Adjustment of Claim alleging a repetitive trauma injury of March 15, 2016 involving both shoulders. PX 6.

On November 3, 2017, about 2 ½ weeks before the hearing, Dr. Sclamberg noted improvement but indicated Petitioner was still experiencing intermittent pain in both shoulders with overhead movement. He noted no abnormalities on right shoulder examination. On left shoulder examination, he noted tenderness at the subacromial space, forward flexion of 160/170, external rotation of 45/60, internal rotation to the sacrum, abduction weakness with 4/5 strength and external rotation weakness with 4/5 strength. He prescribed home exercises and directed Petitioner to return in six weeks. PX 3, pp. 350-352.

Petitioner testified she continues to experience bilateral shoulder pain and bilateral arm weakness. Her right shoulder pain is worse than her left. She cannot lift heavy items and needs assistance to put items on high shelves. It is difficult for her to shampoo her hair or pull a shirt on over her head. She has not reinjured either shoulder since March 15, 2016. She writes with her right hand but otherwise uses both hands to perform manual tasks.

Under cross-examination, Petitioner testified her official job title was "markdown team associate." When she tried to lift a 12-pack of wet jeans out of a bin on March 15, 2016, her arms were straight out and down. There was no riser in that particular bin. As she tried to lift the 12-pack, the plastic encasing the jeans broke, causing the 12-pack to fall back into the bin. The bin was at her chest level. She never lifted boxes before she started working for Respondent. The lifting incident of March 15, 2016 made her shoulder condition worse. She

never underwent a shoulder MRI before March 15, 2016. She described the lifting incident to both Dr. Rosenberg and Dr. Sclamberg. She wrote a letter to Respondent on April 18, 2016, indicating she believed her condition was work-related. She wrote this letter after talking with Dr. Sclamberg. She saw Dr. Karlsson at Respondent's request. She described the lifting incident to Dr. Karlsson. Her shoulder condition was bilateral as of the date she saw Dr. Karlsson. No physician released her to light duty before she began performing light duty for Kohl's on September 4, 2017. She called Dr. Sclamberg on September 2, 2017 to tell him she was starting a light duty job. She has not undergone shoulder treatment with any physicians other than Dr. Rosenberg and Dr. Sclamberg. She is scheduled to return to Dr. Sclamberg on December 8, 2017. Since she began working at Kohl's, she has missed one day due to shoulder problems. Otherwise, she has been able to perform her job duties at Kohl's.

On redirect, Petitioner testified that Dr. Sclamberg addressed her work status in a note dated September 22, 2017. PX 7. In that note, he released her to light duty as of September 1, 2017.

Arbitrator's Credibility Assessment

On direct examination, Petitioner denied injuring either shoulder prior to March 15, 2016. Emergency Room records in PX 2 reflect she in fact complained of right shoulder pain secondary to falling off of a 2-foot ladder while working for Kohl's on January 22, 2005. However, the same records reflect that right shoulder X-rays taken that day were negative and she was released to resume full duty January 23, 2005. PX 2, pp. 3-23. There is no evidence indicating Petitioner underwent additional right shoulder care between January 22, 2005 and March 15, 2016. Given these circumstances, and the passage of more than a decade, the Arbitrator can understand why Petitioner might not have recalled the incident.

Petitioner testified that, while Respondent labeled her a pricing or "markdown team" associate, she almost always performed the duties of a receiving associate. This testimony finds support in Dr. Karlsson's examination report. The doctor indicated he reviewed two written job descriptions, one of which involved the "receiving associate" job. RX 4. The Arbitrator finds it significant that Respondent did not offer the "receiving associate" job description into evidence. "Where a party fails to produce evidence in [its] control, the presumption arises that the evidence would be adverse to that party." REO Movers, Inc. v. Industrial Commission, 226 Ill.App.3d 216, 223-224 (1st Dist. 1992). The Arbitrator also finds it significant that Respondent did not offer into evidence the First Report of Injury and employee "accident alert" it provided to Dr. Karlsson. RX 4.

Petitioner's testimony concerning the equipment she used and the physical requirements of her job was detailed and credible.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident arising out of and in the course of her employment on March 15, 2016?

The Arbitrator finds in Petitioner's favor on the issue of accident. The Arbitrator views this claim as hybrid in nature, in that it involves a specific trauma, i.e., the lifting incident of March 15, 2016, superimposed on repetitive work activities. It has long been held that the term "accident", as used in the Act, is not a technical legal term. E. Baggot Co. v. Industrial Commission, 290 Ill. 530 (1919). In fact, the word "accidental" is a "comprehensive term almost without boundaries in meaning." Ervin v. Industrial Commission, 364 Ill. 56, 60 (1936). In Peoria County Bellwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880, 885 (3rd Dist. 1985), the Appellate Court found that an employee may be "accidentally injured" under the Act "as the result of repetitive, work-related trauma even absent a final, identifiable episode of collapse." In the instant case, the Arbitrator views the incident of March 15, 2016 as an "identifiable episode of collapse" resulting from both the repetitive overhead work Petitioner routinely performed and the specific and awkward lifting of a pack of wet jeans out of a bin that lacked a riser.

The Arbitrator acknowledges that the first treatment note of March 19, 2016, authored by Dr. Rosenberg, contains no mention of an accident, as that term is used by laypeople. The Arbitrator does not find this unusual, given that Petitioner did not fall or strike anything on March 15th. The Arbitrator also acknowledges that Petitioner did not mention the March 15th incident in the history form she completed at Dr. Sclamberg's office on April 8, 2016. The Arbitrator does not find this unusual, either, in that Petitioner had been experiencing shoulder pain prior to the incident.

The Arbitrator also acknowledges that the first treatment note of March 19, 2016 contains no mention of left shoulder complaints. Petitioner initially used her right arm to try to lift the pack of jeans out of the bin. She switched to her left arm only after experiencing a "pop" in her right shoulder. Petitioner initially focused on her right shoulder but Dr. Sclamberg noted bilateral complaints on April 8, 2016, only three weeks after the lifting incident.

Respondent's examiner, Dr. Karlsson, made no mention of the missing riser but his account of the lifting incident is otherwise consistent with Petitioner's. RX 4. He had access to accident-related documents (a First Report of Injury and an employee "accident alert") that Respondent did not offer into evidence. He acknowledged that the incident Petitioner described could have resulted in symptoms, albeit temporary ones. RX 2, p. 16.

Did Petitioner establish a causal relationship between the accident and her bilateral shoulder condition of ill-being?

The Arbitrator finds that the specific lifting incident of March 15, 2016, in combination with the repetitive work activities Petitioner performed for Respondent prior to that date, contributed to Petitioner's bilateral shoulder condition of ill-being and gave rise to the need for treatment. In so finding, the Arbitrator relies on the following: 1) Petitioner's short stature; 2)

Petitioner's credible testimony as to the equipment she used and the type and frequency of lifting she performed; 3) the fact that Petitioner successfully performed physical tasks for Respondent for eighteen months before the lifting incident; 4) the lack of evidence of any shoulder treatment during that eighteen-month period; and 5) Petitioner's credible testimony as to the missing riser and the mechanics of the lifting incident of March 15, 2016.

The Arbitrator gives consideration to Petitioner's particular body habitus because "an employer takes its employees as it finds them." St. Elizabeth 's Hospital v. IWCC, 371 Ill.App.3d 882, 888 (2007).

While there is evidence that Petitioner was experiencing shoulder pain for about a year before the lifting incident, that does not preclude recovery. As the Appellate Court recently noted: "if we were to hold that [the chain of events principle] only applied where a claimant is in a condition of absolute good health, that holding would contradict years of Illinois precedent concerning pre-existing conditions." Schroeder v. IWCC, 2017 IL App (4th) 160192WC.

In analyzing causation, the Arbitrator has considered the opinions expressed by Respondent's examiner, Dr. Karlsson.

Dr. Karlsson opined that the lifting incident was not a "large" enough trauma to cause or contribute to Petitioner's shoulder condition. RX 2, p. 14. Although he acknowledged that Petitioner described having to "lean into" the bin to try to "pull up" the pack of jeans, he ultimately latched onto Petitioner's demonstration that the top of the bin was "less than halfway between her waist and shoulders" in minimizing the event. RX 2, pp. 7-8. The problem with this is that Petitioner never indicated that the pack of jeans was at or near the top of the bin. Instead, she emphasized that the riser, which would have acted to mechanically lift the contents of the bin, was missing and that her arms were "straight out and down" as she tried to lift the pack. The fact she was lifting against gravity is supported by her description of the plastic breaking and the pack falling back into the bin. The Arbitrator disagrees with Dr. Karlsson's conclusion that the lifting incident played no causative role, especially given his concession that force increases when the arms are extended away from the body. RX 2, p. 15.

With respect to the repetitive trauma element of the claim, Dr. Karlsson opined that reaching or lifting items overhead "several to ten times an hour" would not likely cause tearing of the rotator cuff, even in a degenerated tendon. RX 2, p. 22. Petitioner credibly testified that her receiving duties included reaching overhead to place clothing on hangers on "Z" and roll racks that were 5 to 6 feet tall and reaching up to the top shelf of a cart that was 5 ½ to 6 feet tall. She indicated she performed the latter, i.e., the reaching, 30 times per hour.

While Petitioner was diagnosed with lupus and fibromyalgia years ago, and while those conditions can result in certain shoulder problems, Dr. Karlsson acknowledged that neither would cause the kind of problem Petitioner experienced, i.e., tearing of the rotator cuff. Moreover, there is no evidence other than the Emergency Room records of January 22, 2005 indicating Petitioner underwent any shoulder treatment prior to March 15, 2016. Nor is there

any evidence indicating Petitioner lost time due to shoulder problems during the eighteen months she worked for Respondent between September 1, 2014 and March 15, 2016.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from April 8, 2016 (the date Dr. Sclamberg took her off work, pending surgery, PX 3) through September 4, 2017 (the date she began working at Kohl's). Respondent asserts Petitioner is not entitled to any temporary total disability benefits, based on its causation defense.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causal connection. In Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132, 142 (2010), the Illinois Supreme Court held that, when a claimant seeks temporary total disability benefits, "the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement." In Sunny Hill of Will County v. IWCC, 2014 Ill.App. LEXIS 454, the Third District Appellate Court held that the ability to work "may be probative of whether [the claimant's] condition has stabilized."

On August 8, 2017, Dr. Sclamberg removed Petitioner's sutures and prescribed Norco and six weeks of physical therapy. He directed Petitioner to return to him in six weeks and to remain off work in the interim. PX 3, pp. 241-244. At the next visit, on September 22, 2017, he noted that Petitioner was feeling better and was doing home exercises in lieu of the prescribed formal therapy. He directed Petitioner to continue performing the exercises and return to him in six weeks. PX 3, pp. 238-240. He issued a separate note the same day, releasing Petitioner to light duty, retroactively, as of September 1, 2017. Under cross-examination, Petitioner testified she contacted the doctor via telephone on September 2, 2017 and told him about the light duty job at Kohl's. On November 3, 2017, Dr. Sclamberg noted that Petitioner had improved but was still experiencing pain in both shoulders. He directed Petitioner to continue performing home exercises and return to him in six weeks. At the hearing, Petitioner testified she was scheduled to return to the doctor on December 8, 2017.

Based on the foregoing, the Arbitrator concludes Petitioner started the job at Kohl's (a job she secured on her own) only after consulting Dr. Sclamberg. It is to Petitioner's credit that she found a job she was physically able to perform while still under active care.

The Arbitrator finds that Petitioner was temporarily totally disabled from April 9, 2016 (with Dr. Sclamberg having taken her off work the day before) through September 3, 2017 (the day before she started her job at Kohl's). This is a period of 73 2/7 weeks.

Is Petitioner entitled to reasonable and necessary medical expenses?

On the Request for Hearing form (Arb Exh 1), Petitioner claimed unpaid medical bills from Orthopaedics of the North Shore ($105.00) and Presence St. Francis Hospital ($300.00) along with an out of pocket expenditure of $50.00. She also indicated she was seeking to be

held harmless against substantial payments made by her group carrier. [The parties agree these payments were not made by an 8(j) carrier.]

Respondent asserts Petitioner is not entitled to any medical award. Respondent bases this assertion in part on its defenses and in part on its allegation that Petitioner failed to offer any bills into evidence. The claimed bills are in evidence. They appear in PX 2 and PX 3.

The itemized bills from Orthopaedics of the North Shore (PX 3, pp. 321-347) reflect itemized charges as well as insurance and patient payments. A patient ledger covering charges through January 17, 2017 shows patient payments totaling $40.00 to date. A subsequent bill shows an additional patient payment in the amount of $10.00 on June 23, 2017.

Most of the hospital bills reflect $0 balances following substantial Blue Cross Managed Care payments. Three of the bills (relating to shoulder surgery performed on 4/20/16, 8/3/16 and 10/12/16) show $100 balances. PX 2, pp. 981-982, 984-985 and 986-987).

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator finds the treatment to date to be reasonable, necessary and causally related to the repetitive and specific traumas at issue. Respondent's examiner, Dr. Karlsson, took no issue with Petitioner's care, although he did not view it as related to the lifting incident or Petitioner's overall work duties. RX 4. The Arbitrator awards Petitioner the $105.00 balance from Orthopaedics of the North Shore, subject to the fee schedule and to the extent this figure does not represent improper balance billing. The Arbitrator also directs Respondent to reimburse Petitioner for the $50.00 payment she made to Orthopaedics of the North Shore. The Arbitrator also awards Petitioner the $300.00 balance from Presence St. Francis Hospital, subject to the fee schedule and to the extent this figure does not represent improper balance billing. The Arbitrator further orders Respondent to hold Petitioner harmless against the $122,731.20 payment made to Presence St. Francis Hospital by the group carrier.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator has also found the care to date to be reasonable, necessary and causally related. The Arbitrator finds that Petitioner is entitled to prospective care in the form of a return visit to Dr. Sclamberg. As of the hearing, this visit was scheduled for December 8, 2017.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES LOVGREN,

18IWCC0784

Petitioner,

vs.

NO: 16 WC 12957

SERVICE DRYWALL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, both current and prospective, and the imposition of penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

In a preliminary matter, Petitioner filed a motion for the Commission to strike Respondent's brief filed in reply to Petitioner's responding brief and to impose attorney fees against Respondent for filing the brief. The Commission considers Petitioner's motion completely without merit. While the Act does not specifically allow filing a reply brief, neither does it prohibit filing such a brief. In addition, filing a reply brief clearly is not included in the statutory bases upon which the Commission may impose penalties and/or attorney fees. While the Commission might not take such a brief into consideration in arriving at its decision, filing such a brief is no basis upon which to impose attorney fees. Therefore, Petitioner's Motion to Strike Respondent's Reply to Petitioner's Response to Respondent's Statement of Exceptions and Motion for Section 16 Fees is denied.

Findings of Fact & Conclusions of Law

1. Petitioner testified that for financial reasons he, his wife, and two children were currently living with his parents and had for the prior two years. He was a member of Local 1 Carpenters Union for nine years. In August of 2015, he worked for Respondent and had for about eight years. In those eight years he had no issues performing his work activities and never missed a day of work. He had no medical issues other than prepatellar bursitis, for which he had fluid drained. He had no previous treatment on his back, except for some chiropractic adjustments in 2009.

2. On August 12, 2015 he was working for Respondent at the Hyatt in Evanston. On that day, they were preparing windows for installation. They were moving the windows up from the first floor to the second floor. The windows probably weighed close to 300 lbs. They were bringing up five to six windows up at a time, "sliding them off" "like a pitchfork." "The swivel on the forks, you know, started fighting against you. And when [he] went to slide it off, the thing pushed back and slid and overextended [his] back and immediately" injured his back. He felt a "significant pop" in his back and went to the ground in pain. He had 10/10 pain and never experienced that type of pain in his life. A co-worker told him to stay down as he got the foreman. The foreman sent him home and advised him to seek medical attention as soon as possible.

3. Petitioner called his doctor immediately when he got home and saw Dr. Pinney at 2 p.m. that day. Initially, Petitioner was told that a co-worker would come by his home with an accident report. He was then informed that the co-worker "was no longer coming, an accident report was not going to be filed, and that [Respondent] would take care of [Petitioner] on their own." He returned to his doctor that Friday because the pain increased. Dr. Pinney ordered an MRI and referred him to Dr. KellerShabrokh. A couple of days later, Respondent sent him to Dr. Johnson, a chiropractor it uses.

4. After being off work for a week, Petitioner was given a light-duty job doing office work. After a few days, he was sent back out in the field but was told not to lift anything. His apprentice, John Arrichiello, did all the lifting. That went on for "months." His pain reduced to 4/10 through about December, when his workload increased. His pain began to increase, and he noticed "a lot of nerve issues shown" in his legs.

5. After he got no assistance from Respondent, Petitioner sought chiropractic treatment with S&A Chiropractic. He treated there for about 2 weeks, but that treatment actually made his back worse. Thereafter, Dr. Pinney referred him to Suburban Orthopedics where he saw Dr. Chhadia. By then he was almost at full duty and working through pain every day. Petitioner was put back on light duty.

6. Dr. Chhadia referred Petitioner to Dr. McNally. After physical therapy and injections, Petitioner had surgery on November 14, 2016. Respondent sent him for an examination pursuant to Section 12 with Dr. Zelby two weeks after his surgery. He spent 10 to 15 minutes with Petitioner. On December 19, 2016, Petitioner had another procedure to repair a dural leak. His radiating pain returned and on August 9, 2017, Dr. McNally performed spinal fusion surgery. The surgery basically resolved his nerve-related symptoms.

7. Petitioner had a CT about two weeks prior to the hearing and he was scheduled for an EMG that Friday. Physical therapy was prescribed but "insurance denied any work injury claims." Petitioner had not worked for anybody since April 26, 2016. He and his family live in a bedroom at his parents' home rent-free and they are on public assistance.
8. On cross examination, Petitioner agreed that he was not lifting the windows by himself on the day of the accident. He did not go to an Emergency Department on the day of the accident. He drove himself home and later to the doctor. He took about three weeks off on paternity leave in January. His pain improved while on light duty, but then his condition plateaued. It "could be accurate" that he did not see a doctor from August of 2015 to February of 2016. He agreed that he treated with Dr. Hudoba in April of 2012 for his right knee. He did not remember Dr. Hudoba examining his back at the time. Petitioner was there strictly for his knee.

9. On redirect examination, Petitioner testified that Dr. Hudoba never treated, or suggested any treatment for, his back. He had no knowledge of any diagnosis of radiculitis. He was performing his normal job from 2012 to 2015 and had no issues with his back. While his pain waxed and waned, he has been in pain every day since the accident. When the pain plateaued, it was at 4-5/10. Currently, he rated his pain as 6.5/10. Petitioner was currently wearing a back brace prescribed by Dr. McNally. He was also using a bone stimulator.

10. Mr. John Arrichiello was called to testify by Petitioner. Currently, he worked for the Army Corps of Engineers, but previously he was an apprentice carpenter for Respondent. In that position he knew Petitioner and was his apprentice at most job sites. He was present with Petitioner on the Evanston job site on August 12, 2015. Prior to that he had no limitations in his ability to perform his job duties.

11. On that date, he did not witness Petitioner's accident, but noticed him lying on the ground with people crowded around him. He was told Petitioner hurt his back. Petitioner was out for at least a week after. When he came back, Mr. Arrichiello was told to perform "all the heavy lifting, bending, that kind of stuff" because Petitioner was on light duty. He did not see Petitioner lift anything thereafter, though he quit the job shortly thereafter.

12. On cross examination, Mr. Arrichiello testified that when Petitioner returned after his injury, they did the same type of jobs. However, Mr. Arrichiello did all the lifting and bending.

13. On redirect examination, Mr. Arrichiello testified the superintendent Roger Scott told him to perform the heavy activities, or the grunt work. Being on a commercial job, he had to lift heavy gauge steel and a lot of heavy-duty drywall; "just everything in commercial can be a lot heavier and harder." When he came back, Petitioner was not allowed to do any of this grunt work.

14. Jason Avery was called by Respondent, of which he was owner/president. He was "somewhat" familiar with the procedures injured employees are supposed to follow. In an emergency 911 is called. Otherwise, an accident report is filled out, usually by the foreman on the job, and submitted to the office.

15. Mr. Avery knew Petitioner both as an employee and friend of 15 years. He was aware that Petitioner was injured on the job and that he had some chiropractic treatment. He brought Petitioner into the office to perform desk duty for a few days, but Petitioner did not like office work and was eager to get back into the field. He did not recall Petitioner providing him with any medical or work-status notes. He was out in the field for six to eight months before Mr. Avery received notice of the claim. He knew he had contact with Petitioner during that period, and he never complained of any back issues during those encounters.

16. On cross examination, Mr. Avery testified he understood Petitioner sustained a back injury. Over the years of acquaintance prior to the accident, Petitioner talked about his back; his back condition was "common knowledge." He did not know if he had prior treatment for his back. He was not aware of any accident report filed regarding this claim. He believed the foreman responsible for filing such a report would be Bob Masek. He had not spoken to Mr. Masek about Petitioner's injury at any time.

17. Mr. Avery was sure that he talked to Mr. Scott about Petitioner's injury, but he never told Mr. Avery that he assigned an apprentice to Petitioner for heavy work. He wasn't sure of Petitioner's current work status. He explained that Respondent had over 250 carpenters. He agreed that Respondent set Petitioner up with Dr. Johnson, but he did not recall seeing any report about Petitioner's condition. Respondent is self-insured. He thought Petitioner was in multiple motor vehicle accidents and that he injured his back while working for a former employer. Mr. Avery considered Petitioner to be a good employee.

18. Petitioner testified in rebuttal that he was shocked hearing Mr. Avery's testimony that his bad back was "common knowledge." He was "one of the strongest guys out there." The only motor vehicle accident that he could recall was maybe a fender-bender in high school. In addition, he was in contact with Mr. Avery the Saturday after the accident and

he personally asked for a copy of the MRI, which Petitioner provided that day. He also provided Dr. Johnson a copy of the MRI, and he was "very worried" about the condition of his back. He recalled that in days prior to the accident, Mr. Avery was on the job site. Petitioner was "taking the brunt of the weight of these windows." The foreman stated Petitioner needed a rest and Mr. Avery responded: "he's an ox, he can handle it, keep going."

19. On January 12, 2018, Bob Masek testified by deposition in a third-party action. He testified that he no longer worked for Respondent and would not in the near future. He had been a member of the Carpenters' Union for 27 years. He was employed by Respondent as foreman at the time of Petitioner's accident. As such he had supervisory authority over Respondent's personnel on site.

20. Mr. Masek remembered the job on which Petitioner was injured. Installing windows was part of Respondent's responsibilities on that job. It was Mr. Masek's understanding that Petitioner was unloading "multiple windows off the forks, and when he reached and tried to take it off the fork, he hurt his back." Petitioner reported that he injured his back.

21. Mr. Masek also testified that he started filling out an accident report and sent Petitioner home. He did not complete the report because about 20 minutes after the accident, he was told not to by his superintendent, because Respondent's owner was "going to work it out" with Petitioner. They had been friends. He had never previously been told not to file an accident report. He did not believe he worked with Petitioner again after the accident, but he had numerous contacts with him and he knew "he was hurting." He did not know that Petitioner came back to work for Respondent. Petitioner did not complain of back pain prior to the accident.

The Arbitrator awarded Petitioner 94 weeks of temporary total disability benefits, $438,353.03 in medical bills submitted into evidence, awarded Respondent credit of $35,479.80 in temporary total disability benefits paid and $1,3347.71 in medical paid, ordered Respondent to pay for prospective treatment recommended by Dr. McNally/Suburban Orthopedics, and awarded Petitioner $225,917.92 in penalties under Section 19(k), $10,000.00 in penalties under Section 19(l), and $65,880.14 in attorney fees under Section 16. The Commission agrees with the Arbitrator's analysis on the issues of causation, temporary total disability benefits, and medical expenses both current and prospective. Accordingly, the Commission affirms and adopts those aspects of the Decision of the Arbitrator.

In awarding penalties and fees, the Arbitrator noted that "Respondent's conduct in failing to properly document the accident and Petitioner's injury was in and of itself unreasonable and vexatious." He then stressed that Respondent provided no explanation as to why it could no longer accommodate Petitioner's restrictions after April 26, 2016.

The Commission agrees with the Arbitrator that Respondent's actions warrant the imposition of substantial penalties and associated attorney fees. However, the Commission concludes that the failure to properly report an accident does not in itself necessarily constitute unreasonable and vexatious delay in payment of benefits, which is the trigger for imposing penalties under the Act.

An employer's behavior becomes subject to penalties once it refuses to pay legitimate benefits. Dr. Chhadia first imposed formal restrictions on April 18, 2016. At that time, Respondent was put on notice that the work-related injury affected Petitioner's employment status. Respondent no longer accommodated those restrictions as of April 26, 2016, which Petitioner testified was his last day of employment. Therefore, the Commission vacates the award of penalties and fees and directs the Arbitrator on remand to recalculate penalties and fees based on the failure to pay benefits commencing on April 26, 2016 and determine whether that affects the ultimate award of penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,182.67 per week for a period of 94 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $438,353.03 for medical expenses under §8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION, that the award of penalties and fees is vacated and upon remand the Arbitrator is directed to re-calculate penalties and fees for all unpaid benefits commencing on April 26, 2016.

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

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

IT IS FURTHER ORDERED BY THE Commission that Petitioner's Motion to Strike Respondent's Reply to Petitioner's Response to Respondent's Statement of Exceptions and Motion for Section 16 Fees is hereby denied.

18IWCC0784

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: DEC 2 1 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-10/25/18
46

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

18IWCC0784

LOVGREN, JAMES
Employee/Petitioner

Case# **16WC012957**

SERVICE DRYWALL
Employer/Respondent

On 3/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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:

1497 MORICI FIGLIOLI & ASSOCIATES
ROBRT H BUTZOW
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

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

18IWCC0784

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JAMES LOVGREN
Employee/Petitioner

v.

SERVICE DRYWALL
Employer/Respondent

Case # **16** WC **12957**

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 **KURT CARLSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **2/13/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **8/12/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$92,248.00**; the average weekly wage was **$1,774.00**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$35,479.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,347.71** for other benefits, for a total credit of **$36,827.51**.

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

ORDER

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 4/26/16 through 2/13/18, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of **$438,353.03**[total unpaid meds - $1,347.71 credit], as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$65,880.14**, as provided in Section 16 of the Act; **$225,917.92**, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act.

Respondent shall provide prospective medical care and shall be responsible for payment of all prospective medical expenses, including but not limited to the medical treatment recommended by the Petitioner's current treating orthopedic surgeon, Dr. Thomas McNally/Suburban Orthopedics, as provided in Section 8(a) of the Act

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

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

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

Signature of Arbitrator

03-22-18
Date

ICArbDec19(b)

MAR 22 2018

James Lovgren v. Service Drywall
IWCC # 16 WC 12957

ARBITRATOR'S FINDING OF FACTS

Petitioner testified that his occupation is that of a union carpenter, and he had been doing that type work for nine (9) years. The Petitioner testified that he worked for the Respondent for eight (8) of those years, and his job required physical "heavy work" which involved the installation of commercial structural framing and heavy carpentry duties. Petitioner testified that for the entire time he worked for the Respondent, he was not under any physical restrictions or limitations and that he was able to do his job as a union carpenter without difficulty, and never missed work due to health issues. The Petitioner did testify that he had treated for a knee injury with Dr. Pavel Hudoba, but did not receive any treatment for his low back (PX 5, RX 6). The Petitioner also testified that 2009, he occasionally had some general chiropractic adjustments due to the physical nature of his job, but never under a doctor's care for his low back and never had an injuries to his back.

On August 12, 2015, the Petitioner testified that he sustained an injury while working for the Respondent at Hyatt Evanston. He had been on this project for two to three months staging windows and moving them off a truck and onto to the roof. On that date he was sliding a heavy windows, weighing approximately 300 pounds, off of a drywall boom with the assistance of a co-worker, Adam Rogers. The Petitioner testified that he had to reach in an awkward fashion and the boom "bucked back" and slid overextending his low back. The Petitioner testified that he felt a "pop" and the pain that he experienced was excruciating, a 10 out of 10, and it was unlike any pain he may have previously experienced. Robert Masek, the job foreman for the Respondent was called to the scene of the incident, and observed he was in pain and sent him home. The Petitioner testified that he was later informed that no accident report was going to be made and that the Respondent "would take care of him".

The Petitioner testified that he first sought treatment on the date of his injury with Dr. Richard Pinney, whose office was down the street from where he lived. On August 12, 2015 the Petitioner testified that he gave a history of the work accident to Dr. Pinney who noted a consistent curve in the lumbar area. The Petitioner testified that when he returned to see him on August 14, 2015, Dr. Pinney prescribed and MRI and made a referral to Spine and Sports Physiatrists (PX1). The Petitioner saw Dr. Kellershabrokh on August 18, 2015, who noted that the Petitioner was injured lifting a window and had a history of occasional back problems that resolved spontaneously. Dr. Kellershabrokh diagnosed lumbosacral spondylosis and a lumbar disc herniation at the L5-S1 level, and placed the Petitioner off work (PX 4). Petitioner then testified that he then saw Dr. John B. Johnson a chiropractor, on August 21, 2015, on the referral from Jason Avey, the owner of Service Drywall. The Petitioner testified that he only saw Dr. Johnson on one occasion (PX 2). After that visit, the Petitioner testified that he was allowed to return to work for the Respondent on light duty.

The Petitioner testified that he worked light duty with the help of an apprentice carpenter, Mr. John Arrichiello, but his back pain continued. The Petitioner testified that he took three weeks off due to the birth of his child, but after he returned his work restrictions were "loosened up" and the pain level increased; and that he was also having nerve issues in his legs and buttocks. As a result, the Petitioner attempted to treat his increasing pain by seeing S & A Chiropractic (PX 3). He had manipulation and traction, but testified that this treatment was hurting his back more than helping. As a result, the Petitioner returned to see Dr. Pinney, who then made a referral to Suburban Orthopedics (PX 1).

The Petitioner testified that he was first seen by Dr. Ankur Chhadia at Suburban Orthopedics on April 18, 2106. Dr. Chhadia reviewed the Petitioner's x-rays and the lumbar MRI's and placed the Petitioner back on light duty work restrictions (PX 7). Petitioner testified that he was then able to work light duty for the Respondent until April 24, 2016. On that date the Petitioner testified that the employer had apparently received a notice that he filed a worker's compensation claim, and that was the last time he was able to work for the Respondent, as they would no longer accommodate his light duty restrictions. The Petitioner continued to see Dr. Chhadia at Suburban Orthopedics and was referred to see Dr. Thomas McNally who specialized in spinal orthopedics. After two spinal injections failed to reduce the Petitioner's pain, he testified that he underwent a surgical procedure on November 14, 2016 for a right L4-5, S5-S1 laminectomy and partial discectomy (PX 6 and PX 7). The Petitioner testified that he had surgery which was paid for, in part, by his insurance provided by Union's Health and Welfare Fund.

After the surgery, the Petitioner testified that he was requested to be examined by Respondent's evaluating physician, Dr. Andrew Zelby, which took place on December 2, 2016. As he was only two weeks post-surgery, the Petitioner's testified that the examination was limited and mostly concerned the history of the work injury. As a result of his examination, Dr. Zelby issued a report opining that the work injury did not cause the Petitioner's current condition, but that it was due to an underlying pre-existing degenerative health condition, due to the fact that medical records supplied to him from Dr. John B. Johnson and Dr. Pavel Hudoba which indicated a history of prior back problems (RX 2).

Post operatively, the Petitioner had periodic follow-ups with Dr. McNally (PX 7). The Petitioner testified that he continued to have back pain and a spinal fluid leak which required surgery on December 19, 2016 (PX 6), and after the Petitioner's low back condition failed to improve, the Petitioner then underwent a lumbar fusion which was performed by Dr. McNally on August 9, 2017 (PX 6). The Petitioner testified that he is currently living with his parents, wife and children, due to financial reasons as a result of not receiving his worker's compensation benefits and he still has appointments to see the physicians at Suburban Orthopedics for physical therapy and ongoing diagnostic tests for treatment of his low back condition.

Testimony of Pavel Hudoba

Dr. Hudoba testified that he saw the Petitioner for right knee bursitis in 2012. He made an "observation" of a history of lumbar radiculitis, but no treatment was rendered. Dr. Hudoba testified that he saw the Petitioner in 2015 and again made incidental findings regarding Petitioner's low back. He testified that the Petitioner had no functional limitations and the sensory exam at L1-S2 was normal, and no prescribed medical treatment for the low back was made as all treatment focused on the Petitioner's right knee. With respect to Petitioner seeing a chiropractor in 2009, Dr. Hudoba testified that people do have occasional symptoms which are treated by chiropractors, and that it is quite actually common (PX 8).

Testimony of Dr. Thomas McNally

Dr. Thomas McNally is the Petitioner's treating back surgeon, who saw the Petitioner after conservative treatment by Dr. Chhadia and Dr. Novoseletsky had failed to improve his low back condition. He testified that he treated the Petitioner as a result of the back symptoms the Petitioner experienced after the work injury on August 12, 2015. Dr. McNally indicated that that prior to that date the Petitioner never had been prescribed physical therapy, injections or an MRI for his low back. Dr. McNally performed surgery on the Petitioner to take pressure off of the L5 nerve root, and a follow-up procedure for a spinal fluid leak. Dr. McNally testified that the MRI findings taken after the August 12, 2015 were consistent with his medical diagnosis and treatment. Dr. McNally also testified that it would be common for back pain symptoms that the Petitioner experienced after the accident could be waxing and waning (PX 9).

Testimony of Dr. Andrew Zelby

Dr. Andrew Zelby performed on IME on Behalf of the Respondent, and generated a report on December 2, 2016 (Rx 2). He testified that based upon the history given by the Petitioner that he had no back treatment prior to the August 12, 2015 work injury, the records from Dr. Hudoba and the one treatment note of John B. Johnson Chiropractic Clinic, the Petitioner's surgery was a result of the pre-existing lumbar spondylosis or a degeneration of the lumbar spine, and that he is currently unable to work because of the recent surgery related to this degenerative back condition. However, Dr. Zelby did testify that Dr. Hudoba's records indicate that the Petitioner had no subjective symptoms in his low back and did admit that the record of the John B. Johnson Chiropractic visit was made on August 21, 2015 (post-accident) and not on June 21, 2015. Dr. Zelby also testified that prior to the work injury on August 12, 2015, he had no knowledge that the Petitioner had never had taken off work because of back pain, never had an EMG or MRI, never had injections in his low back, never sought treatment from a surgeon, never been diagnosed or had a finding of gait disturbances or limping due to back pain, never had formal physical therapy, never had been placed on light duty due to back pain (RX 3).

Testimony of John Arrichiello

Mr. John Arrichiello is a current employee of the Army Corps of Engineers. He testified that he had previously worked for the Respondent, and started with them in January of 2013, as an apprentice carpenter. Mr. Arrichiello testified that he previously worked with the Petitioner on all but one jobsite and never noticed any difficulties or limitations with the Petitioner performing his job duties, that the Petitioner was a "strong guy in good shape" and never complied of pain in his low back. Mr. Arrichiello testified that he was working Hyatt Evanston jobsite on August 12, 2015. At the time of the Petitioners injury Mr. Arrichiello testified that he was on the floor below the Petitioner, loading windows. When he took his break at 9:00am, he went up to the floor where the Petitioner was working and noticed him lying on the ground in pain. Mr. Arrichiello testified that he then continued to work with the Petitioner when he returned to work at light duty after his injury. He testified that he did all the heavy lifting and bending or "grunt work", for the Petitioner at the instructions of his superintendent, Roger Scott, and site foreman Robert Masek. Mr. Arrichiello testified that he left the employment with Respondent shortly before the Petitioner stopped working in April of 2016.

Testimony of Robert Masek

Mr. Robert Masek testified that he was the site foreman for the Respondent on August 12, 2015. He testified that he worked with the Petitioner on several prior occasions and the Petitioner was able to perform all of his job duties with the Respondent without difficulty. Mr. Masek testified that the Petitioner had helped him lift windows out of a truck a couple of days prior to August 12, 2015 work injury. He testified that although he did not witness the accident, he was aware of Petitioner's injury occurring on that date as he noticed the Petitioner in extreme pain after he was called to the site. Mr. Masek further testified that he sent the Petitioner home and started to fill out the report of the accident, but was told by the site superintendent, Roger Scott, not to complete the accident report for the August 12, 2015 injury and that the Petitioner and Jay Avey were "going to work it out" (PX 10). This fact was confirmed in the "Daily Injury Free Conformation" form indicating that no injury report had been filled out for the Petitioner (RX8).

Testimony of Jason Avey

Jason Avey testified that he is the owner/president of the Respondent, Service Drywall. He testified that he was a personal friend of the Petitioner for 15 plus years as well as his employer. Mr. Avey testified that he was aware that the sustained an injury while working for his company, but had no knowledge of an accident report being completed after the August 12, 2015 accident. Mr. Avey did testify that he had given the Petitioner the name of Dr. John B. Johnson, a chiropractor who he personally knows, for treatment of his low back. Mr. Avey testified that after the Petitioner saw the chiropractor, he was given desk work and eventually returned to his position as a carpenter until the "lawsuit notice". Mr. Avey testified that it was "common knowledge" that the Petitioner had a "bad back" and was involved in multiple car accidents. However,

Mr. Avey also testified that the Petitioner was a good employee and was able to perform all of his job duties of a carpenter prior to his accident in August of 2015. Mr. Avey also testified that he did not know whether the Petitioner continues be an employee of Service Drywall, even though he was a personal friend and owner/president of the company.

ARBITRATOR'S CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "F" Is Petitioner's present condition of Ill-being causally related to the injury, the Arbitrator finds as follows:

Based on the evidence produced at trial, the Arbitrator finds that the injury of August 12, 2015 was a causative factor in Petitioner's resulting condition of ill-being relating to the Petitioner's low back. The Petitioner testified that he was working for the Respondent without any back issues until his injury on August 12, 2015. The Arbitrator finds that this testimony was credible and un-rebutted, and no medical evidence was submitted showing that the Petitioner was under the care of a licensed physician or back surgeon at the time of his injury. The Arbitrator finds that while the Petitioner most likely had some type of a pre-existing back condition, which may or could have warranted a lumbar back surgery, at some indeterminable point in the future, the Petitioner had no imminent medical directives for the same. It was not until the August 12, 2015 accident, that the Petitioner sought extensive medical treatment and eventual surgeries for his low back condition.

On the issue of whether the August 12, 2015 work injury caused the need back surgery, or if this work accident only caused a temporary exacerbation of some pre-existing lumbar condition, which eventually subsided, the Petitioner's treating physician, Dr. McNally and the IME physician Dr. Zelby give differing medical opinions. Dr. McNally opined that the Petitioner was able to work full duty prior to the August 12, 2015 work injury. He stated the Petitioner did not have a pre-existing problem with his low back which prevented him from working until the injury sustained on August 12, 2015. (PX 9). Dr. Zelby testified that the accident only caused a temporary exacerbation of the petitioner's pre-existing degenerative condition, and ruled out any relationship between the Petitioner's work injury and Petitioner's diagnosed medical condition. Dr. Zelby testified that the Petitioner's inability to work and the cause of his diagnosed condition was due solely to the Petitioner's degenerative condition in his lumbar spine (RX 2 and RX 3).

The Arbitrator finds that prior to the date of August 12, 2015 the Petitioner had some chiropractic treatment in 2009 and the medical records of Dr. Pavel Hudoba show only some notations of some low back pain in 2012 and 2015, which were not disabling or preventing the Petitioner from working. Therefore, the Arbitrator finds that Dr. Zelby's causation opinion is in conflict with the applicable case law that the Petitioner's work injury can be a contributing factor to the present condition of ill being; and that the Petitioner has shown through a preponderance of evidence, that some act of his employment was a causative factor with regard to his injury. The Arbitrator finds that the act need not be the sole or even principal causative factor, in order for compensation or benefits to be awarded. Upon a review of the differing medical opinions and the

comprehensive medical records, the Arbitrator finds that the Petitioner experienced significant pain as a result of the work injury of August 12, 2015, his condition never returned back to the condition that the Petitioner experienced prior to the injury and the condition worsened resulting in multiple back surgeries. It is axiomatic that employers take their employees as they find them, and worker's compensation benefits should not be limited to only those individuals who have no underlying health condition. It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process. The work injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being, Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 797 N.E.2d 665, (2003). Thus, even though an employee may had possibly had a pre-existing condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Caterpillar Tractor Co. v. Industrial Commission, 92 Ill.2d 30, 440 N.E.2d 861 (1982).

Additionally, medical evidence is not the only essential ingredient to support a conclusion as to whether a workplace accident caused the Petitioner's resulting disability. A chain of events which demonstrates a previous condition of good heath, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's resulting injury, Shafer v. Illinois Worker's Compensation Commission, 2011 IL App (4th) 100505, quoting International Harvester v. Industrial Commission, 93 Ill. 2d 59, 442 N.E 2d 908 (1982). This "chain of events" principle is not limited to an employee who had a previous condition of good health, or did not have a preexisting condition involving the same area of the body for which an injury is claimed, but can also be used to demonstrate the aggravation of a preexisting condition, Schroeder v. The Illinois Worker's Compensation Commission, 2017 IL App (4th) 160192WC. The Arbitrator finds that the Petitioner sustained a work injury to his low back, any preexisting condition which the Petitioner may have had in his low became symptomatic and Petitioner never returned to the pain free condition that he experienced prior to the work accident of August 12, 2015. In support of this decision, the Arbitrator cites to the credible testimony of the Petitioner, John Arrichiello, Robert Masek, and the testimony and opinions of Dr. McNally, the Petitioner's treating physician.

In support of the Arbitrator's Decision relating to "J" Were the medical services that were provided to the Petitioner reasonable and necessary and; and has Respondent paid all appropriate charges for all reasonable and necessary medical services the Arbitrator finds as follows:

The Arbitrator finds that all of the medical treatment received by the Petitioner was causally related to the work injury he sustained while working for the Respondent. As a result of his condition the Petitioner received medical care from August 12, 2015 to the present date, from various providers. The Arbitrator finds that this medical treatment

was not contemplated by the Petitioner prior to August 12, 2015, and was rendered for the purpose of attempting to provide relief from symptoms caused by his work injury.

The Arbitrator finds that these medical charges constitute reasonable, necessary and causally related to the injury to the Petitioner's lumbar spine. The Arbitrator notes that the treatment dates on bills correspond with the medical records which have been admitted into evidence, and corresponds to the treatment which has been provided to the Petitioner (ARB. X2 and PX Group 11). Additionally, the Arbitrator notes that Dr. Andrew Zelby, the Respondents evaluating physician, opined that the prescribed course of treatment which was being rendered to the Petitioner (although in his opinion the Petitioner's condition at the time of the examination was not related to the Petitioner's work injury) was appropriate, reasonable and necessary (RX 2). The Arbitrator finds that the Respondent has presented no evidence countering the reasonableness of the bills for Petitioner's medical treatment.

Accordingly, the Arbitrator concludes that these amounts of the bills which were submitted at Arbitration, constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. Specifically, the Arbitrator awards the itemized medical charges which were submitted at Arbitration (ARB. X2), subject to the Medical Fee Schedule and allows the Respondent credit for payment of $1,347.71 for medical benefits which have been paid (ARB. X1).

In support of the Arbitrator's Decision relating to "K", is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Given the findings that the work injury on August 12, 2015 was a causative factor in bringing about the Petitioner's current low back condition and the ensuing need for treatment, the Petitioner is entitled to prospective medical care as prescribed by his treating orthopedic back surgeon, Dr. Thomas McNally and the physicians located a Suburban Orthopedics. The Petitioner testified that despite his multiple surgeries, he continues to have continuous pain in his low back which prevents him from working. The Petitioner testified in detail with respect to his continued symptoms and his inability to perform various activities due to his back pain. The Arbitrator finds the Petitioner's un-rebutted testimony with respect to his current condition of ill-being to be credible and consistent with the medical records submitted at arbitration. The Arbitrator notes that the Petitioner has remained under the care of Dr. McNally and Dr. Novoseletsky, in an attempt to alleviate his ongoing pain symptoms (PX 7).

The Arbitrator notes that the Petitioner's last evaluation with Dr. McNally was on January 30, 2018, and at the time, Dr. McNally recommended a EMG/NCS of the bilateral lower extremities, continue pain management with Dr. Novoseletsky, and to restart physical therapy (PX7, pp.3-7). Given the credible and un-rebutted testimony of the Petitioner, a review of the medical records, containing the opinions of the treating orthopedic surgeon, Dr. McNally, the Arbitrator finds that these recommendations are both reasonable and necessary.

Therefore, based upon the above, and the record taken as a whole the Arbitrator finds that the Petitioner is entitled to prospective medical care and treatment as prescribed by Dr. McNally, and that the Respondent is hereby liable for the reasonable and necessary costs associated therewith pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

In support of the Arbitrator's Decision relating to "L" What amount of compensation is due for Temporary Total Disability, the Arbitrator finds as follows:

Based upon the findings that Petitioner's current condition of ill-being causally related to the accident of August 12, 2015, The Arbitrator also finds that this condition prevented the Petitioner from working as a Union Carpenter from April 26, 2016 through February 13, 2018. The Arbitrator finds that Petitioner's inability to work is supported by the testimony and medical evidence presented in this case. Dr. McNally has opined that the Petitioner's inability to work as a carpenter has caused his disability for this period of time (PX 7), which is also supported by the credible and un-rebutted testimony of the Petitioner. Therefore, the Arbitrator awards temporary total disability benefits for a period of 93 & 6/7 weeks and continuing, less the stipulated credit for TTD benefits which had previously been paid by the Respondent (ARB X1).

In support of the Arbitrator's Decision relating to "M", should penalties or fees be imposed upon the respondent, the petitioner finds the following facts.

Given the facts presented in this case, and after considering the Petitioner's Penalties Petition alleging that the Respondent's failure to pay temporary total disability benefits and the Petitioner's medical bills was unreasonable and vexatious, the Arbitrator finds that there is no reasonable basis in the record for the Respondent's failure to pay these claimed benefits and the Respondent's conduct in failing to pay the appropriate benefits is unreasonable, vexatious and is contemplated under Sections 19(l), 19(k) and 16 of the Act. The testimony of Robert Masek, the Respondent's foreman at the time of August 12, 2015 accident, concerning the Respondent's conduct in failing to properly document and report the accident and Petitioner's injury was in and of itself unreasonable and vexatious. The Arbitration also finds no reason why the Respondent was no longer able to accommodate the light duty restrictions or pay TTD benefits after Jay Avey, owner/ president of Respondent, received the notice of the filing of the worker's compensation claim. These benefits remained unpaid for the seven (7) months prior to the Independent Medical Examination of Dr. Zelby, which took place subsequent to the Petitioner's first lumbar surgery. In addition, it is noted that the Respondent only paid 30 weeks of TTD in order to secure a continuance, after this matter had been originally set for trial in December of 2017.

The eight month treatment gap from August 19, 2015 to March of 2016 is inconsequential when one considers that Petitioner was on light duty for most of this period of time. John Arrichiello testified that he did all the "grunt work" for Petitioner at the instructions of superintendent. There was no evidence of an intervening, superseding event to break casual connection and when the Petitioner returned for more treatment

with Dr. Chhadia in April, he related his continued pain to the original occurrence and the elimination of his light duty restrictions, most likely when Arricchiello quit working for respondent.

Dr. Zelby's opinion has little credibility in light of the record as a whole. There was no pre-existing MRI, no prior EMG or prescription for surgery to objectively prove this was a temporary aggravation of a pre-exisiting condition. Instead, the record shows the lifting occurrence at work was the primary cause of the Petitioner's current lumbar condition. As a result, it was unreasonable for Respondent to rely on Dr. Zelby's opinion at trial.

Therefore, as a result of the findings set forth in this Decision, the Arbitrator concludes that the Petitioner has provided by a preponderance of evidence that the Respondent's action were unreasonable, vexatious and within the meaning of Sections 19(k) and 19 (l), as well as Section 16 of the Act. As a result, Petitioner is entitled is entitled additional compensation in the maximum amount of $10,000.00 (447 days [4/26/16 -2/13/18 less 210 days x $30.00]) under Section 19(1) of the Act. Petitioner is further entitled to $255,917.92 ($73,482.82 [unpaid TTD] + $438,353.03[total unpaid meds - $1,347.71 credit] x 50%) under Section 19(k); and $65,880.14 (unpaid TTD + 19k penalty x 20%) under Section 16 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 Temporary disability; Permanent disability; Penalties and fees	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA ARREOLA,

Petitioner,

vs.

NO: 09 WC 49383
09 WC 49384

DISTRICT 97,

Respondent.

18IWCC0785

DECISION AND OPINION ON REVIEW

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

I. Causation

The parties stipulated Petitioner sustained accidental injuries arising out of and in the course of her employment on May 27, 2009 and November 4, 2009. Petitioner alleged those accidents resulted in orthopedic injuries to her right shoulder, arm, elbow, and hand; depression; and complex regional pain syndrome ("CRPS"). The Arbitrator determined all Petitioner's alleged conditions of ill-being were causally related to her work accidents on May 27, 2009 and November 4, 2009. Respondent's only challenge to the causation determinations is as to the CRPS diagnosis. Respondent posits there can be no causal connection because Dr. Noren opined Petitioner does not have CRPS. Respondent's argument is untenable.

The Commission notes Respondent does not address, nor in any way acknowledge, the contrary conclusions of Dr. Romano, Dr. Torres, the University of Illinois pain management

physicians, or Dr. Wolin[1], all of whom diagnosed Petitioner with CRPS. Certainly, the weight to be accorded medical opinion evidence is not simply a matter of adding up the number of experts. *Cinch Manufacturing Corp. v. Industrial Commission*, 393 Ill. 131, 134, 65 N.E.2d 383 (1946) (holding that the weight of the evidence in a workers' compensation case does not lie with the party producing a greater number of expert witnesses on its behalf); *ABF Freight System v. Illinois Workers' Compensation Commission*, 2015 IL App (1st) 141306WC, ¶22, 45 N.E.3d 757 (holding that the number of witnesses testifying to a particular fact is not controlling). Nonetheless, where a party argues a single expert's opinion should be adopted to the exclusion of multiple others' conclusions, some explanation for why the fact finder should disregard all the conflicting opinions should be provided.

As to Dr. Noren, he opined Petitioner did not have any physical examination findings to support the diagnosis of CRPS. Dr. Noren testified his opinion was based on the examinations he performed, the history provided, and the records he reviewed. RX1, p. 53. The Commission notes there is a significant foundational weakness with Dr. Noren's causation opinion in that he was not provided with all the relevant medical records: excluded from Dr. Noren's review were the pain management records and the majority of Dr. Romano's records. As Dr. Noren had an incomplete medical picture, the Commission finds his causation conclusion should be afforded little to no weight. See, *e.g.*, *Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

As the Arbitrator did, we find the opinions of Dr. Romano, Dr. Torres, the University of Illinois pain management physicians, and Dr. Wolin to be highly persuasive and afforded substantial weight. The Commission affirms and adopts the Arbitrator's causal connection findings.

II. Temporary benefits

Petitioner alleged entitlement to, and the Arbitrator awarded, Temporary Total Disability benefits from December 1, 2009 through September 24, 2012. The Commission notes Dr. Romano first authorized Petitioner off work on December 1, 2009; Dr. Romano thereafter continued to authorize Petitioner off work until July 26, 2012, wherein he imposed light duty restrictions of no lifting over 20 pounds and limited use of the right arm. PX12. By that point, Respondent had terminated Petitioner's employment, so no accommodated position was provided. Petitioner testified she remained off work until September 25, 2012, the date she commenced paid part-time employment at the Illinois Coalition for Immigrant and Refugee Rights ("ICIRR"). The Commission affirms the Arbitrator's award of 147 weeks of Temporary Total Disability benefits, representing December 1, 2009 through September 24, 2012.

The Arbitrator found Petitioner was temporarily partially disabled from September 25, 2012 through October 29, 2012. During this period, Petitioner remained under restrictions but worked part-time at ICIRR earning $250.00 per week. On October 29, 2012, Dr. Romano placed Petitioner at maximum medical improvement, permanently restricted her to Light Physical Demand Level work with specific limitations per the October 11, 2012 FCE, and discharged her

1 The entirety of Dr. Wolin's report is contained within Petitioner's Exhibit 15 which was admitted without objection.

from care. PX11. The Commission affirms the Arbitrator's award of 5 weeks of Temporary Partial Disability benefits, representing September 25, 2012 through October 29, 2012.

The Arbitrator awarded maintenance benefits of $371.83 per week from October 30, 2012 through October 27, 2016. For the reasons set forth below, the Commission vacates the maintenance award.

Under Section 8(a), maintenance benefits are associated with some sort of rehabilitation effort. It is well established a claimant's self-initiated and self-directed job search or vocational training may constitute a "vocational-rehabilitative program" under §8(a). *Roper Contracting v. Industrial Commission*, 349 Ill. App. 3d 500, 506, 812 N.E.2d 65 (2004). The evidence demonstrates Petitioner began a self-directed job search in February 2012. Her job search efforts continued after Dr. Romano placed her at maximum medical improvement on October 29, 2012. Susan Entenberg, CRC, reviewed Petitioner's job search logs and opined Petitioner conducted a good faith job search. While these facts standing alone would implicate an award of maintenance benefits, our analysis must also incorporate the fact Petitioner was working at ICIRR earning $250.00 per week. The Arbitrator endeavored to offset Petitioner's ICIRR earnings by awarding maintenance benefits at the Temporary Partial Disability rate. This, however, is not permissible under Section 8(a), which states, "The maintenance benefit shall not be less than the temporary total disability rate determined for the employee." *820 ILCS 305/8(a)*. The parties stipulated Petitioner's average weekly wage is $807.74. This yields a temporary total disability rate of $538.49. Pursuant to the plain language of Section 8(a), any maintenance benefit would necessarily be awarded at $538.49. Such an award would result in a $250.00 per week windfall to Petitioner, something that is clearly not contemplated by the Act. Therefore, the Commission finds Petitioner's permanence benefit commences as of October 30, 2012, and the wage data is properly considered as evidence of earning capacity under Section 8(d)1.

III. Wage differential

At arbitration, Petitioner sought wage differential benefits. Under Section 8(d)1, an impaired worker is entitled to a wage differential award when she is (1) "partially incapacitated from pursuing [her] usual and customary line of employment" and (2) there is a "difference between the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which [she] was engaged at the time of the accident and the average amount which [she] is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (West 2012). The Arbitrator concluded Petitioner proved both elements and, in calculating the benefits owed, relied on Ms. Entenberg's opinion as well as *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, 73 N.E.3d 654, in determining Petitioner is capable of earning $9.38 per hour for a 40-hour workweek. While the Commission agrees Petitioner established entitlement to wage differential benefits, we view the evidence as to earning capacity differently. Instead, we find the evidence establishes three distinct Section 8(d)1 awards for three separate durations.

Calculating the wage differential rate requires the Commission to make two earnings determinations: (1) "the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which…[she] was engaged at the time of the accident," and (2)

"the average amount which [she]...is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. It is certainly clear the rate for future wage differential benefits must be determined as of the hearing date. *See, e.g., United Airlines, Inc. v. Illinois Workers' Compensation Commission*, 2013 IL App (1st) 121136WC, ¶22, 991 N.E.2d 458 ("The statute, under its plain and ordinary language, does not contemplate multiple figures to be computed and awarded at future dates."). However, as the Supreme Court of Illinois made clear in *Cassens Transportation Co. v. Industrial Commission*, the Commission must consider evidence of changing circumstances and the effect of new information as it developed prior to arbitration:

> By its plain language, [Section 8(d)1] allows arbitrators and the Commission the option of determining that a claimant's disability is likely to end, abate, or increase after a certain duration, and awarding compensation accordingly. *See, e.g., Phillips v. Consolidated Personnel Corp.*, Ill. Workers' Compensation Comm'n, No. 01WC 59242 (May 25, 2005) (awarding worker three separate section 8(d)(1) wage differential awards for three separate durations)...the Act establishes that employees and employers alike must use the opportunity of their initial hearing to present evidence showing the likely duration of an injury and its effect on the claimant's earning capacity." *Cassens Transportation Co.*, 218 Ill.2d 519, 529-30, 844 N.E.2d 414 (2006).

As stated above, the Commission finds Petitioner's permanent disability commenced on October 30, 2012. As of October 30, 2012, the sole information available as to what Petitioner was capable of earning in the full performance of her duties in the pre-accident occupation is her average weekly wage of $807.74. Regarding what Petitioner was earning or able to earn in some suitable employment or business after the accident, the evidence establishes Petitioner was earning $250.00 per week working at ICIRR. This yields a wage differential of $371.83 ($807.74 - $250.00 = $557.74 x 2/3 = $371.83). These facts remained undisturbed until February 10, 2013, the date Susan Entenberg issued her vocational assessment. Therefore, the Commission finds Petitioner is entitled to Section 8(d)1 benefits of $371.83 per week for 14 5/7 weeks, representing October 30, 2012 through February 9, 2013.

On February 10, 2013, new expert evidence regarding Petitioner's earning capacity came into existence when Ms. Entenberg issued her vocational assessment. Based on Petitioner's work history, age, education, lack of computer skills, and restrictions, Ms. Entenberg concluded Petitioner has a realistic maximum earning capacity of $8.50 to $10.00 per hour. As to specific vocational targets, Ms. Entenberg concluded Petitioner "would be qualified to work in entry-level positions such as information clerk, restaurant hostess, and desk clerk." PX8, DepX3. "Suitable employment is employment which the claimant is both able and qualified to perform." *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, ¶24, 73 N.E.3d 654. The Commission finds Ms. Entenberg's opinions persuasive and concludes Petitioner is physically capable and qualified to perform all three of the positions, and these, therefore, represent suitable employment.

Ms. Entenberg detailed the "entry-level hourly wages for these occupations, respectively, are $9.83, $8.76 and $8.99." PX8, DepX3. Petitioner is not restricted from full-time employment, and Ms. Entenberg confirmed the wages she cited were for full-time work. PX8, p. 54. The average

hourly wage of these positions is $9.19 ($9.83 + $8.76 + $8.99 = $27.58 / 3 = $9.19). Calculating weekly earnings utilizing a full-time workweek, Petitioner's earning capacity as of February 10, 2013 was $367.60 ($9.19 x 40 = $367.60). This yields a wage differential of $293.43 ($807.74 - $367.60 = $440.14 x 2/3 = $293.43). These facts remained undisturbed until the October 27, 2016 arbitration date when the parties entered into a stipulation regarding what Petitioner would be earning in the full performance of her pre-injury position. Therefore, the Commission finds the evidence establishes Petitioner is entitled to Section 8(d)1 benefits of $293.43 per week for 193 4/7 weeks, representing February 10, 2013 through October 26, 2016.

On October 27, 2016, the matter proceeded to hearing. The Request for Hearing submitted that day includes the parties' stipulation that Petitioner would be earning $49,388.00 annually if she was still employed as a custodian for Respondent. (ArbX1; ArbX2) Therefore, the Commission finds as of October 27, 2016, the proper measure of the average amount Petitioner would be able to earn in the full performance of her duties as a custodian is $949.77 per week ($49,388.00 / 52 = $949.77). Petitioner's earning capacity continued to equal $367.60. This yields a wage differential of $388.11 ($949.77 - $367.60 = $582.17 x 2/3 = $388.11). Therefore, the Commission finds the evidence establishes Petitioner is entitled to Section 8(d)1 benefits of $388.11 per week commencing October 27, 2016 and continuing for the duration of her disability.

To summarize, pursuant to *Cassens*, the Commission is to consider evidence of the likely duration of an injury and its effect on the claimant's earning capacity. We believe the effect on the earning capacity is best considered contemporaneously with the development of the evidence. The record before us yields separate benefit rates for three distinct periods. Therefore, the Commission finds Petitioner is entitled to Section 8(d)1 benefits as follows:

$371.83 per week for October 30, 2012 through February 9, 2013;

$293.43 per week for February 10, 2013 through October 26, 2016; and

$388.11 per week commencing October 27, 2016 and continuing for the duration of her disability.

IV. Penalties and Fees

The rationale for the Act's penalties provisions is well known. The Act "provides an income stream to an injured worker, who is typically left without income while he is disabled. [Citation omitted]. The penalty sections attempt to prevent bad faith and unreasonable withholding of compensation benefits from employees. (*Board of Education v. Industrial Com.* (1982), 93 Ill. 2d 1, 442 N.E.2d 861.)" *Ford Motor Co. v. Illinois Industrial Commission*, 140 Ill. App. 3d 401, 405, 488 N.E.2d 1296 (1986). It is equally clear, however, those sections are "not intended to inhibit contests of liability or appeals by employers who honestly believe an employee not entitled to compensation; they are intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives. A failure to pay because of a good faith belief that no payment is due will not warrant a penalty." *Avon Products v. Industrial Commission*, 82 Ill. 2d 297, 412 N.E.2d 468 (1980).

The employer bears the burden of justifying the delay in paying the benefits (*City of Chicago v. Industrial Commission*, 63 Ill. 2d 99, 104, 345 N.E.2d 477 (1976)), and the test is whether the employer's reliance was objectively reasonable under the circumstances. *Ford Motor Co.*, 140 Ill. App. 3d at 405.

Section 19(l) provides as follows:

> In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits *** have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)* (West 2012).

In *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998), the Supreme Court of Illinois explained the compensation authorized by §19(l) is in the nature of a late fee:

> The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory. *McMahan*, 183 Ill. 2d at 515.

Section 19(k) of the Act provides, "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." *820 ILCS 305/19(k)* (West 2012). In contrast to Section 19(l), Section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory and "is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.'" *McMahan*, 183 Ill. 2d at 515. Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under 19(k) is appropriate. *820 ILCS 305/16* (West 2012).

In late 2012, Respondent forwarded to Petitioner's Counsel a "Payment Transaction Register Report" detailing the timing and amounts of the Temporary Total Disability benefits Respondent paid to Petitioner; this printout was admitted as Petitioner's Exhibit 9, Deposition Exhibit 1. In awarding penalties and fees, the Arbitrator addressed seven specific instances of late payment of TTD benefits. For each period, the Arbitrator determined the delay was both unreasonable and vexatious. The Commission views the evidence differently. To be clear, there is no question there were repeated instances of delayed payment of TTD benefits. However, having considered Mr. Duffy's testimony, we find those delays were, for the most part, the result of incompetence or neglect and were therefore properly penalized under §19(l). As set forth below, however, we find three delays went well beyond neglect and instead reflect deliberate refusal to

pay with no good-faith basis.

1. December 29, 2009 through May 10, 2011

Petitioner was first authorized off work by Dr. Romano on December 1, 2009. Respondent commenced payment of Temporary Total Disability benefits on December 10, 2009. A second check was issued on January 7, 2010 paying TTD benefits through December 28, 2009. At that point, Respondent terminated TTD benefits, and no further payments were issued until May 2011. During that 16-month span, Petitioner was actively treating and remained authorized off work by Dr. Romano.

Respondent attempted no justification or explanation for failing to pay benefits. The Commission observes there was no conflicting medical opinion upon which Respondent could have relied for not paying benefits, for Respondent did not obtain a Section 12 opinion until February 2011, more than 13 months after it had already terminated benefits. Furthermore, when Dr. Wolin issued his report of the February 25, 2011 examination, he causally related Petitioner's rotator cuff tear and CRPS to her work accidents and further indicated Petitioner was restricted to a three-pound limitation with the right upper extremity. PX15. Respondent nonetheless did not reinstitute TTD payments until May 2011. Certainly, an examining expert is not an agent of a respondent nor is the expert's report binding. See *Kraft General Foods v. Industrial Commission*, 287 Ill. App. 3d 526, 531, 678 N.E.2d 1250 (1997) ("as a matter of law, an expert witness is not *per se* an agent of the party who hired him or her and therefore, the witness' statements are not admissible as admissions against interest of that party," citing *Taylor v. Kohli*, 162 Ill. 2d 91, 642 N.E.2d 467 (1994)). The expert's conclusions, however, do have weight and can be considered in the context of a penalties petition when a respondent is required to provide an objectively reasonable basis for its refusal to pay benefits. In response to our questioning on this issue at oral argument, Respondent argued the benefits had been paid, despite the documentary evidence to the contrary, and therefore no penalties were warranted. We disagree. Respondent has failed to provide facts which could be considered an objectively reasonable basis for a 16-month interruption in benefits.

Respondent, without explanation, unilaterally terminated benefits as of December 28, 2009. The payment log evidences Petitioner was not made current on receipt of benefits until May 11, 2011 when TTD benefits were issued through May 10, 2011. The Commission finds this was an unreasonable and vexatious delay in payment of $38,309.72 in TTD benefits (12.29.09 through 5.10.11 is 71 1/7 weeks; $538.49 x 71 1/7 = $38,309.72).

2. January 4, 2012 through January 17, 2012

The payment for the January 4, 2012 through January 17, 2012 benefit period was issued at the end of February 2012, five weeks late. On this occasion, a written denial of benefits was provided. The written denial states Respondent terminated TTD benefits as Petitioner was receiving Social Security disability benefits. The receipt of such benefits is not a good faith basis for refusing to pay TTD, and to his credit, Mr. Duffy, the adjuster's supervisor, conceded as such during his deposition. Therefore, the Commission finds this was a bad faith delay in payment of $1,076.98 in TTD benefits.

3. January 18, 2012 through January 31, 2012

The payment for the January 18, 2012 through January 31, 2012 benefit period was issued three weeks late. A written denial was provided which stated Respondent terminated TTD benefits due to Petitioner's termination in January 2011. Given Petitioner remained off work pursuant to her doctor's authorization and the 2010 holding of *Interstate Scaffolding v. Illinois Workers' Compensation Commission*, the fact Petitioner was terminated one year prior to the benefit period at issue does not constitute a good faith basis for terminating TTD. Again, Mr. Duffy conceded this during his deposition. The Commission finds this was a bad faith delay in payment of $1,076.98 in TTD benefits.

Unpaid medical expenses

The Arbitrator declined to award penalties on the unpaid medical bills finding, "because Petitioner did not reduce the unpaid medical bills, where applicable, fee schedule adjusted amounts, in accordance with section 8.2 of the Act," that Petitioner failed to prove entitlement to penalties and fees on the unpaid medical. The Commission first notes failure to convert a medical bill to the fee schedule is not a bar to penalties. The Commission further notes the unpaid medical expenses include amounts incurred for orthopedic treatment of the right shoulder condition. Notable among the outstanding bills is the December 18, 2009 surgical bill from Trinity Orthopedics in the amount of $16,661.00. PX12. As detailed above, the February 25, 2011 examination report of Dr. Wolin causally related Petitioner's rotator cuff tear to her work accidents. Significantly, the December 18, 2009 operative report was included in the records Respondent provided to Dr. Wolin and, therefore, was incorporated in his conclusion that "the treatment rendered to date appears to be in [*sic*] reasonable necessary and related to the work episodes described above." PX15. While Respondent subsequently obtained a second expert opinion from Dr. Noren, this was limited to Petitioner's CRPS diagnosis and did not address the orthopedic component of the claim. Respondent has provided no explanation for its failure to pay these expenses, and the Commission finds Respondent had no reasonable basis for its five-year refusal to pay for Petitioner's right shoulder surgery. The Commission finds this was an unreasonable and vexatious delay in payment of $16,661.00.

As detailed above, Respondent unreasonably and in two instances, in bad faith, delayed payment of $40,463.68 in TTD benefits and $16,661.00 in medical expenses. The Commission imposes Section 19(l) penalties of $10,000.00, Section 19(k) penalties of $28,562.34 ($57,124.68 x 50% = $28,562.34), and Section 16 attorney fees of $5,712.47 ($28,562.34 x 20% = $5,712.47).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $538.49 per week for a period of 147 weeks, representing December 1, 2009 through September 24, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent is entitled to a credit of $83,462.19 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $371.83 per week for a period of 5 weeks, representing September 25, 2012 through October 29, 2012, that being the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $371.83 per week for a period of 14 5/7 weeks, representing October 30, 2012 through February 9, 2013, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $293.43 per week for a period of 193 4/7 weeks, representing February 10, 2013 through October 26, 2016, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $388.11 per week commencing October 27, 2016 and continuing for the duration of her disability, as provided in §8(d)1 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $38,690.53 for the reasonable, necessary, and related medical services rendered to Petitioner pursuant to §8(a) and 8.2 of the Act. Pursuant to *Tower Automotive v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 427, 943 N.E.2d 153 (2011), Respondent shall also pay the total of the amounts actually paid by Petitioner out-of-pocket and other sources to (1) West Suburban Medical Center (which includes the $36,8989.00 amount paid to them by Blue Cross Voucher), (2) University of Illinois Medical Center, (3) Dr. Georgeann Russell, and (4) Dr. Ondrej Chudoba, for the reasonable necessary and related medical services rendered to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(l) penalties in the amount of $10,000.00.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(k) penalties in the amount of $28,562.34.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §16 attorney's fees in the amount of $5,712.47.

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school

district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 2 1 2018

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 10/24/18

43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARREOLA, ROSA
Employee/Petitioner

Case# **09WC049383**
09WC049384

DISTRICT 97
Employer/Respondent

18IWCC0785

On 7/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0758 KREITER, BYCK & ASSOC LLC
PAUL BYCK
188 W WASHINGTON ST
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW P SHERIFF
ONE N LASALLE ST SUITE 900
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

ROSA ARREOLA
Employee/Petitioner

v.

DISTRICT 97
Employer/Respondent

Case # 09 WC 049383

Consolidated cases: 09 WC 049384

18IWCC0785

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **October 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Is Petitioner entitled to a wage differential award, pursuant to §8(d)1 of the Act?**

FINDINGS

On **May 27, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,002.48**; the average weekly wage was **$807.74**.

On the date of accident, Petitioner was 58 years of age, *married* with 0 dependent children.

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

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

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

ORDER

PLEASE SEE DECISION FOR CONSOLIDATED CASE # 09 WC 19331.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 18, 2017
Date

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARREOLA, ROSA
Employee/Petitioner

Case# **09WC049384**

09WC049383

DISTRICT 97
Employer/Respondent

18IWCC0785

On 7/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0758 KREITER BYCK & ASSOC LLC
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180 W WASHINGTON ST SUITE 800
CHICAGO, IL 60602

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MATTHEW P SHERIFF
ONE N LASALLE ST SUITE 900
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

ROSA ARREOLA
Employee/Petitioner

v.

DISTRICT 97
Employer/Respondent

Case # 09 WC 049384

Consolidated cases: 09 WC 049383

18IWCC0785

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **October 27, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Is Petitioner entitled to a wage differential award, pursuant to Section 8(d)1?**

FINDINGS

On **November 4, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,002.48**; the average weekly wage was **$807.74**.

On the date of accident, Petitioner was 56 years of age, *married* with 3 dependent children.

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

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

Respondent is entitled to a credit of **$83,462.19** for TTD, **$0.00**for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of $83,462.19.

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

ORDER

[In Conjunction with Decision for Case #09 WC 49383]

Respondent shall pay Petitioner temporary total disability benefits of **$538.49**/week for **147** weeks, commencing **12/1/2009** through **9/24/12**, which is the period of temporary total disability for which compensation is payable under Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$371.33**/week for **5** weeks, commencing **9/25/12** through **10/29/12**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$371.33**/week for **208-5/7** weeks, commencing **10/30/12** through **10/27/16**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $83,462.19 for temporary total disability benefits (TTD) that they have paid Petitioner.

Respondent shall pay Petitioner **$38,590.53** for the reasonable, necessary and related medical services rendered to her, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Please see page 20 of the Arbitrator's Decision.

Pursuant to the Court's holding in *Tower Automotive v. Illinois Workers' Comp. Comm'n*, 943 N.E.2d 153, 341 Ill. Dec. 863 (1st Dist. 2011), Respondent shall also pay Petitioner the total of the amounts actually paid by other sources and Petitioner to (1) West Suburban Medical Center (which includes the **$36,898.00** amount paid to them by Blue Cross Voucher), (2) University of Illinois Medical Center, (3) Dr. Georgeann L. Iacono Russell, and (4) Dr. Ondrej J. Chudoba, for the reasonable, necessary and related medical services rendered to her. Please see pages 20-21 of the Arbitrator's Decision.

Respondent shall pay Petitioner permanent partial disability benefits of **$383.05**/week, commencing **10/28/16** and for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner Section 19(l) penalties in the amount of **$10,000.00.**

Respondent shall pay Petitioner Section 19(k) penalties in the amount of **$20,730.86.**

Respondent shall pay attorney's fees in the amount of **$4,146.17**, pursuant to Section 16 of the Act.

Respondent shall pay Petitioner benefits that have accrued since **October 29, 2012**, and shall pay the remainder, if any, in weekly payments.

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

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

Signature of Arbitrator

July 18, 2017
Date

ICArbDec p. 2

JUL 19 2017

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA ARREOLA, Petitioner,	)	
vs.	)	Case No. 09 WC 049384; Consolidated with 09 WC 049383
DISTRICT 97, Respondent.	)	18IWCC0785

DECISION OF ARBITRATOR

FINDINGS OF FACT:

The parties agree that Petitioner suffered 2 accidents involving her right arm, the first on May 27, 2009 (case #09 WC 049383) and the second on November 4, 2009 (case #09 WC 049384). The cases were consolidated prior to the hearing date.

Petitioner testified that at the time of her accidents, she was employed as a Custodian for Respondent. She began working for Respondent sometime in the 1990's. Her duties included lifting and moving furniture, carrying heavy boxes of copy paper, cleaning the premises, waxing and stripping floors, carrying buckets of water, shoveling snow in the winter. One of her duties required closing the windows at Lincoln School. According to Petitioner, some of the windows would get stuck and were very difficult to shut. She testified that some of the windows were so difficult to close that she would wear a belt around her waist because she was afraid of getting a hernia.

On May 27, 2009 (case #09 WC 049383), while attempting to close a jammed window, she needed to step on a radiator to reach the top of the window and gain added leverage. She testified that the window was high up and she is 4'11" tall, so it was difficult to reach. She grabbed the top of the window with her arms about chin high, and

pushed down very hard with both forearms. She testified she heard a pop in the area of her right shoulder and neck and experienced immediate pain. Her supervisor completed an investigation report and wrote that the windows are sometimes very difficult to close and needed to be checked for repairs. (Px #7, Ex #6)

According to Petitioner, after reporting the incident to her supervisor, she was referred by her employer to West Suburban Occupational Clinic, where she was seen the following day by Abhijit Shinde, M.D. (Px #20) The history of the accident was documented in the records. (Px #20) Dr. Shinde indicated tenderness at the insertion of the trapezius muscle on the right with spasms. He noted pain in the right shoulder and upper back, with a pain level of 3/10. (Px #20) She was seen again on May 30, 2009. Heat was applied and the doctor discussed physical therapy. She was told to continue medications. (Px #20) She continued to complain of right shoulder and neck pain and on July 20, 2009, she was prescribed an additional 3 weeks of therapy. Her pain level was a 7/10. (Px #20) Petitioner completed a diagram in physical therapy that shows the area of tenderness to the right side of her neck and shoulder. (Px #22) The therapist focused on treating her right scapula, neck and shoulder. (Px #22)

Petitioner was discharged from physical therapy on August 19, 2009 and two days later, underwent carpal tunnel surgery, which had been previously planned and was not related to her accident. Victor M. Romano, M.D., an orthopedic surgeon, performed the carpal tunnel surgery.

Petitioner had seen Douglas Johnson, Physician's Assistant to Dr. Romano, on July 23, 2009, with complaints of pain in her neck with increased burning, numbness and pain in her right shoulder, elbow and hand following the incident at work while attempting to close a window. (Px #12). He ordered a cervical MRI to rule out radiculopathy.

With regard to the unrelated carpal tunnel syndrome, Dr. Romano ordered physical therapy beginning on September 1, 2009. The therapy records indicate that treatment for her wrist was complicated by ongoing complaints of right shoulder and neck pain. (Px #22)

On October 6, 2009, at the time she was discharged from therapy for her hand, the therapist wrote that she continued to have moderate to severe pain and radiating

symptoms in her right shoulder, upper trapezius and neck area. (Px #22) According to Petitioner, she returned to work full duty following her carpal tunnel surgery on September 10, 2009, and her hand had improved. Dr. Romano discharged her for the unrelated carpal tunnel syndrome on September 3, 2009, and noted that she was doing well with good range of motion in her fingers and good improvement of pain. (Px #12)

However, Petitioner continued to have right shoulder pain and complained to her primary care physician, Paul Kungl, M.D., who ordered an MRI of the right shoulder. (Px #16, 21) Petitioner underwent the MRI on October 16, 2009 and the radiologist's interpretation was that she had a small full thickness tear in her rotator cuff and noted a defect in the supraspinatus and fluid in the subacromial-subdeltoid bursa and into the subcoracoid recess. (Px #21) Petitioner testified that Dr. Kungl referred her back to Dr. Romano after he reviewed the MRI.

Petitioner testified that on November 4, 2009, while mopping the floor in the school cafeteria at work, she slipped on some grapes on the floor and fell forward onto her right hand, arm and side. The mop handle hit her in the face as she fell. She felt pain and an electric type shock from her right hand all the way up to her shoulder. She was helped up by another custodian. The accident was reported and she was taken to the company clinic the same day, where she complained of pain in her right wrist, elbow, shoulder and knee. (Px #20) She had soft tissue swelling along the dorsal aspect of her right wrist, tenderness and limited range of motion and grip strength. She had tenderness in her right elbow, right index finger and little finger. (Px #20) She complained of pain traveling from her right hand up to her shoulder, and also complained of a sore right knee. (Px #20) X-rays were taken and she was fitted for a wrist splint and given an arm sling. (Px #20)

Petitioner was seen by Dr. Kungl on November 5, 2009, with complaints that her right wrist was swollen and painful after falling the previous day. (Px #16) At that time, the doctor wrote that she has had chronic shoulder pain for the past three years. On April 30, 2010, Dr. Kungl entered a note that said his November reference to chronic shoulder pain was with regard to her left shoulder. (Px #16; Px #7, Ex #17)

Petitioner returned to the company clinic on November 9, 2009, and rated the pain to her right wrist and shoulder 9/10. (Px #20) She was wearing a wrist splint and an arm

sling. She informed the clinic physician that she had an appointment with Dr. Romano the following day, and the company doctor agreed that she should return to the orthopedic physician who performed the right hand surgery. (Px #20)

Petitioner was seen by Dr. Romano on November 10, 2009. Dr. Romano made two chart entries at that visit in which he noted both of Petitioner's work accidents. (Px #12) Dr. Romano noted swelling to the dorsum of her right wrist that he felt was tendonitis and not related to her carpal tunnel syndrome. (Px 7, pp. 20-21) He ordered an MRI and physical therapy for her right hand. (Px #12; #7, pp. 20-21) He testified that compared to the date of her discharge for carpal tunnel syndrome in July, 2009, there had been a big change in her condition. (Px #7, pp. 65-66) Petitioner testified that her right hand symptoms were different than what she experienced with her previous carpal tunnel syndrome. The MRI showed some subchondral cysts. (Px #13) Dr. Romano also noted persistent pain in her right shoulder after her accident in May, and noted the previous MRI showing a small full thickness tear of her rotator cuff and the supraspinatus. (Px #12) He testified that her symptoms were consistent with those described by his Physician's Assistant, Mr. Johnson, in July, 2009. (Px #7, pp. 22-23) She had a positive impingement sign and tenderness in the subacromial space. He ordered physical therapy for her shoulder and scapular stabilization. (Px #12; Px #7, pp. 23-24) She was given work restrictions.

Petitioner testified that on December 1, 2009, Dr. Romano took her off work and she never returned to her former position.

Dr. Romano prescribed right shoulder surgery, which he performed on December 18, 2009. The procedure involved repair of the rotator cuff tear and labral tear, as well as a subacromial decompression and distal clavicle excision. The labral tear was not appreciated on the MRI. (Px #7, pg. 74, Dep. Ex. #21) Petitioner continued to follow up with Dr. Romano, with shoulder, wrist and forearm complaints. On February 5, 2010, her pain was described as very intense. (Px #12) She became very guarded in terms of her right shoulder and wrist. (Px #12) There was swelling in her arm, questionable Finkelstein's test, positive Thomas sign and positive Phalen's test. (Px #12) Physician's Assistant Johnson thought the inflammation in her shoulder that traveled down the extremity could be causing some compression of her nerve, and possibly an acute onset

of de quervain's tenosynovitis. There was consideration for a corticosteroid injection. (Px #12)

On February 23, 2010, Petitioner experienced more pain and swelling, with a significant decrease of motion, of her shoulder. (Px #7, pp. 81-82) An injection of the first compartment of the right hand provided good relief. (Px #12) There was little improvement in her shoulder on April 27, 2010, and significant swelling in the dorsum of her wrist. (Px #12) An injection was administered to her hand. It was noted that she was very apprehensive or guarded due to pain. (Px #12) Dr. Romano felt that the injury on November 4, 2009 aggravated her carpal tunnel syndrome that had recently been surgically repaired and caused de quervain's syndrome. (Px #7, pp. 34-35; 58, 60-61, 81-82) Physical therapy was continued. Dr. Romano was concerned about the possibility of Complex Regional Pain Syndrome (CRPS) or Reflex Sympathetic Dystrophy (RSD), which are terms he uses interchangeably. (Px #7, pp. 84-88) He described the disease as nerves going "haywire" that cause pain out of proportion, with findings such as burning, swelling, color changes, hypersensitivity to touch, fluctuating symptoms with flare-ups, all of which were exhibited by Petitioner throughout her course of treatment. (Px #7, pp. 78-79; 85-86; 99; 105; 107; 113-114; #11; #12) As an orthopedic surgeon who has performed numerous shoulder, wrist and hand surgeries, he has had the occasion to treat patients who have developed CRPS / RSD. (Px #7, pg. 10) He referred Petitioner to Daniel G. Torres, M.D., a rheumatologist, as well as to the University of Illinois Pain Clinic. (Px #7, pg. 87)

On June 29, 2010, Petitioner was seen by Dr. Romano with complaints of swelling and pain in her whole hand, with changes in color and temperature fluctuations between very hot and very cold. (Px #12; Px #7, pp. 87-88). Petitioner testified that she noticed changes in color to her right hand and she would often wake up with right her arm much colder than her left. Dr. Romano diagnosed Petitioner with CRPS / RSD and wanted to review a triple-phase bone scan, ordered by Dr. Torres. (Px #7, pp. 87-88; Px #12, Px #13; Px #17) Dr. Romano testified that a bone scan is an objective test and cannot be manipulated by the patient. (Px #7, pp. 89-90)

The triple-phase bone scan was carried out at West Suburban Medical Center on June 30, 2010. The radiologist analyzed the results and compared the right hand with the

left hand. He found, in all three phases, an increased uptake to the radial aspect of the right hand and wrist as compared with the left, which is consistent with RSD on the right side. (Px #7, pg. 89; Dep. Ex. #22) Dr. Romano testified that Petitioner's diagnosis of RSD is causally related to her work injuries, but stated that it is impossible to determine why this condition develops in some patients and not in others. (Px #7, pp. 78-79; 85-87; 99; 105; 107; 113-114; 155-157)

On July 16, 2010, Andrei M. Rakic, M.D., at the University of Illinois Pain Clinic recommended stellate ganglion block injections, and indicated that Petitioner presented with symptoms of RSD including allodynia, hot and cold hypersensitivity, and some muscular atrophy of the right hand. (Px #14) Petitioner underwent two block injections on July 30, 2010 and August 18, 2010. (Px #14) Petitioner testified that she experienced adverse reactions to the injections, which caused her to shake uncontrollably. The Pain Clinic records corroborate such testimony. (Px #14) After the second injection, Dr. Rakic questioned the diagnoses of RSD, but ultimately continued to treat Petitioner for CRPS / RSD. He reconfirmed the diagnoses in subsequent visits. (Px #14)

Petitioner testified that she then received treatment from Dr. Tapia that included acupuncture. Petitioner testified that the acupuncture provided only a few days of pain relief.

Petitioner's pain began to spread to the opposite extremity, which Dr. Romano confirmed is a hallmark of RSD. (Px #7, pg. 119) Dr. Romano also testified that Petitioner's left hand was becoming symptomatic due to overuse, as she had been avoiding using her right upper extremity. (Px #7, pp. 102; 106; 154)

On March 24, 2011, Dr. Rakic recommended a spinal cord stimulator and provided Petitioner with information on the procedure that included a DVD and educational material. (Px #14) Petitioner testified that she was afraid of the spinal cord surgery, which she described as have two holes put in her back.

On September 23, 2011, Petitioner advised the pain clinic that she was not interested in pursuing any further invasive treatment. She was therefore discharged from care. On the last visit, it was noted that Petitioner continued to have what was described as "significant swelling" and pain in her wrist as well as pain from her neck to her fingers with numbness in a glove distribution over her arm and entire hand. (Px #14) The

diagnoses on the date of her discharge was RSD vs. CRPS. (Px #14) Dr. Torres also diagnosed Petitioner with CRPS. (Px #17)

On February 25, 2011, Petitioner was seen by orthopedic surgeon Preston M. Wolin, M.D., at Respondent's written request. (Px #1) Petitioner testified that Dr. Wolin thoroughly examined her. Dr. Wolin's report was not offered into evidence by Respondent and the Arbitrator rejected the report offered by Petitioner on the basis of hearsay. (Px #23)

Petitioner called Respondent's Supervising Adjuster, Dan Duffy, to testify at an evidence deposition on July 13, 2016. (Px # 9) Mr. Duffy testified that he reviewed Dr. Wolin's report and that the doctor opined Petitioner's rotator cuff surgery was reasonable, necessary and causally related to her work accidents. (Px #9, pp. 31; 68) He further testified that he was aware that Dr. Wolin diagnosed Petitioner with CRPS due to her work accidents, which was consistent with the opinions of Dr. Romano. (Px #9, pg. 31) Mr. Duffy did not know exactly why Petitioner was paid roughly 16 months of TTD in two checks that covered the period December 29, 2009 through April 12, 2011, but due to the timing, he agreed that it would make sense that it was the result of the opinions provided by Dr. Wolin. (Px #9, pp. 19-20; 26-31)

On November 1, 2011, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented to Richard L. Noren, M.D., a pain management physician, for an examination. Dr. Noren authored a report following such examination. He found that the bone scan was negative for RSD. He declared Petitioner to be at MMI. Although he found Petitioner capable of returning to work, he wrote that any restrictions regarding the right upper extremity would be based on her treating orthopedic surgeon or an FCE. (Rx #1, Dep. Ex. 2)

Dr. Noren testified by way of evidence deposition on February 11, 2015. (Rx #1) Dr. Noren agreed that swelling, atrophy, changes in color, changes in temperature and a bone scan are all objective findings. (Rx #1, pp. 78-80) Dr. Noren felt that Petitioner's pain complaints were non-specific and diagnosed her with depression, anxiety, and hypothyroidism, all of which he felt could contribute to her symptoms. (Rx #1, pp. 30-31) This was a diagnosis of exclusion. (Rx #1, pg. 30) Dr. Noren agreed that pain can lead to or aggravate depression.

Petitioner began treating with a psychologist and a psychiatrist following her accidental injuries. On February 4, 2010, through the West Suburban Ambulatory Care Department, she first saw Georgeann L. Iacono Russell, Ph.D., a clinical psychologist. (Px #18) Petitioner also began treating with a psychiatrist, Ondrej J. Chudoba, M.D. (Px #19) Dr. Noren was aware that Petitioner had been treating with Dr. Russell and Dr. Chudoba, but never reviewed any of their records as they were not made available to him. (Rx #1, pp. 16-17; 71-72; 75-76) He could not offer opinions with respect to her psychological condition within a reasonable degree of medical certainty. (Rx #1, pp. 69-70)

Dr. Noren testified that based on his examination, Petitioner was functioning at a light-duty level of function. (Rx #1, pp. 93-94) He opined that any restrictions regarding Petitioner's right upper extremity would be based on her treating orthopedic surgeon, Dr. Romano, and a functional capacity evaluation ("FCE"). (Rx #1, pg. 94)

Petitioner underwent an FCE at Accelerated Rehabilitation on July 6, 2012. (Rx #3). The evaluator opined that Petitioner presented with limiting factors during the test due to her perceived maximum ability. (Rx #3) The report indicates that Petitioner had a moderately decreased range of motion in her right upper extremity that would have a negative impact on her overall level of physical functioning. (Rx #3; #1, pg. 99) There were also findings of a positive Tinel's sign on the right wrist and positive Tinel's sign on the right cubital tunnel. (Rx #3, #1, pg. 99) The evaluator concluded that Petitioner was functioning at the light-medium level, but that the test was not valid due to Petitioner's self limiting behavior and inconsistencies. The evaluator wrote: "Given the fact that the client demonstrated 41.4% inconsistent effort, she is capable of greater functional abilities than that demonstrated during the FCE." (Rx #3)

Dr. Noren agreed that one's own perception of pain or fear of re-injury can result in self-limiting behavior and thus an invalid FCE. (Rx #1, pp. 96-97). The evaluator did not recommend that Petitioner return to work full duty and did not indicate that Petitioner would be able to function as a Custodian. (Rx #3, #1 pg. 98; Rx #2, pg. 39)

The FCE that was administered on July 6, 2012 had been arranged by Kathleen M. Dytrych, C.R.C., a vocational counselor hired by Respondent to interview Petitioner and perform a vocational assessment. (Rx #2, pp. 8-9, 49-50, 56-57) Ms. Dytrych

testified by way of evidence deposition on December 10, 2015. (Rx #2) Ms. Dytrych testified that she met with Petitioner on one occasion June 20, 2012, and subsequently set up the FCE. (Rx #2, pg. 56) Ms. Dytrych communicated with the FCE evaluator 30 times, 16 times prior to the test and 14 times after the test. (Rx #2, pp. 43-46) Ms. Dytrych did not explain such communication.

Petitioner followed up with Dr. Romano on July 26, 2012. At that time, it was the doctor's opinion that Petitioner was suffering from CRPS of the right arm, as well as of the left arm, in addition to fibromyalgia. (Px #11) Dr. Romano was of the opinion Petitioner should continue using a brace on her arm/hand and continue to see Dr. Tapia for pain control and acupuncture, Dr. Torres for her fibromyalgia, and Dr. Cantu for chiropractic manipulation. (Px #11) Dr. Romano was of the opinion that Petitioner could return to work light duty with no lifting more than 20 pounds and limited use of the right arm.

On August 16, 2012, Petitioner was seen by Dr. Noren for a second time, at Respondent's request. (Rx #1). This examination was arranged by Ms. Dytrych. The examination lasted 15 to 20 minutes. (Rx #1, pp. 48-49) He reviewed the FCE and acknowledged that the evaluator's finding of a positive Tinel's was consistent with his own findings. (Rx #1, pg. 99) It was Dr. Noren's opinion, as expressed in his report as well as in his deposition testimony, that Petitioner did not have CRPS. In reference to Dr. Romano's note of July 26, 2012, Dr. Noren pointed out that he Dr. Romano reviewed the FCE and concluded that such evaluation was limited due to fibromyalgia and RSD. Dr. Noren noted there was nothing quoted in Dr. Romano's note to document any objective physical findings of CRPS, and Dr. Noren did not make such findings in his examination of Petitioner. Dr. Noren was of the opinion Petitioner had reached maximum medical improvement. Dr. Noren reviewed Petitioner's job description and opined, and compared his physical examination with the job description. Dr. Noren opined that Petitioner was capable of returning to full-duty work, based on his examination, the Petitioner's job description and the invalid FCE. (Rx #1, pp. 54-55) Dr. Noren agreed that the FCE evaluator did not recommend full-duty work as a janitor. (Rx #1, pg. 98) He noted that Petitioner continued to receive chiropractic care, though her primary medications appeared to be anti-depressants and anti-anxiety medication. Dr.

Noren agreed that Petitioner suffered an orthopedic injury and testified that functionality issues with respect to orthopedic injuries would be more in the purview of an orthopedic surgeon. (Rx #1, pg. 94-95). Dr. Noren testified that an orthopedic surgeon or an FCE evaluator would be "better at objectifying, greater than what I felt comfortable stating." (Rx #1, pg. 95) He further opined that an FCE can be an objective tool in determining a person's physical limitations. (Rx #1, pg. 96) A valid FCE could determine whether a person is using maximum effort during the test and can be relied upon not only by treating physicians, but by everyone, since that would be the purpose of the FCE. (Rx #1, pg. 98; 100)

Petitioner underwent a second FCE on October 11, 2012 at the request of Dr. Romano. (Px #7, pg. 123-129; Px #15) The test was determined to be valid based on objective criteria that included heart rate monitoring, which is an objective finding that cannot be manipulated by a patient. (Px #7, pp. 128-129, Px#15) The FCE evaluator concluded that Petitioner was functioning at a light physical demand level, with limits on grasping, lifting and carrying, which did not meet the Petitioner's job description as a custodian. (Px #15)

On October 29, 2012, Dr. Romano placed Petitioner at MMI, with permanent light-duty restrictions consistent with the valid FCE, which included maximum lifting of 20 pounds, rarely lifting, carrying, pushing or pulling, limited use of right hand, rare repetitive motion of the limb and occasional overhead reaching. (Px #7, pg. 134; Px #4)

Until his evidence deposition, Dr. Noren was not aware of the second FCE, which was administered 3 months after the first one. (Rx #1, pp. 100-102). Dr. Noren was also aware of the permanent restrictions from Dr. Romano based on the valid FCE, but testified that this would be consistent with his previous statement that "any restrictions regarding the right upper extremity would be based on her treating orthopedic surgeon, Dr. Romano and an FCE." (Rx #1, pp. 100-102) Dr. Noren did not dispute Dr. Romano's opinion that Petitioner has limited function in her right upper extremity due to her work injuries. (Rx #1, pp. 105-106).

On each of the 2 occasions he examined Petitioner, Dr. Noren did not believe she had evidence of CRPS. (Rx #1, pp. 106-107). He cannot agree or disagree with how the physicians at University of Illinois Pain Clinic made their diagnosis of CRPS. (Rx #1,

pp. 106-107). He disagreed with the diagnosis of CRPS by both Dr. Romano and Dr. Torres. (Rx #1, pp. 106-107) Dr. Noren did agree that certain symptoms and/or physical findings can be associated with CRPS / RSD, including persistent pain, numbness, swelling, changes in color, temperature changes, allodynia, depression and anxiety. (Rx #1, pp. 80-82) Dr. Noren testified that a triple-phase bone scan can also suggest a diagnosis of RSD. (Rx #1 pg. 68) He never actually reviewed the triple-phase bone scan but mistakenly wrote in his report that the test was negative. (Rx #1, pp. 66-68) He thought that Petitioner's acupuncture treatment was inconsistent with CRPS because patients with CRPS do not want to be stuck with needles. (Rx #1, pp. 112-113) Dr. Romano noted that acupuncture provided Petitioner with several days of relief. (Px #7, pg. 107)

Petitioner began treating with clinical psychologist Georgeann L. Iacono Russell, Ph.D., in February 2010. (Px #18) Petitioner testified that each session with Dr. Russell would last one hour. On February 4, 2010, Petitioner complained of difficulty sleeping, and struggled with being unable to function after spending all of her life working. (Px #18) Dr. Russell's records document complaints of depression that related to Petitioner's decreased functionality since her work injuries. (Px #18) Petitioner testified that she felt like a bird without wings. She had difficulty getting out of bed, but her husband insisted that she get out of the house. Her psychiatrist, Dr. Chudoba, prescribed medications to help her deal with "major depression." (Px #19) Petitioner also complained about financial pressure.

On August 4, 2011, Dr. Russell wrote that Petitioner was under a tremendous amount of stress because she had not been paid her workers' compensation checks since June and was struggling to pay for her medications. (Px #18) Petitioner testified that her husband had to take out a loan against his profit-sharing account in order to pay the bills. Dr. Russell wrote that she had continued depression secondary to decreased functional ability and financial pressure from her workers' compensation situation. (Px #18)

Petitioner filed two penalties and fees petitions in which she alleged a pattern of late payment of TTD benefits. (Px #9, Dep. Ex. 1 and 2, Px #6) In the second penalties and fees petition which she filed on October 26, 2012, Petitioner claims penalties and fees for the period from December 28, 2009 through the present. (Px #6) Respondent

provided a TTD payment history, which was discussed during Mr. Duffy's evidence deposition. (Px #9, Dep. Ex. #1) Mr. Duffy could not explain why there was roughly an eight-week delay in TTD benefits from June 6, 2011 through August 1, 2011. (Px #9, pp. 34-35) The term "created" in the payment history log, is the date the check is entered into the computer and is "good to go" according to Mr. Duffy. (Px #9, pp. 16-18). Mr. Duffy testified that he could not confirm or deny Petitioner's attorney's assertion that he sent numerous emails and made numerous phone calls to the adjusters who handled this file to demand payment. (Px #9, pg. 35, pp. 55-56) He could not explain why a TTD check that was due on September 13, 2011 was created on September 22, 2011 and issued on October 19, 2011. (Px #9, pp. 37-44)

Mr. Duffy was not aware of any written explanation given for the delays. (Px #9, pp. 34-47) He did agree that the Workers Compensation Act and Commission Rules require Respondent to provide in writing, timely, good faith basis for delay or denial of benefits. (Px #9, pp. 14-16) He understood that a 14-day delay in benefits creates a rebuttable presumption of an unreasonable delay according to Section 19 i) of the Act. (Px #9, pg. 15) When asked whether he had reason to doubt the efforts of Petitioner's attorney to secure benefits, including numerous phone calls, e-mails and/or messages, Mr. Duffy responded: "If you were calling Segrario Ramirez, I could probably believe that. She historically had complaints about not returning calls. She was let go. As a matter of fact, I fired her." (Px #9, pg. 46) Ms. Ramirez was one of 5 adjusters that had been assigned to Petitioner's claims at bar. (Px #9, pg. 74) Since the beginning, Mr. Duffy has been assigned such claims in a supervisory capacity. (Px #9, pp. 9-11)

While there were no written explanations offered regarding the delay in TTD benefits, Respondent did provide several written explanations to the denial of benefits. (Px #6, Ex. A, B) On February 3, 2012, Adjuster Sharla Gatson wrote that TTD was terminated because Petitioner is receiving Social Security Disability benefits. (Px #6, Px #9, pp. 52-56) The written explanation came over 4 weeks from the date TTD was due, on January 3, 2012, and Mr. Duffy agreed that this is a violation of Commission Rule 7110.70, requiring a written denial to be sent on the last date TTD was due. (Px #9, pg. 52) Mr. Duffy also agreed that Ms. Gatson's justification for denial of benefits based on

her receipt of social security benefits is "absolutely not" a good faith reason for denying TTD and is a violation of Illinois law. (Px #9, pg. 55)

On February 21, 2012, Ms. Gatson provided another written denial. (Px #6, Ex B) On this occasion, she explained that TTD was stopped because Petitioner had been terminated from her employment on January 25, 2011, which was 1 year before Ms. Gatson's denial. (Px #6, Ex. B) Mr. Duffy was aware that Petitioner was terminated from employment on January 25, 2011. (Px #9, pp. 56-57; Px #2) Mr. Duffy agreed that Ms. Gatson's explanation was not a good faith basis for denial of benefits. (Px #9, pp. 57-59) He testified that Ms. Gatson would have been terminated by him for poor performance had she not been transferred to another unit. (Px #9, pp. 49-50)

Petitioner testified that she wanted to return to work for Respondent, however, she could not perform the physical duties of the custodial job. Dr. Romano never released her to return to her full-time position. Petitioner testified that she asked Trish Carlson, Director of Human Resources for Respondent, whether she could work in another department, such as the cafeteria or as a crossing guard, but she was told that no positions available. (Px #2; Rx #2, pp. 50-52)

Petitioner testified that Dr. Russell encouraged her to do volunteer work. She testified that she performed volunteer work at the Illinois Coalition for Immigrants and Refugees. She helped new citizens register to vote, but could not recall the exact date she began this volunteer work. According to Dr. Russell's records, Petitioner was volunteering in September, 2011. (Px #18)

Petitioner testified that she began searching for restricted work in February, 2012. She documented her attempts to find employment in a job search log. (Px #3) The log contains printouts of jobs searches on line. (Px #3) Petitioner testified that she does not know how to use a computer but received help applying for jobs online from her friend Salome'. Petitioner provided evidence of 348 job searches from February 2012 through June 27, 2013. (Px #3) Petitioner testified that she applied for work at fast food restaurants, stores in malls, as well as custodial work with the hope of finding a job within her restrictions. She testified that she was looking for any kind of work. She was unsuccessful in her efforts until September 24, 2012, when she was offered a paid position with the organization for whom she volunteered her time, Illinois Coalition for

Immigrant and Refugees. (Px #5) According to Petitioner, she hands out voter registration information and makes sure the new citizens complete the forms. The position is light duty and within her restrictions. She testified that she enjoys working in this position.

On October 29, 2012, Dr. Russell wrote that her new job has given her purpose and meaning to her life. (Px #13) On November 5, 2012, Petitioner told Dr. Russell that she has improved energy and is feeling like the "old Rosa" again, who is busy and productive. (Px #13)

On February 6, 2013, Petitioner met with Susan A. Entenberg, C.R.C., who has been a Certified Rehabilitation Counselor since 1978. (Px #8, pp. 4-5, 13-14) Ms. Entenberg also works as an independent vocational expert for the Federal Government in Social Security cases. (Px #8, pp. 7-9) Ms. Entenberg reviewed various medical records, both FCE reports, Respondent's job description, the Section 12 examination report from Dr. Wolin, as well as both reports from Dr. Richard Noren, the vocational assessment from Kathleen Dytrych, and Petitioner's job search logs up through the date of the meeting. (Px #8, pp. 11-12) After conducting an interview of Petitioner, Ms. Entenberg issued a vocational assessment report. (Px #8, Dep. Ex. #3) Ms. Entenberg testified by way of evidence deposition on August 18, 2015. (Px #8) She testified that Petitioner completed 4 years of schooling in Mexico, where she was born. She came to the USA on a permanent basis in 1970. She took some classes in English as a Second Language in the 1980s, but has learned English mostly on her own. She never completed a GED. (Px #8, pg. 15) Her only other education or training was a one-week sanitation course in 1984. (Px #8, pg. 16) She can read basic English but has difficulty writing. She has no computer skills. (Px #8, pp. 16, 23, 32-33)

Petitioner's symptoms at the time of her meeting with Ms. Entenberg included stabbing pain in the palm and wrist of the right hand, electric pain in her right arm, and limited range of motion in her right shoulder. (Px #8, pp. 22-23). She had difficulty making a fist with the right hand and complaints of dropping things. (Px #8, pp. 22-23) She needs help putting on her bra and shoes and uses her left hand to brush her teeth and hair. She drives with her left hand even though she is right-hand dominant. (Px #8, pp. 22-23)

Petitioner's work history includes prior work as a custodian, some experience as an assembler, packer and solderer, sandwich maker, pantry worker and nursing home aide. (Px #8, pg. 24) She has never been employed in the skilled workforce. (Px #8, pp. 37-38; Rx #2, pg. 54)

Ms. Entenberg reviewed the job logs and felt Petitioner conducted a good faith, self-directed job search, especially without formal assistance. (Px #8, pp. 40-41) She opined that Petitioner's position with the Illinois Coalition for Immigrants and Refugees is a suitable light-duty position. (Px #8, pg. 41) Ms. Entenberg testified that Respondent's job description of a Custodian includes duties that are beyond the permanent restrictions provided to Petitioner by Dr. Romano and the second FCE evaluator. (Px #8, pp. 34-35, Dep. Ex. #4) Petitioner is therefore precluded from pursuing her usual and customary line of employment as a custodian. (Px #8, pg. 36) Ms. Entenberg opined that Petitioner is capable of performing such jobs as an information clerk, restaurant hostess or desk clerk and that based on the 2014 Illinois Department of Employment Security and Occupational Employment Statistics, which is the last year the wage statistical information was reviewed, the pay rate for these three job categories ranged from $8.79 to $9.96 per hour. (Px #8, pp. 27-29)

Petitioner testified that she currently earns $1,000.00 per month. Petitioner's yearly earnings at the time of the accidents was $42,002.48. (Ax #1, Ax #2)

The parties stipulated on February 25, 2016 that Petitioner's wages with Respondent were $49,388.00 at the time. (Ax #1, Ax #2)

Ms. Dytrych opined that Petitioner's light-duty restrictions would prohibit her from work as a custodian, but based on her work history, she would qualify to work in certain unskilled jobs as a housekeeper in a hotel setting, assembler or work with laundry, in a pantry or kitchen. (Rx #2, pp. 21-22; 23-24; 57) She did not provide any details regarding Petitioner's potential future wages. (Rx #2)

Ms. Entenberg testified that while some of the jobs identified by Ms. Dytrych may require some reasonable accommodations, they all fall into the range of $8.50 to $10.00 per hour. (Px #8, pp. 48-58) Ms. Entenberg did not believe that any training would increase Petitioner's job opportunities or earning capacity at this point. (Px #8, pg.

55) She felt that Petitioner should continue to work in her current position as it is perfect for her. (Px #8, pg. 56)

Ms. Dytrych was not aware that Petitioner found employment since meeting with Petitioner. (Rx #2, pg. 57) She met with Petitioner on one occasion, and did not assist her in finding employment, or perform a labor market survey. (Rx #2, pp. 56-57) She never reviewed Petitioner's job search logs. (Rx #2, pg. 57)

Petitioner testified that she continues to have swelling in her right hand and arm. She applies cold packs, hot packs and cream on the right arm and hand. He uses a roller on the arm. Her ring finger and middle finger are numb and tingly. She often wakes up with her right arm colder than her left. She testified that her husband helps her to get dressed. She continues to drive with her left hand only. In the bathroom, she cannot clean herself with her right hand. She pays neighbors to do her laundry and to vacuum and dust. Petitioner testified that she could no longer perform the physical functions required in the custodial position, such as moving heavy furniture, lifting heavy boxes, shoveling snow, or carrying heavy buckets of water to wax and strip the floors. Petitioner testified that per Dr. Romano's recommendation, she wears braces on both hands. She testified that she takes Gabapentin for her nerves and sees Dr. Torres every 3 months. She misses her job as a custodian but she is happy working in her current light-duty position.

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 the following:

The Arbitrator finds that there is a causal connection between Petitioner's accident on May 27, 2009 and her current condition of ill-being (case #09 WC 49383). The description of the accident was significant and forceful. She reported this window-closing accident promptly and was treated at the company clinic for what was eventually diagnosed as a right rotator cuff tear and neck sprain. Surgery was performed by Dr. Victor Romano.

The Arbitrator further finds that there is a causal connection between Petitioner's accident on November 4, 2009 and her current condition of ill-being (case #09 WC 49384). Petitioner fell forward on her right hand, shoulder, and elbow, which aggravated her rotator cuff tear as well as her right wrist, from which she had just recovered for an unrelated carpal tunnel surgery. She also suffered a contusion to her right knee.

The Arbitrator further finds that Petitioner's current psychological/psychiatric condition is causally related to these two accidents.

Dr. Romano testified that her initial injury, case #09 WC 49383, caused the rotator cuff tear as evidenced on the MRI, and her subsequent injury, case #09 WC 49384, aggravated the shoulder resulting in the need for surgery. He further opined that her right hand symptoms following the November 4, 2009 accident caused de quervain's syndrome, as well as an aggravation to her carpal tunnel syndrome, which had previously resolved.

No opinion was offered that contradicts Dr. Romano's opinion as to Petitioner's orthopedic injuries.

Respondent's Section 12 examiner, Dr. Richard Noren, did not dispute that Petitioner suffered orthopedic injuries to her right shoulder and hand. (Rx #1 pg. 69) However, he disagreed with the diagnosis of CRPS / RSD.

The Arbitrator notes that Dr. Noren's opinions contradict the opinions of Dr. Romano, Dr. Daniel Torres and the pain management physicians at the University of Illinois Hospital, all of whom confirm the diagnosis of CRPS / RSD. Furthermore, Dr.

Noren was unable to explain the findings on the triple-phase bone scan, which showed evidence of RSD, or his mistaken opinion in his initial report that the test was negative.

In his June 22, 2009 chart note, Dr. Kungl wrote that a diagnosis of depression was made two years ago. (Px #16) Moreover, the Health Insurance Claim Forms in Dr. Russell's records indicate that Petitioner's condition is not related to her employment. (Px #18)

Yet, Dr. Kungl's June 22, 2009 chart note also states that her visit that day was "because of worsening symptoms." Dr. Kungl wrote that she recently had an injury at work and was told to go on light duty, but apparently there was no light duty and therefore was told to stay off work. She went through PT and when she was ready to go back, Dr. Kungl wrote, she was verbally abused/harassed by her supervisor and sent to a new school as a punishment. Since then, she has had increased depressive symptoms. (Px #16)

On April 29, 2010, Dr. Kungl wrote: "patient notes worsening depression symptoms due to her issues with workman's compensation and her persistent pain." (Px #16)

In her October 18, 2010 Psychology Note, Dr. Russell, a clinical psychologist, wrote the following:

> "Pt. seen today for F/U. Pt. continues to be tearful + upset 2° pain syndrome. She is to have a procedure for pain control – Pt. not clear on exactly what this will be – She is fearful of further procedures. Pt. to see psychiatrist today at Resurrection Behavioral [illegible]. Pt. to see PCP also today. Pt. wishing to go to [illegible] for evaluation. O: Ø A: Pt. ẽ [with] significant pain + 2° [secondary] depression due to functional limitations. Pt. ẽ nominative negative and anxious thoughts. P: Cont. tx. Will contact her PCP regarding status in therapy." [Words in brackets added.] (Px #18)

When Dr. Chudoba, the psychiatrist, first saw Petitioner on October 18, 2010, he diagnosed her with major depression and CTS/Thyroidism/Chronic pain. He wrote that the patient appears unable to engage in competitive employment "for mult. 'P' reasons." On November 22, 2010, Dr. Chudoba wrote: "Physically: Chronic pain Rt. Shoulder after accident at work." On May 18, 2011, Dr. Chudoba wrote that the patient is upset with

workman's comp. for canceling an appointment, and noted that her mood is dysphoric and she is overwhelmed by the memory of her supervisor treating her like a dog." On July 20, 2011, Dr. Chudoba wrote that the patient is worried about not receiving compensation check several weeks ago. (Px #19)

After carefully reviewing their records, the Arbitrator finds that Dr. Russell causally related Petitioner's psychological condition with her functional limitations that resulted from the work accidents, and Dr. Chudoba intimated that her psychological condition was related to her chronic pain.

Dr. Noren could not dispute the relationship between Petitioner's psychological and psychiatric treatment and her work injuries, since he did not review any of the related records. He did concur that pain can lead to or aggravate depression. (Rx #1, pg. 70)

Dr. Noren testified that when he provides opinions in legal cases for which he is not the treating physician, at least 95% of them are for the employer or the insurance company. Dr. Noren agreed with Petitioner's attorney that the website for his medical group, Pain Care Consultants, states that Dr. Noren has been "an expert consultant for the insurance industry." (Rx #1, pp. 57-58)

The Arbitrator finds the opinions of Dr. Romano, Dr. Torres and the UIC Pain Clinic physicians to be more persuasive than those of Dr. Noren.

Finally, the Arbitrator notes that Petitioner was examined by Dr. Preston Wolin at the request of Respondent. (Px #1) On the basis of hearsay, the Arbitrator rejected Dr. Wolin's report that Petitioner offered into evidence. Respondent did not offer Dr. Wolin's report.

While the report itself is inadmissible hearsay, the arbitrator may draw an inference from respondent's failure to offer the report that it would not have been favorable to the respondent. *Wasfi Alsaraj v. Taxi Affiliation Services, Inc., LLC*, 14 IWCC 0217.

In the case at bar, the Arbitrator does not have to make an inference. Respondent's Supervising Adjuster, Dan Duffy, actually testified that Dr. Wolin opined that Petitioner's accidents caused injuries to her right upper extremity and that her rotator cuff surgery was reasonable and necessary. Mr. Duffy also confirmed that Dr. Wolin

believed her CRPS was causally related and that his opinions were consistent with Petitioner's treating surgeon, Dr. Romano.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds the following:

Petitioner submitted the same attachment to both Ax #1 and Ax #2. In such attachment, she claims the following outstanding medical bills, as well as a vocational rehabilitation bill, for medical and vocational services rendered to her:

"Medical and Vocational Bills Unpaid by Respondent:

West Suburban Medical Center	$39,711.00
University of Illinois Medical Center	$ 3,108.64
Trinity Orthopedics, SC	$30,237.96
Hinsdale Orthopaedics	$ 249.88
ATI Physical Therapy	$ 2,613.96
Dr. Georgeann L. Iacono Russell	$ 3,408.64
West Suburban Occupational Health	$ 1,055.28
Dr. Ondrej J. Chudoba	$ 640.00
Res. Health Advanced Imaging Center	$ 1,330.00
Rehabilitation Services Associates	$ 720.00"

The Arbitrator has carefully reviewed the medical records and the bills associated with such records, and finds that such treatment rendered was reasonable, necessary and related to the accidental injuries. (Ax #1, Ax #2; Px #10, Px #11, Px #12, Px #13, Px #14, Px #15, Px #18, Px #19, Px #20, Px #21)

The Arbitrator awards Petitioner an amount equal to a sum of the outstanding medical bills from Hinsdale Orthopaedics (Px #11), $249.88, Trinity Orthopaedics (Px #12), $30,237.96, ATI Physical Therapy (Px #15), $2,613.96, West Suburban Occupational Health (Px #20), $1,055.28, Resurrection Health Advanced Imaging Center (Px #21), $1,330.00, West Suburban Medical Center (Px #13), $1,361.12, University of Illinois Medical Center (Px #14), $418.60, and Dr. Georgeann L. Iacono Russell (Px #13), $1,374.00, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The Arbitrator notes that the invoices from 4 of the medical providers, West Suburban Medical Center (Px #13), University of Illinois Medical Center (Px #14), Dr.

Georgeann L. Iacono Russell (Px #18), and Dr. Ondrej J. Chudoba, (Px #19), indicate that various insurance companies, including "HFN W/C" and "WORKERS COMP," paid for much of the medical care and applied numerous adjustments.

Yet, Respondent is not asserting a credit pursuant to Section 8(j) of the Act. (Ax #1, Ax #2) Therefore, the Arbitrator draws the reasonable inference that other sources, perhaps Petitioner's husband's group insurance, paid for much of Petitioner's medical care. Petitioner made co-payments on some of the medical bills.

Petitioner did not testify with regard to the medical bills.

The parties did not clarify the amounts actually paid by other sources, and the invoices are old.

Notwithstanding these deficiencies, and pursuant to the Court's holding in *Tower Automotive v. Illinois Workers' Comp. Comm'n*, 943 N.E.2d 153, 341 Ill. Dec. 863 (1st Dist. 2011), the Arbitrator also awards Petitioner the total of the amounts actually paid by these other sources and Petitioner to (1) West Suburban Med. Center (which includes the $36,898.00 amount paid to them by Blue Cross Voucher), (2) University of Illinois Medical Center, (3) Dr. Georgeann L. Iacono Russell, and (4) Dr. Ondrej J. Chudoba.

With regard to the $720.00 expense for the vocational rehabilitation evaluation, the Arbitrator finds that this expense was for a report prepared in anticipation of litigation. Ms. Entenberg did not provide Petitioner with true vocational rehabilitation, vocational testing, or job placement. Therefore, the Arbitrator finds that Respondent is not liable for such expense as the services provided to Petitioner by Ms. Entenberg do not fall under Section 8(a) of the Act.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD, TPD, Maintenance", the Arbitrator finds the following:

Petitioner claims to be entitled to temporary total disability benefits for the period December 1, 2009 through September 24, 2012. (Ax #1, Ax #2)

Petitioner further claims to be entitled to temporary partial disability benefits from September 25, 2012 through October 29, 2012, the date of hearing. (Ax #1, Ax #2)

Respondent claims to have paid temporary total disability benefits from December 1, 2009 through September 11, 2012, but denies further liability for any

additional claimed temporary total disability benefits after September 11, 2012. (Ax #1, Ax #2)

Petitioner agreed with Respondent's statement that they claim to have paid $83,462.19 to Rosa Arreola in TTD benefits. (Ax #1, Ax #2)

Respondent relies on the opinions of Dr. Noren, who found that Petitioner did not have CRPS / RSD and was able to return to work full duty. However, Dr. Noren did not disagree that Petitioner had limited function of her right upper extremity due to her work injuries. (Rx #1, pp. 105-106) Dr. Noren testified that an orthopedic surgeon or an FCE evaluator would be "better at objectifying, greater than what I felt comfortable stating." (Rx #1, pg. 95) He agreed with Petitioner's attorney that any restrictions regarding her right upper extremity would be based on Petitioner's treating orthopedic surgeon, Dr. Romano, and the FCE. (Rx #1, pp. 100-102)

The Arbitrator notes that while the first FCE was not valid, it did not recommend that Petitioner return to her previous custodial position. The Arbitrator further notes that the second FCE, performed 3 months later, was, in fact, valid and provided recommendations consistent with Dr. Romano's permanent restrictions.

Dr. Noren testified that he was not provided with the second FCE. (Rx #1, pg. 101)

Respondent's vocational rehabilitation expert, Kathleen Dytrych, opined that various light positions would be appropriate for Petitioner, given her work history and experience. Petitioner's vocational rehabilitation expert, Susan Entenberg, concurred with most of the positions identified by Ms. Dytrych. All of the positions identified were [illegible]. (Rx #2, Px #3)

Respondent terminated Petitioner's employment on January 25, 2011, for her failure to return to her regular work assignment within 12 months of her injury. (Px #2)

Petitioner conducted a self-directed job search from February 4, 2012 through June 27, 2013. Ms. Entenberg reviewed Petitioner's job search log and felt that Petitioner conducted a good faith, self-directed job search, especially without formal assistance. Ms. Dytrych never reviewed the job log.

Petitioner was able to find a job within her restrictions working for the Illinois Coalition for Immigrants and Refugees. Her job title is Oath Ceremony Coordinator.

She is charged with registering new citizens to vote. This was a position she volunteered for prior to being hired. Petitioner testified that she earns $1,000.00 per month at this job. However, according to the Commitment of Employment document signed by Petitioner, she earns $250.00 per week. (Px #5) Petitioner began working for the Illinois Coalition for Immigrants and Refugees on September 25, 2012 and continues to do so. (Px #5)

The Arbitrator finds that the work restrictions Dr. Romano imposed on Petitioner are appropriate, including the permanent restrictions he provided on October 29, 2012, which are consistent with the valid FCE.

Respondent is therefore liable to pay temporary total disability benefits (TTD) to Petitioner at a rate of $538.49 per week for 147 weeks, which represents the period from December 1, 2009 through September 24, 2012.

Respondent is also liable to pay temporary partial disability benefits (TPD) to Petitioner for 5 weeks, which represents the period from September 25, 2012 through October 29, 2012. Temporary partial disability benefits shall be equal to ⅔ of the difference between the average amount that Petitioner would be able to earn in the full performance of her duties with Respondent and the gross amount she was able to earn within her restrictions. Petitioner's average weekly wage is $807.74. Petitioner's current gross wages are $250.00 per week. Therefore. Petitioner is entitled to receive from Respondent ⅔ of the difference, or $371.83 per week, for 5 weeks.

Respondent is also liable to pay maintenance benefits to Petitioner for a period of 208-5/7 weeks, which represents the period from October 30, 2012 through October 27, 2016, at the same rate of $371.83 per week.

Respondent shall receive credit in the amount of $83,462.19 for TTD benefits paid.

In support of his decisions with regard to issues (L) "What is the nature and extent of the injury?", and (O) "Is Petitioner entitled to a wage differential award, pursuant to §8(d)1 of the Act?", the Arbitrator finds the following:

Based on the foregoing, the Arbitrator finds that Petitioner sustained an injury to her neck and right shoulder on May 27, 2009 (case #09 WC 49383). The Arbitrator further finds that Petitioner's right shoulder was aggravated as a result of the injury

sustained on November 4, 2009 (case #09 WC 49384), and she sustained additional injuries to he right hand, elbow and right knee. Petitioner also suffered psychological injuries as a result of her claims.

Petitioner's right shoulder injury required surgical intervention, including repairs to Petitioner's rotator cuff and labrum. She developed tendonitis in her right hand, de quervain's syndrome and an aggravation of her carpal tunnel syndrome, which required physical therapy and injections. Her hand became swollen and discolored. She became increasingly guarded. She underwent pain management treatment for a diagnosis of CRPS / RSD, which involved two stellate ganglion block injections that caused adverse reactions. Petitioner was ultimately prescribed a spinal cord stimulator, which she declined due to fear of the procedure. She continues to take Gabapentin for her symptoms.

Petitioner's pain began to spread to the opposite extremity, which Dr. Romano confirmed is a hallmark of RSD. Dr. Romano also testified that Petitioner's left hand was becoming symptomatic due to overuse, as she had been avoiding using her right upper extremity.

Petitioner testified that she continues to have swelling in her right hand and arm. She applies ice and analgesic cream to both areas every day. Her ring and middle finger are numb and tingly. She often wakes up with her right arm much colder than her left. She testified that her husband helps her to get dressed. She continues to drive with her left hand only. In the bathroom, she cannot clean herself with her right hand. She pays neighbors to do her laundry, clean her house and carry grocery bags. Petitioner testified that she could no longer perform the physical functions required in the custodial position, such as moving heavy furniture, lifting heavy boxes, shoveling snow, or carrying heavy buckets of water to wax and strip the floors.

On October 29, 2012, Dr. Romano placed Petitioner at MMI, with permanent light-duty restrictions, consistent with the valid FCE, that include maximum lifting 20 pounds, no pushing or pulling, rarely lift, carry, push or pull, limited use of right hand, rare repetitive motion of the limb and occasional overhead reaching. Petitioner testified that after she was terminated by Respondent for failing to return to work full duty within the prescribed time, she attempted to return in a different capacity, such as work in the

cafeteria or as a crossing guard. According to Petitioner, no other position with Respondent was available.

Petitioner has no experience in the skilled workforce. She completed only 4 years of school in Mexico. She can read basic English but has difficulty writing in English. She has no computer skills. Her only other education or training was a one-week sanitation course in 1994. She is currently 64 years old.

Nonetheless, Petitioner's vocational expert Susan Entenberg opined that Petitioner "loves helping the people," that is, the new citizens whom she meets in her job at the Illinois Coalition for Immigrants and Refugees. (Px #8, pg. 27)

Respondent retained a vocational counselor, Kathleen Dytrych, to perform a vocational assessment. She met with Petitioner on 1 occasion and did not assist her in finding a job. Ms. Dytrych agreed that according to Dr. Romano's restrictions, Petitioner cannot return to her previous position as a custodian.

Susan Entenberg also met with Petitioner on 1 occasion. She testified that Respondent's job description of a Custodian includes duties that are beyond Petitioner's permanent restrictions, as provided by Dr. Romano and the valid FCE. She opined that Petitioner is therefore precluded from pursuing her usual and customary line of employment as a Custodian.

Petitioner testified that she conducted a self-directed job search. The Arbitrator has reviewed the job search log and notes there are 348 names of prospective employers. (Px #3) The dates in the job search log are from February 14, 2012 through June 27, 2013. In the log, one of the handwritten pages is duplicated. For some of the entries, Petitioner did not include the date of contact. Many of the jobs that Petitioner identified had physical requirements that exceed Petitioner's restrictions, such as the janitorial jobs. Many of jobs listed were internet job postings. Petitioner testified that she received assistance from a friend, Salome', who helped her apply for jobs online. There is no evidence that Petitioner received any electronic confirmation of any inquiry she made from any prospective employer. (Px #3)

Ms. Entenberg reviewed Petitioner's job search logs and felt that Petitioner conducted a good faith, self-directed job search, especially without formal assistance. Ms. Dytrych never reviewed the job logs.

Ms. Dytrych opined that Petitioner is capable of working in certain unskilled jobs as a housekeeper in a hotel setting, assembler or work with laundry, in a pantry or kitchen. She did not provide any details regarding Petitioner's potential future wages, nor did she conduct a labor market survey. At the time of her deposition, Ms. Dytrych was not aware that Petitioner had found employment. (Rx #2, pg. 57)

Petitioner currently earns $250.00 per week, which would equate to $12.50 per hour for 20 hours per week, in her job for the Illinois Coalition for Immigrants and Refugees. She would like to work full time in this position.

The parties stipulated on February 25, 2016 that "had Rosa not been injured her current yearly income with Respondent would be $49,388.00 pursuant to the collective Bargaining Agreement." (Ax #1, #2)

In order to qualify for a wage differential award under Section 8(d)(1), a claimant must prove: (1) partial incapacity which prevents her from pursuing her usual and customary line of employment, and (2) an impairment of earnings. *Ulbrecht v. Indus. Comm'n*, 271 Ill.App.3d 756, 648 N.E.2d 923 (1995)

The Arbitrator finds that the permanent restrictions as provided by Dr. Romano, and those given by the evaluator of the second FCE preclude her from returning to her previous job as a Custodian.

The Arbitrator further finds that Petitioner has suffered an impairment of earnings. Petitioner provided evidence of 16 months of job searches through June 27, 2013. She continued her job search efforts for 9 months after finding employment with the Illinois Coalition for Immigrants and Refugees. Despite her efforts, she was unable to find any other employment. Respondent offered no vocational assistance. Ms. Entenberg felt that Petitioner should continue to work in her current position as she felt it was a very appropriate job for her and within her restrictions. However, Ms. Entenberg, Petitioner's expert, then testified:

> "I felt that she had realistically an earning capacity of about $8.50 to $10.00 an hour, even if we look at a full-time basis. And given her background, the types of jobs that would be appropriate for her and given her restrictions would be jobs such as an information clerk - - sort of like what she is doing now - - a restaurant hostess, a desk clerk, all running between 9 to $10 an hour. So, 8.50 to $10 an hour at that time [2011]." (Bracketed content added) (Px #8, pp. 27-28)

Ms. Entenberg further testified at her August 18, 2015 deposition that based on the most recent Illinois Department of Employment Security and Occupational Employment Statistics from 2014, the hourly wage for these same jobs range between $8.79 and $9.96 per hour.

The Arbitrator finds that the Court's holding in *Crittenden v. Illinois Workers' Comp. Comm'n*, 273 N.E.3d 654, 411 Ill. Dec. 570 (1st Dist. 2017), is applicable:

"In making the calculation of a wage differential under section 8(d)(1) of the Act (820 ILCS 305/8(d)(1) (West 2012)), the Commission must determine "the average amount which [the claimant] is able to earn in some suitable employment or business after the accident." In calculating this average amount, if the claimant is working at the time of the calculation, the claimant must prove his actual earnings for a substantial period after he returns to work, and the Commission may apply his then current average weekly wage to the calculation. *** However, as in the case at bar, if the claimant is not working at the time of the calculation, the Commission must rely on functional and vocational expert evidence. *** We note that in the case where the claimant is working at the time of the calculation, but functional and/or vocational evidence is submitted which is sufficient to determine another suitable occupation for the claimant, there is nothing in section 8(d)(1) of the Act (820 ILCS 8(d)(1) (West 2012)) that would prevent the Commission from utilizing such evidence to determine the average weekly wage the claimant could make in some suitable employment as set forth in this opinion, and *vice versa.*"

The *Crittenden* court defined "suitable employment" as employment in which the claimant is both able and qualified to perform. Although Dr. Romano and the FCE evaluator imposed permanent restrictions, neither of them limited Petitioner to part-time work.

Based on the opinions of Susan Entenberg, Petitioner's vocational expert, and the Court's holding in *Crittenden*, the Arbitrator finds that Petitioner is capable of earning $9.38 per hour (the average of $8.79 and $9.96) on a full-time basis, which would be $375.20 per week.

The parties stipulated on February 25, 2016 that Petitioner's wages with Respondent would be $49,388.00, or $949.77 per week. (Ax #1, Ax #2)

Therefore, Respondent shall pay Petitioner permanent partial disability benefits, commencing October 28, 2016, of $383.05 per week (= ($949.77 - $375.30) x ⅔) for the duration of the disability, because the injuries sustained on May 27, 2009 and November 4, 2009, caused a loss of earnings, as provided in Section 8(d)1 of the Act.

In support of his decision with regard to issue (F) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds the following:

Petitioner filed a petition seeking penalties and attorneys' fees under Sections 16, 19(g) and 19(l) of the Act. (Px #6) The intent of penalties and fees "is to implement the Act's purpose to expedite the compensation of industrially injured workers and penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee." *Avon Products, Inc. v. Industrial Commission*, 82 ILL.2d 297, 301; 412 N.E.2d 468, 470 (1980). Penalties for delayed payment are intended to 'promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment for other than legitimate motives." Id. 412 N.E.2d 468 at 470

Petitioner alleges a pattern of late TTD benefits from December 29, 2009 through June 2, 2012. (Px #6)

According to Respondent's TTD payment history log, TTD was timely paid for the period December 1, 2009 through December 14, 2009, and paid at least 10 days late for the period December 15, 2009 through December 28, 2009. (Px #9, Dep. Ex #1) After January 7, 2010 (the date on which the TTD check was created for the second half of December 2010), Respondent did not resume paying benefits until April 29, 2011, approximately 16 months later. The payment history log shows a DATE CREATED of April 29, 2011 for the period December 29, 2010 through April 12, 2010, and a DATE CREATED of May 9, 2011 for the period April 13, 2010 through April 12, 2011. Respondent offered no explanation whatsoever for the termination of benefits. Mr. Duffy, Supervising Adjuster for Respondent's TPA, could not explain this delay. (Px #9, pp. 19-20) No written termination letter was submitted into evidence. Mr. Duffy acknowledged that it would make sense that TTD was paid shortly after receiving the

report from Dr. Preston Wolin, Respondent's Section 12 examiner. (Px #9, pp. 19-20; 26-31) The Arbitrator finds this delay to be unreasonable and vexatious.

If one were to carefully examine Respondent's TTD payment history, one would find, in addition to the 16-month gap above, 5 other pay periods in which the DATE CREATED (i.e., the date the TTD check was created) is 14 or more days after the DATE OF SERVICE TO date (i.e., the last day of the pay period), and no reasonable explanation is offered for the delay. (Px #9, Dep. Ex.#1)

The first period was from April 13, 2011 through April 26, 2011. The TTD check was created on May 11, 2011, which was 15 days after the end of the period. (Px #9, Dep. Ex. #1) No termination letter was sent. No explanation was given for the delay. The Arbitrator finds this delay to be unreasonable and vexatious.

The second period was the second half of June 2011. The two-week period began on June 22, 2011. The DATE CREATED was August 1, 2011. The difference between the last day of this two-week period and August 1, 2011 would exceed 14 days. No termination letter was sent. No explanation was given for the delay. The Arbitrator finds this delay to be unreasonable and vexatious.

The third period was from August 31, 2011 through September 13, 2011. Although the payment history log shows that the TTD check was created on September 22, 2011, which was 9 days after the end of the period, Petitioner has proven that TTD check # 2456118 was not issued until October 19, 2011. Petitioner actually included a copy of the check. (Px #9, Dep. Ex. #5) No termination letter was sent. Mr. Duffy's explanation for this delay was not persuasive. The Arbitrator finds this delay to be unreasonable and vexatious.

The fourth period was from January 4, 2012 through January 17, 2012. The TTD payment history log shows that the check was unfunded on February 17, 2012, but was funded on February 21, 2012, which was 5 weeks after the end of the period. Respondent provided a written denial of TTD on February 3, 2012. At that time, Adjuster Sharla Gatson wrote that TTD was terminated because Petitioner is receiving Social Security Disability benefits. (Px #6, #9, pp. 52-56) Even Mr. Duffy agreed that this is a violation of Commission Rule 7110.70, requiring a written denial to be sent on the last date TTD was due. (Px #9, pg. 52) Mr. Duffy also agreed that Ms. Gatson's justification for denial

is "absolutely not" a good faith reason for denying TTD and is a violation of Illinois law. (Px #9, pp. 52-56) The Arbitrator agrees with Mr. Duffy. The Arbitrator finds this delay to be unreasonable and vexatious.

The fifth period was from January 18, 2012 through January 31, 2012. The TTD payment history log shows that the check was unfunded on February 17, 2012, but was funded on February 21, 2012, which was 3 weeks after the end of the period. On February 21, 2012, Ms. Gatson provided another written denial. (Px #6, Ex B) On this occasion, she explained that TTD was stopped because Petitioner had been terminated from her employment on January 25, 2011, which was 1 year prior to Ms. Gatson's denial. (Px #6, Ex B) Petitioner did not reach MMI until October 29, 2012, and therefore, pursuant to the Supreme Court's 2010 holding in *Interstate Scaffolding v. Illinois Workers' Comp. Commiss'n*, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010), the Arbitrator finds that Respondent did not have a good faith basis for terminating TTD benefits. The Arbitrator finds this delay to be unreasonable and vexatious.

When Respondent terminated benefits on September 11, 2012, they relied on Dr. Noren's opinions in his August 16, 2012 report in which he found Petitioner capable of returning to full-duty work. Although the Arbitrator has found the opinions of Dr. Romano, Dr. Torres and the UIC Pain Center physicians to be more persuasive than those of Dr. Noren, the Arbitrator finds that Respondent had a good faith basis for terminating benefits on September 11, 2012.

The Arbitrator finds that the delayed TTD benefits at issue total $41,461.72 ($8,076.90 + $27,999.92 + $1,076.98 + $1,076.98 + $1,076.98 + $1,076.98 + $1,076.98). (Px #9, Dep. Ex. #1)

Section 19(l) of the Act states in part, "In case the employer or his or her insurance carrier shall without good cause and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow the employee additional compensation in the sum of $30 per day for each day that benefits...have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19l (2010) Payment of an award of 19(l) penalties is mandatory "if the payment is late, for whatever reason, and the

employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Indus. Comm'n*, 183 Ill.2d 499, 515; 702 N.E. 2d 545, 552 (1998).

Section 19(k) of the Act states that the Commission may award additional compensation equal to 50% of the amount payable at the time of the award, "where there has been any unreasonable or vexatious delay of payment..." 820 ILCS 305/19k (2010) Attorneys' fees under Section 16 are appropriate when penalties under Section 19(k) are appropriate. 820 ILCS 305/16 (2010) Penalties and attorneys' fees under sections 19(k) and 16 are "intended to address situations where there is not only delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 702 N.E.2d 545, 553; *Oliver v. IWCC*, 2015 Ill. App. 1st, 143836WC.

For the foregoing reasons, the Arbitrator awards 19(l) penalties to the extent of $30.00 per day, not to exceed $10,000.00, for a late period in excess of 16 months, which represents the amount of time that compensation was unjustly withheld from Petitioner, pursuant to Section 19(l) of the Act. Therefore, the Arbitrator awards 19(l) penalties of $10,000.00.

The Arbitrator also awards 19(k) penalties of 50% of the $41,461.72 in TTD benefits in which there were unreasonable and vexatious delays in the payment of such benefits. Then, $41,461.72 x .50 = $20,730.86 in 19(k) penalties.

Because Petitioner did not reduce the unpaid medical bills, where applicable, to fee schedule-adjusted amounts, in accordance with Section 8.2 of the Act, the Arbitrator finds that Petitioner failed to prove entitlement to penalties and fees on unpaid medical bills in which no reasonable explanation for denial of payment has been asserted.

Finally, the Arbitrator orders Respondent to pay attorney fees to the extent of 20% 19(k) penalties, which would be $4,146.17.

Brian T. Cronin
Arbitrator

7-18-17
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derrick McCoy,

Petitioner,

vs.

NO: 15 WC 39733

Paragon Systems, Inc.,

18IWCC0786

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, causation, temporary total disability, medical expenses and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

Petitioner a 45-year old protective service officer (PSO), testified that he started training in January and began working for Respondent in August of 2015. (T.14). As part of his training, he noted that "[w]e did Ash Baton. We did speed cuffing, handcuffs, we did OC, which some people call it maze or pepper spray. We did weapons training. We did CPR. We also did the Smart Book… [or] procedures from the client that they want us to go by." (T.14-15). He indicated that the client was the Federal Government, and that part of his training would require physical training in endurance. (T.15). He stated that before he was hired he would "…have to pass all of the training courses, you have to pass all of those, the background check. You also have to pass a physical." (T.16). He noted that you would not get hired if you didn't pass the physical, and that the physical consisted of push-ups, sit-ups, running on a treadmill for 15-30

minutes and stretching. (T.17). He indicated that the physical took about an hour, an hour-and-a-half, and that he did not have any difficulty passing it. (T.17). He was then hired as a PSO, after which there was a 90-day probation period. (T.18). He indicated that he did not have any difficulties during this probation period. (T.18). He noted that prior to 11/26/15 he did not have any difficulties performing his job. (T.19).

Petitioner was shown PX1, a Certificate of Appreciation awarded to him on 10/8/15 by the Director of Security in recognition of his outstanding work. (T.19-20). He agreed that he worked as a PSO at all times after he was permanently hired by Respondent. (T.20). He testified that his general duties as a PSO involved "... protect[ing] the federal properties, the federal employees, the general public." (T.20). He noted that to carry out these duties "[w]e did several things, we did screening as far as for when they enter the properties. We would screen everyone to make sure they have no weapons, no explosives. We would check the properties out to make sure there is no suspicious packages that were left. We would keep an eye out on everyone entering the building, make sure all federal employees were taken care of and secure. We make sure that the threat level was minimum. It wasn't that high." (T.21). He indicated that "[w]e pretty much walked all day. We had a 15 minute break, but outside of that, we are walking all day." (T.21). He agreed he was on his feet the majority of the day walking or standing. (T.21-22). He noted that his shift varied from 8 to 12 hours, and that on an average day he spent the "[m]ajority, 90 percent" of his time walking or standing. (T.22). He indicated he was able to sit part of the shift at "[s]ome locations, but not many." (T.22-23). He noted he worked 30 to 40 hours a week, and that he worked "[t]here to four [days], sometimes five" days a week. (T.25).

Petitioner testified that on 11/26/15 he was assigned to "Delta 400 which is mobile patrol." (T.23). He later noted that this was Thanksgiving Day. (T.42). He indicated that he had never worked that shift before, so this was the first day he had to drive at work. (T.23). He noted that "[a]s mobile patrol, I was given a list of properties to go and physically inspect them. So I would drive to the locations, get out of the vehicle, go inside and walk through, make sure there is no suspicious package, no one broke into the location, everything was secure. And also I would walk around to the back of the dock and all around the property on the outside and inside." (T.24). He indicated that his duties in rover patrol on the date in question required a lot of walking and standing "... because I had to go to each property, get out, physically inspect each property, and then get back into the vehicle, drive to the next location, get out, go inside, and also walk around each property." (T.24).

Petitioner testified that on 11/26/15 he started work at "0800", or for the uninitiated, 8:00 a.m., and that he was scheduled to work until 4:00 p.m., or "1600." (T.26). He noted that the night before he was feeling "[e]xcellent" and that his right knee was likewise "[e]xcellent" when he got to work on 11/26/15. (T.27). He indicated that the occurrence happened at "[a]round 10:45", and that prior thereto he did not have any difficulty walking or standing. (T.28-29). He noted that at the time of the incident he was "[i]n front of the 450 [Federal] garage... responding to a call [from dispatch over the radio] of an employee stranded inside the garage that couldn't get out." (T.28-30). He testified that "I got to the 450 garage. I pulled in front. I put the car in park. And then I quickly proceeded to go inside the garage to get the employee that was inside there out." (T.30). He noted that "[w]hen I pulled up, I put the car in park. And then I opened up the driver's door, and I proceeded to start to step down out of the truck towards the ground,

which is, it's a nice lift from the truck to the ground. And I started with my left leg out of the vehicle, and then I slipped and lost my footing and twisted my right knee. It was slippery and wet inside the truck... The flooring, the floor board was slippery and wet." (T.31). Petitioner testified that "[i]t was raining outside, it was moist and wet inside of the truck... [i]t was wet, it was wet from water from my feet, from getting in and out, and it was moist inside the vehicle." (T.31). He noted that "... there was no resistant mats inside. So it was a smooth surface. There was no grip, no friction to keep you from sliding inside." (T.31-32). When asked what caused his right knee to twist as he was exiting the truck, Petitioner stated: "I was rushing, I was rushing out of the vehicle, moving quickly to go get the employee out, and I lost my footing by slipping inside of the truck... [o]n the wet surface..." (T.32).

Later, when asked to explain why he was rushing to get out of his truck, Petitioner testified that "I take my job very seriously and the threat level is high because we are dealing with the general public. And we're the security that's contracted under the Federal police to make sure that the Federal employees and the general public is well taken care of, well secure. So I take each incident, each call very seriously." (T.54). He also claimed that he generally rushes or walks quickly to perform his duties while working as a PSO for Respondent. (T.54).

Petitioner was shown a photograph of the truck at RX5A. (T.32). He acknowledged that all of the photos were of his truck. (T.33). Using the photo as a reference, he testified that he "... put the car in park. Then I opened up the door. Then I started to step down with my left leg, and with my right foot, and I lost my footing, slipped and twisted, and my knee twisted and popped while I am trying to get down out of the truck. There was no step down bar to step on to the step down. I was a nice little distance, my feet being in there, it was slippery and wet inside. I twisted and popped my knee." (T.33-34).

Petitioner testified that after the incident "I had to pause because I was in a lot of pain. And I had to pull myself back up and sit in the truck because I couldn't hardly move at all. It was throbbing and aching." (T.34). The Arbitrator noted the record should reflect that Petitioner was pointing to his right knee. (T.34). Petitioner indicated that following the incident he felt "[s]harp pain, aching, it was stiffness, unbearable." (T.34-35). He noted that if the occurrence hadn't happened, he was going to get out of the truck and use his PIF or Federal I.D. card to open the garage door and let the employee out. (T.35-36). However, he indicated that he was in so much pain that he instead "... drove up to the garage, used my key card, and then drove inside the garage, drove throughout the garage and then they drove out behind me." (T.36-37).

Petitioner testified that he continued with his patrols thereafter, noting that "I didn't know that I was that hurt, and I had my shift to finish, and I thought I could withstand the pain, and it was just so much pain." (T.37). He went on to note that "... I was in a lot of pain. I was hobbling at each location. As soon as I got out, I exited the vehicle and went inside each property, so I was hobbling, hobbling through the whole day, trying to make my rounds around the properties inside and outside." (T.37). He indicated that "[i]t was very difficult for me to get out and walk throughout the buildings, and I had to sit and take a couple extra breaks." (T.38). He also noted that he had difficulty with standing because "[t]here was so much pain, I had to put all my pressure on my right leg and try to keep the pressure off of – I had to put all the pressure on my left leg, to keep all the pressure off of my right knee." (T.38).

Petitioner testified that after he left work that day he "... went home, I ate with my family, and then I started to put ice, Icy Hot, I started to put heat on my leg. I started taking Ibuprofen and then I wrapped it up." (T.38). It was noted for the record that Petitioner indicated his right knee. (T.38-39). Petitioner stated that the next day he "... was in more pain." (T.39). He noted he worked that day because "I have bills and I was scheduled to work." (T.39). He stated that he was "... in a lot of discomfort... [a] lot of pain" when he was at work, and that "[i]t was very bad for me to do my duties that day." (T.39). He indicated that "[t]he other employees, they saw how much pain, how much [*sic*] hurt I was, so they helped me to do my job that day because I couldn't really go up and down the escalators to open them, to turn them on, to turn them off, to make the rounds around the outside of the properties. They helped me out, the other employees helped me out throughout the whole day." (T.39-40). He noted that he would sit at his desk while they helped him. (T.40). He also stated that his assignment that day was "Alpha, which is the supervisor at that location right there." (T.40). He indicated that "Alpha duties are desk duties, they [*sic*] you have to let the employees and also the general public in and out of the doors. When they enter the other side of the building, you have to go outside to do patrols around the building on the outside perimeters. You have to turn on the escalators and also make a round throughout the building." (T.40-41). He testified that without the help of his co-workers he "... wouldn't be able to do none of the work, none of the work." (T.41). He indicated that prior to 11/26/15 he never had any difficulty performing any of his duties. (T.42).

Petitioner testified that after he finished his shift on 11/27/15 he "... went home, and I put ice and some more heat and Icy Hot on my knee, and put ice on it, too, then I wrapped it up and laid down, and I took Ibuprofen again." (T.42). He indicated that he was not scheduled to work the next two days, Saturday 11/28/15 or Sunday 11/29/15. (T.43). He noted that during those two days he was "... in a lot of pain and discomfort" and that he "... put Icy Hot on it [his right knee] everyday, rubbed in heat every[ ]day, put ice and also I wrapped it up, and laid down in the bed and just relaxed." (T.43).

Petitioner indicated that he worked on Monday 11/30/15 because "I was scheduled to work and I have bills to pay." (T.44). He stated that on that day he "... was in so much pain standing in the lobby at the 230 building. I spoke to Lt. Clark, and I asked him, I told him, I said, I'm in a lot of pain and I hurt myself and I need to do an Incident Report." (T.44). Petitioner agreed that Lt. Clark is one of his supervisors. (T.44). He indicated that this was not the first time he told a superior or supervisor about his work-related accident, and that "[t]here was a lieutenant that was in the class with me, in the training class, I told him about it" after he got hurt on Thanksgiving Day, noting that "I told him I hurt myself in the truck when I was responding to a call." (T.45-46). He also stated that he "... spoke to the captain about it, briefly" on 11/26/15 when he was at the 230 building. (T.46). He noted that he eventually prepared a written report "[a]fter I talked to Lt. Clark, and he said he did not have access to none of the Incident Reports, so I would have to come back the following day [11/30/15] or so in order to get the Incident Report." (T.46-47). Petitioner testified that he did not make out an incident report before 11/30/15 "... because I didn't think it [*sic*] had to do one. I thought I would get over the pain and keep it moving, so I didn't do an Incident Report." (T.47).

Petitioner testified that he first sought treatment following the accident the day after he talked to Lt. Clark, or on Tuesday 12/1/15. (T.49-50). He indicated that he sought treatment at

that time because he "... was in so much pain, unbearable pain." (T.50). He noted that he waited until then because he "... thought I could withstand the pain, and I thought the pain would probably go away." (T.50). He noted that on 12/1/15 he visited Doctors Immediate Care at which time he "... told the doctor I got hurt at work." (T.50-51). He agreed that he also told the doctor how he got hurt. (T.51). He also agreed that even though the note did not state that his foot slipped on the wet floor of his cab, that is what happened. (T.52). He noted that the doctor (Dr. Sheeba Mahnaz) examined him and wrote a couple of referrals, and also sent him for x-rays of his right knee. (T.53). He also agreed that she prescribed Ibuprofen and took him off work at that time. (T.53).

X-rays of the right knee performed on 12/1/15 at Salt Creek Medical Imaging revealed 1) Arthritic changes; 2) Spurring and irregular calcification involving the infrapatellar and distal quadriceps tendon attachments to the patella and tibial tubercle, and 3) Small spur versus loose body along the medical aspect of the intercondylar notch. (PX5). In the intake form filled out by Petitioner at that time, when asked whether this was a Work Comp claim, he stated: "No Not Yet." (PX5).

Petitioner was shown PX5, a history he filled out when he visited Salt Creek Medical Center for his x-rays. (T.56). When asked why he indicated on this form that it was not a work comp claim "yet", Petitioner testified that he "... thought maybe my pain would go away and I won't have to do – I didn't even do an Incident Report. So I thought the pain would go away and it didn't." (T.57). He agreed that when he talked to Lt. Clark on 11/30/15 he wasn't sure if he was going to file a workers' comp claim. (T.57). Petitioner indicated that he gave this note to his employer. (T.64).

Petitioner indicated that he followed up with Dr. Mahnaz on 12/2/15 at which time she "... gave me a return to light work, with restrictions, and also she gave me referral to have an MRI done and also for therapy" for his right knee. (T.58). He noted that he had the MRI of his right knee performed at Illinois Bone & Joint on 12/17/15, noting that he had to wait until then for the company to approve same. (T.59). He agreed that he paid for both visits to Dr. Mahnaz and for the x-ray; however, he noted that he did not pay for the MRI because he couldn't afford it. (T.60). Petitioner agreed that he was billed for the MRI as well as the subsequent visit with Dr. Forman. (T.68). He also agreed that Dr. Mahnaz gave him light duty restrictions on the date of this visit. (T.63). Petitioner indicated that he gave this note to his employer. (T.64-65).

In an office note dated 12/2/15, Dr. Mahnaz of Doctors Immediate Care recorded a history of "...right knee pain for 6 Days. On Thanksgiving 11/26/15 he was at work at Paragon [S]ytems as a Protection Security Officer, he had to drive his truck to get a customer who was stuck in the garage on his patrol, as he tried to get out of the truck he turned and felt the right knee pop and has a limp from pain since then..." (PX4). It was noted that x-rays of the right knee revealed arthritic changes, loose spur medial to intercondylar notch, calcification of infrapatellar tendon. (PX4). The assessment was sprain/strain of the right knee/leg. (PX4). Petitioner was given a knee brace, referred to an orthopedist and sent for an MRI. (PX4). He was also given a slip that stated he could do "[l]ight duty, may do desk job" as of 12/3/15. (PX4).

In a notarized statement dated 12/3/15, Petitioner indicated, in part, that he "... received a

call from Mega Center that there's an employee stuck inside of the 450 garage they can't open up the doors. Writer D. McCoy pulled up in front of the 450 garage put the truck in park and opened up the truck door and then started to get out of the truck to go in[]side of the garage. I stepped one leg out of the truck and twisted my knee and heard a pop sound I paused for a couple minutes because I was in pain. Then I got all the way back in[]to the truck and drove to the doors and use[d] my key card and drove throughout the parking lot looking to rescue whoever was locked inside of the garage. There was only one person in their car they exited the garage behind me after I drove out. [T]hen I [c]ontinued my [p]atrol when I was the lieutenant I went over to talk to him, [h]e asked me was I ok I responded yes I should be I just twisted my knee getting out of the truck responding to a call at [t]he 450 garage. Then I went inside 77 West Jackson the Alpha sitting at the desk open[ed] up the door for me and said in a joking way are you okay I hope I don't have to do a report on you to[]day. [I]t started raining hard outside so I dropped off the pso lady that was giving out breaks to [t]he 536 building and [c]ontinued my patrol..." (PX2).

Petitioner was shown PX2, which he noted was a written statement he prepared on 12/3/15. (T.47). He noted that he "... did this myself because Lt. Clark said he did not have access to any of the Incident Report forms. So I typed this out and I gave it to [one of the lieutenants], this was everything that happened that day." (T.48).

In an "Employee Injury Report" dated 12/5/15, Petitioner noted that he was injured "[i]n the Company Truck in front of the 430 Building while I was getting out of the truck responding to a call [illegible] Employee back in the garage." (PX3). When asked the cause of the injury, Petitioner noted "[n]o slip resistence [*sic*] mats. Step down running boards." (PX3). He indicated that he was first aware of the injury "[w]hen I tried to get out of the Truck." (PX3). When asked when he first notified his supervisor of the injury, Petitioner stated" "I seen [*sic*] the Captain and Lieutenant the same day of the Injury but did not think it was serious to do a report. On November 30, 2015 I asked my Supervisor to do a report, because I was in a lot of pain standing." (PX3). He noted that the body part affected was "[m]y Knee (Right)." (PX3). When asked whether anyone witnessed the accident, Petitioner stated "[n]o, [b]ut there was [*sic*] several people aware of the injury on my Shift." (PX3).

Petitioner was shown PX3, which he noted was a true and accurate copy of an Employee Injury Report which he filled out on 12/5/15. (T.49). He indicated that he was eventually given this report to fill out, and that he gave it to his supervisor on that day (12/5/15). (T.49).

An MRI of the right knee performed on 12/17/15 revealed "[c]omplex tearing of the lateral meniscus with a flipped meniscus as described. High-grade chondromalacia of the patellofemoral joint. Small to moderate popliteal cyst. Abnormal appearance of the insertion of the patellar tendon which may represent the sequela of Osgood-Schlatter disease. Correlation with point tenderness is recommended." (PX6).

Petitioner agreed that after he obtained the results of the MRI he visited Dr. Forman at Illinois Bone & Joint in Chicago, Illinois on 12/21/15. (T.60). He indicated that he still had a lot of pain and discomfort in his right knee at that time, which he described as "... unbearable, sharp pain, stiffness." (T.61). He noted that he provided Dr. Forman a history of injury, and that Dr.

Forman examined him and reviewed the x-rays and MRI before recommending surgery and sedentary work restrictions. (T.61-62). He indicated that he gave this note to his employer. (T.65). Specifically, Petitioner stated that he gave this and the other notes to the lieutenant, his supervisor at work, "[a]s soon as they gave it to me..." (T.66). He testified that Respondent never allowed him to return to work after he gave them these restricted duty notes. (T.66).

In a "Medical History Form" completed by Petitioner at the time of his visit to Dr. Edward Forman on 12/21/15, Mr. McCoy stated that the injury occurred when he "[t]wisted my right knee getting out of truck." (PX6).

In a "Referral Letter" dated 12/21/15, Dr. Forman recorded that the patient "... tells me that he was working on Thanksgiving Day 2015, as a security officer in Federal Buildings in Chicago, when he was getting out of the truck in a garage to let a stranded employee out of the garage. He states when he got out, it was raining and he twisted his knee. He has had pain and discomfort ever since. He felt a pop and has had swelling in there as well. He reported this... He comes in today in evaluation and consultation. No previous history of injury or trauma reported." (PX6). Upon examination, Dr. Forman noted "[q]uite a bit of lateral joint line tenderness with a positive McMurray test." (PX6). He indicated that x-rays demonstrated "normal bony anatomy" but that an MRI performed on 12/17/15 revealed a torn lateral meniscus. (PX6). He also noted a prominent tibial tubercle "... consistent with old Osgood-Schlatter disease." (PX6). Dr. Forman's impression was internal derangement of the right knee. (PX6). Dr. Forman recommended arthroscopy for the torn lateral meniscus in the right knee. (PX6).

In a "Work/School Status Report" dated 12/21/15, Dr. Forman indicated that Petitioner could return to sedentary work as of 12/22/15. (PX9).

In a "Narrative Report" dated 3/22/16, Dr. Forman noted a diagnosis of internal derangement of the right knee, and that "...while the patient denied any previous history of injury or trauma to the right knee prior to this episode, I do feel that the patient's condition was causally connected to the work episode as reported." (PX10). He stated that this opinion was based on "[t]he medical examination including obtaining the history from the patient as well as the physical examination and review of diagnostic studies." (PX10). Dr. Forman noted that he had "... recommended an arthroscopy for Mr. McCoy's right knee. I felt that if this were to be able to be performed, this should help to take care of his pathology and get him back to his normal activity."(PX10). However, Dr. Forman stated that he could not "... comment on maximum medical improvement as when I saw him on December 21, 2015, I have recommended an arthroscopy and I have not seen him subsequent to this." (PX10).

Petitioner testified that he would like to have the recommended surgery because "I want to get healed and I want to go back to work..." (T.63). He indicated that Dr. Forman has never given him any notes returning him to full duty work. (T.66). He agreed that Respondent paid him TTD for part of the time he was off work, and then cut him off. (T.66-67). He also agreed that he is asking the Arbitrator to award him any underpayment of TTD as well as TTD until Dr. Forman releases him to return to work. (T.67).

On cross examination, Petitioner agreed that he was driving a Chevy Silverado pick-up

truck on the date of the incident, although he did not know the model year, and that the photos he was previously shown by his attorney depict the vehicle he was driving. (T.70). He indicated that during the approximately 2 hours and 45 minutes he worked prior to the incident he went to several buildings, including the 610 Canal and 77 Jackson locations. (T.71-72). He estimated on average it would take him about 30 minutes to perform his duties in each building. (T.72-73).

When asked why he had the statement he prepared notarized, Petitioner replied: "[t]o make it a legal document." (T.73). He agreed that by getting it notarized he was basically swearing that the information contained therein was accurate. (T.73-74). He agreed that in this statement he represented that he had decided to park his truck outside the garage at 450 Federal and walk inside. (T.75). He also agreed that he could have used his PIF card to open the garage door and drive in. (T.75). When asked why he decided to walk instead, Petitioner stated that he "... had no need to drive inside of the garage. I take the PIF card, put it in, drive right out." (T.76). When asked if he knew for sure where the employee was, Petitioner testified that he "... didn't know exactly which location inside of the garage they were at. I just knew they were in the garage... I didn't know for sure" that they were at the exit door. (T.76). He indicated if they were not there, his plan was to "[w]alk up the ramp." (T.76). Petitioner explained that he "... was going to put the PIF card in and whoever couldn't get out – we have a lot of PIF cards, some of the cards don't work, but the ones we have, they do work. A lot of employees have cards and their cards don't work all the time. There is a lot of people get stranded inside of the garage." (T.77). He noted that there was "... maybe like five or six, maybe eight floors" in the garage" and that "[t]hey could be anywhere in the garage." (T.77-78). However, he conceded that he "... wasn't going to walk up eight floors or nine floors of the building..." and that there was nothing preventing the employee from driving down. (T.78-79).

Petitioner agreed that even though it was raining he still decided to walk to the garage door as opposed to drive inside, noting that he "... just wanted to get out of the truck, put the PIF card in, and whoever was in there, they could come right out." (T.78). He agreed that according to his statement he stepped out of the vehicle with his left leg and twisted his right knee while his right leg was still in the car. (T.79-80). He also agreed that his right foot was still kind of located near the pedals of the car when he began to push off his right foot, and that he twisted his right knee when he "... lost my footing and slipped..." (T.80). He agreed that he was still sitting in the car at this time. (T.80-81). He also agreed that in the paragraph where he describes the actual accident, he does not mention that he slipped because it was wet. (T.81-82). He likewise agreed that nowhere in this statement does he claim that he was rushing. (T.82).

Petitioner agreed that after the incident he decided to drive the vehicle into the garage to find the employee. (T.83). He indicated that he subsequently found the employee, although he could not remember on which level the employee was found. (T.83). He agreed that after he let the employee out he continued his patrol, and that he later saw the lieutenant, although he could not recall his name. (T.83-84). He also agreed that he told the lieutenant about his knee and the accident. (T.84). He likewise agreed that his training included what to do when you sustain a work-related injury, although he claimed not to recall what they told him to do. (T.84-85). However, he indicated that "... I know we [are] suppose[d] to report it to, if anything happens, to our, to our supervisor." (T.85-86). He also agreed that they told him "[t]o do an Incident Report." (T.86). However, Petitioner acknowledged that he "... did not do an Incident Report

that day. I told the lieutenant exactly what happened. And he asked me to drive him to a location, and I drove him to that location. And he said, come upstairs, I couldn't go upstairs because I was in so much pain, I couldn't get out of the truck. He did not say, let's do an Incident Report. He said, are you okay. I said, I should be okay." (T.86). He noted that the lieutenant "... got into the vehicle with me, and I drove him to the office... He told me to come upstairs and I was in so much pain, he said don't worry about [it], stay inside of the truck. Then he came back down and he went with me when I went to make a couple, couple rounds." (T.87). Petitioner agreed that his statement does not mention that the lieutenant got in the car with him. (T.87-88). He stated that he saw the lieutenant at two locations, first at 77 Jackson and then at the 230 building. (T.88).

When asked again why he did not complete an accident report on 11/26/15, Petitioner testified that he "... went inside 77 Jackson, the alpha was setting [*sic*] at the desk. I opened, he opened up the door for me, and he said, in a joking way, are you okay, I hope I don't have to do a report on you today." (T.88-89). Petitioner stated that he decided not to complete an Incident Report that day because he "... thought the pain would go away and I didn't think it was that serious." (T.89). When counsel pointed out to him he previously testified that he was in a lot of pain, Petitioner testified that "I'm a big guy and I felt the pain would go away." (T.89). He indicated that he had had pain like that "[h]ere and there" before. (T.89).

Petitioner indicated that he saw a captain later that day named Captain Abrams, and that he "... spoke to him briefly. He was going home that day when I spoke to him briefly." (T.90-91). When asked whether he reported the accident to Captain Abrams that day, Petitioner replied: "[w]ell, reported, well, they were aware because I told them about it, but as far as doing a report or anything like that, no." (T.91). He noted that Captain Abrams "... saw me hobbling because I went to the 230 building, he saw me hobbling. I told him what happened." (T.92). Petitioner stated that he told Cpt. Abrams "I hurt myself responding to a call at the 450 building." (T.92). When asked why Cpt. Abrams decided not to write a report at that time, Petitioner indicated that "[h]e was going home" and "[w]e were outside the 230 building..." (T.92).

Petitioner agreed that did not see a lieutenant at all the next day (11/27/15). (T.92-93). He also agreed that his right knee pain became worse overnight from 11/26 to 11/27/15. (T.93). He likewise agreed that if he had seen a lieutenant on 11/27/15 he would have reported the injury and completed the Incident Report. (T.93). However, he claimed that as of 11/27/15 he did not believe that this was a workers' compensation claim, although he believed it warranted an Incident Report. (T.93-94). He indicated that there is "[s]upposed" to be a lieutenant on duty at all time, but that he "... was Alpha for that day (11/27/15) and I couldn't leave that location, from the building, I couldn't leave the building and go to another location." (T.94). When asked whether he had cell phone numbers or contact information for the lieutenants, Petitioner stated that "[i]t's at the location" and that whether he had that information "... varies, because there is a phone, and I think they pass it around to different people." (T.94). He indicated that if there is an emergency he is supposed to call "Mega Center first, call one of the supervisors, between them and the Mega Center for the emergency." (T.95). He agreed that he had contact information for supervisors "... at the post." (T.95). When asked why he didn't contact the lieutenant that day to report the injury, Petitioner testified that "[a]s far as I, when we worked that day, the lieutenant

they're like, they usually go and hide, they usually are not available, not available like that. If you call them, probably take a long time to respond, unless you call through Mega Center to call for the lieutenant." (T.95).

Petitioner agreed that his knee pain continued to get worse over the weekend. (T.96). He noted that he did not call the lieutenant that Saturday or Sunday because he "... was off and I was at home doing home treatment myself, as far as heat, ice, wrapping it, and trying to rest, hoping it would improve." (T.96-97). He agreed that on 11/30/15 he reported the accident to Lt. Clark, which led him to complete the Incident Report dated 12/5/15. (T.97-98). Petitioner stated that Lt. Clark "... told me he didn't have access to any Incident Reports. He couldn't get no forms for me to fill out. I would have to come back the following day in order to get, to do an Incident Report." (T.98).

Petitioner denied having any issues with his right knee prior to 11/26/15, and he did not recall any prior issues with or taking any medication for his right or left legs. (T.98). Petitioner initially could not recall "offhand" having a conversation with PSO Eric Fowler. (T.99). He then stated that there were two people who asked him to switch so they could sit, "... one white guy and one black guy..." (T.100). He agreed that one guy had an injury of his own and wanted to switch so he could sit. (T.101-102). However, Petitioner stated that he did not switch with this individual, and "... the supervisor called me and said, hey McCoy, is it okay for you to go upstairs and stand in the lobby and let this guy downstairs? And I said, well, if you want me to, I'll do it. But if that's not my job duties then I'm going to stay here and do my position what I am supposed to do. I don't want to do anything else outside of that. If you are telling me to go upstairs, I will go upstairs and stand in the lobby." (T.102). Petitioner said they ended up not switching, noting that the lieutenant "... said McCoy, you don't have to. I'm not forcing you to go upstairs and stand in the lobby. So don't worry about it. Stay there at your post." (T.103).

Petitioner was asked about the Employee Injury Report he completed on 12/5/15. (T.104). He agreed there is no mention in this report of rushing out of the vehicle. (T.105). He also agreed the first time he saw a doctor was on 12/1/15, and that he told that doctor that he tried to get out of the truck, turned and felt his right knee pop. (T.106). He was shown Dr. Mahnaz's record for that date and agreed there was no mention in the history about it raining or his foot slipping when he went to get out of the vehicle on the date of the accident. (T.106-107).

Petitioner agreed he was involved in a motor vehicle accident in August of 2014. (T.108). He stated that he was rear-ended, noting that "I was at the spotlight and someone hit my car from the back..." (T.108). He indicated he was driving his personal car at the time, a 2003 Jeep Liberty. (T.108). He noted that this was still his personal car as of 11/26/15. (T.109). Petitioner was shown a photograph (RX4) of what he acknowledged was an accurate depiction of what his car looked like, and still looks like. (T.109). Petitioner disputed that the step down and into the Chevy Silverado was similar to the Jeep Liberty, noting that "[t]he height, you would need like what they call 'step down bars' to step down out of the truck [Chevy Silverado] because it is a cab, and then you have to step down out of cab from the truck down, so it's different." (T.110-111). He then conceded that he would have to measure the heights to see if there was a difference. (T.111).

On re-direct, Petitioner noted that in the Employee Injury Report from 12/5/15 (PX3) he mentioned that the cause of the injury was "[n]o slip resistant mats, no step down running boards." (T.112). He indicated that he wrote this because "[i]t was wet inside. There was a smooth surface inside of the truck, and I lost my footing inside of there. And there is no grip, as far as gripping inside of the truck, like resistant mats. And then stepping out, there is no step down bar to get from the height of the vehicle down to the concrete of the ground." (T.113). As a result, he was of the opinion that the work truck caused or contributed to his objection [*sic*], noting that "[m]y opinion inside of the truck it is a smooth surface like this glass here, and when it is wet, your foot is going to move around. There is no friction, as far as resistant mats, something with grooves in it to keep your feet from sliding and moving around. And then as far as the height of the truck, you are stepping down out of the truck to reach the ground. So if there was a step bar there, you could step on the step bar and then proceed to go down, it would be a lot easier." (T.114). He indicating that placing slip resistant mats in all the trucks would "... give[] your feet a lot of grip, that way your foot won't be sliding and moving around." (T.115).

Petitioner agreed that he never told anyone, including the doctors, that the floor of his cab was dry or wasn't wet. (T.116). He also indicated that he was not hurt as a result of the August 2014 car accident, noting that "[t]hey hit my car from the back. They hit the bumper. I was okay. Allstate paid for the bumper. There was no claim filed. There was no injury, no medical, no nothing." (T.118).

On re-cross, Petitioner noted that the shoes provided by Respondent "... hurt my feet, but these [that he was wearing at arbitration] are similar, law enforcement boots." (T.119). He indicated that he was wearing these shoes on 11/26/15. (T.119). When asked if they are slip resistant shoes, Petitioner stated that "[o]n a surface like this, and your feet is [*sic*] wet, it is going to slide... The surface inside the truck is a smooth surface. You can glide your hand like this, like this, it is a very smooth surface." (T.119-120). He noted that the inside of the truck was "... hard plastic, smooth, like this, no grip." (T.120). He described the boots that he was wearing as "[l]aw enforcement boots, all of the police, military, security wear these boots." (T.120). He noted that "[i]f they get wet, then it will, on this type of carpet, it is great, if there is friction, it is great. But if it is smooth surface, it will slide." (T.121). He reiterated that these were the same boots that he was wearing on 11/26/15. (T.121).

Under questioning by the Arbitrator, Petitioner noted that the Jeep he drove, as his personal vehicle, did not have running boards and was lower to the ground because of the weight. (T.121-122). He also indicated that there was no mat of any type in the truck he was driving at work, just a smooth surface made of hard plastic. (T.122).

Jerry Lemke was called to testify by the Respondent. Mr. Lemke indicated that he has worked for Respondent for four-and-a-half years and that his current title is program manager. (T.124). He noted that his job duties are "[s]upposed to be the caretaker, if you would, SOW, which is State of Work for Contracts, for a variety of contracts. Supposed to know all of the items in that contract and how to execute that contract with our hired officers and to insure that the client is receiving the service that they paid for." (T.125). He stated that "I have contracts, first of all, the entire State of Illinois for the FPS, which is the Federal Protective Service, under Homeland Security." (T.126).

Mr. Lemke testified that he oversees approximately 204 PSO's in Northern Illinois, with 8 lieutenants and one captain. (T.127). He indicated that they provide approximately four weeks of training to PSOs prior to beginning work, and that as part of this training they are provided with classes or guidelines as to how to report work-related injuries. (T.127-128). He noted that "[f]irst of all, PSO's are given a Security Officers Handbook. In that Security Officers Handbook are many of the policies that the company has. Each PSO has to sign for one of those handbooks. In regards to incidents and accidents, the PSO is told to report that incident as soon as possible, but not later than 24 hours." (T.128). He indicated that PSOs are to provide notification of work-related injuries "[d]irectly to their supervisor. If their supervisor isn't available, then to the captain. If the captain is not available, then I get that report." (T.128). He noted that lieutenants are on duty at all times, and that an injury can be called in or "... any kind of way, but it must be reported as quickly as possible." (T.129). He indicated that if the PSO is "... in pain or there is some life-threatening injury or something like that, [the lieutenant or captain is] going to provide First Aid, and also get medical help as quickly as possible. Secondly, they have the reporting responsibility to insure that the statement are [*sic*] made from PSA, their own statement of observation, and also the Incident Report." (T.129-130). He noted that these guidelines are mandatory. (T.130).

Mr. Lemke testified that one of the three vehicles that someone in the 400 Delta position would drive while on duty is a Chevy Silverado, and that the vehicle depicted in RX5A-5F would be that vehicle. (T.133-134). He described the garage at 450 Federal (where the incident occurred) as "... a six-story garage facility that has an entrance and an exit which are roll-up doors, those are electronically controlled. It also has a single access door immediately to the right of the entrance door, but that's, that door is rarely used." (T.135).

On cross, Mr. Lemke stated that "[t]here are rubber mats inside that truck [that cover the entire floor]... [and] [t]here is some type of tread on there...," although he could not say whether they are slip resistant or are slippery when wet. (T.142-143). He testified that he did not have a chance to look at the truck Petitioner was driving on the date of the incident, and that he did not see if there were any mats inside the vehicle. (T.144-145).

Mr. Lemke indicated that Petitioner did not notify him of a work accident. (T.149). However, he noted that "[a]s along [*sic*] as the captain knows and the report went in, I would later on know from that, from the reporting procedures." (T.149). He stated that Petitioner did email him "... a statement that I had asked for, that was way, I would probably say at least two weeks into the matter." (T.149). When it was pointed out that Petitioner gave statements on 12/3/15 and 12/5/15, Mr. Lemke stated: "[r]ight now, I'm not sure of the dates. I know it was much later than the incident." (T.150).

On re-direct, Mr. Lemke acknowledged he has never driven the 2007 Chevy Silverado in question, but he has been driven in it. (T.153). He noted over a four-year period he may have ridden in that vehicle "... maybe a dozen times", or about three times per year. (T.153-154). He indicated the truck in question has a "[p]ermanent mat that goes all the way across and underneath the truck itself." (T.154). He stated it is not something that is laid down or pulled out." (T.154). He also indicated that he would recommend disciplinary action for any lieutenant or captain that did not report or notate a work injury that was reported to them. (T.155).

On re-cross, Mr. Lemke testified that the permanent mat in question was not hard plastic but rubber that was "... pretty pliable." (T.155-156).

Paul Suski was called to testify by the Respondent. (T.157). Mr. Suski indicated that he has worked for Paragon Systems for about five years. (T.157). He noted that his current title is lieutenant supervisor, and that his "[j]ob duties consist of insuring that all schedules are put out to the security officers themselves, do random and post inspection checks, daily occurs. Also any paperwork that has, if the PSO gets checked in, any issues that the PSO might have, resolve that, take it to appropriate management." (T.158). He agreed that part of his training includes what to do when someone reports a work-related injury. (T.160). He noted that "[w]e are taught as soon as humanly possible to get a report done, full detail of what happened, where it happened, what might have caused it, the accident to happen. We have a general list of guidelines we have to follow that we must report right away." (T.161). He agreed that a PSO can report an injury in person or over the phone to either a supervisor, lieutenant or captain. (T.161). He also agreed that when he is on duty as a lieutenant/supervisor he has a cell phone on him at all times, and that all PSOs currently working on that shift have his contact information. (T.161-162). He likewise agreed that he is trained to fill out an accident report every single time a PSO reports an injury, no matter what. (T.162).

Mr. Suski testified that he is familiar with the 400 Delta position, and that a PSO in that position would drive either a 2000 Chevy Silverado or a 2012 Toyota Corolla, as well as a Ford Escape in an emergency. (T.163). He indicated that he took the photos of the 2007 Chevy Silverado shown in RX5A-5F. (T.163-164). He stated that these photos accurately reflect the vehicle the PSO was driving in the 400 Delta position. (T.164). He noted the gentleman standing next to the vehicle in RX5F is named John Jones, and that Mr. Jones stands "[f]ive, eleven." (T.165). Mr. Suski stated that his personal vehicle is a 2015 Nissan Quest. (T.165). He indicated he has driven the 2007 Chevy Silverado and that the two vehicles are "[f]airly the same." (T.165). He noted that he has driven the Silverado "[a] lot, sir, at least 75 percent of the time." (T.166). He indicated that he works five days a week and would drive that truck "[a]t least four times" a week. (T.166).

Mr. Suski testified that the Silverado they use "... is a work truck... due to the interior of the vehicle itself because it's one of those where you abuse it, because it's designed to use at the job site, instead of having cloth seats, it's interior with rubber flooring." (T.166). He noted that the floor "... goes all around the whole vehicle. It does not detach at all. It does have little rivets on it for foot support, getting in and out of the vehicle." (T.167). She stated that he had driven this vehicle when it was raining outside and he has never personally had any issues with his foot slipping. (T.167).

On cross, Mr. Suski agreed that the rubber floor covering is permanent and does not detach. (T.168). He also indicated that this rubber flooring did not have big textured dents, "... just very small minimal, trucks got wear on it a little bit, so, it has a little bit in there, but not much." (T.168). In addition, he stated that to his knowledge this vehicle has had the same flooring since 2007, the model year. (T.168-169). He also agreed that the vehicle has been used basically everyday by Paragon Systems officers, and that officers would step in and out of this vehicle multiple times a day. (T.169). However, he testified that over the five years he has

worked there that the flooring has not worn down any, noting that he has checked. (T.170). He agreed it would not be inaccurate to say that there were no floor mats on the floor, just that the whole bottom was rubber flooring. (T.171). He likewise agreed that when it is raining, water can get on the rubber flooring and that there is nothing to prevent the rubber flooring from getting wet. (T.171-172). However, he noted that he "... never really noticed puddles of water or anything." (T.172). He agreed that when he took the above referenced photos he did not take any photos of the mat. (T.173). He testified that the program manager instructed him to take photos of the outside of the vehicle. (T.173). He also indicated that he has never actually spoken to Petitioner. (T.173).

Mr. Suski testified that the vehicle in question was inspected "[p]robably within the next few days, when I got into it. I'm not sure if anybody else inspected it, but I know I have inspected it." (T.174).

On re-direct, Mr. Suski agreed that the flooring has some sort of texture or little ribs, and that when he has driven this truck when it is raining he has never noticed any puddles inside. (T.175). He indicated that he wears the employer provided boots or shoes when he works as a lieutenant, and that when he has driven this truck wearing those shoes he has never noticed any puddles or anything accumulating inside the vehicle, including when it is pouring rain. (T.176).

On re-cross, Mr. Suski conceded "[i]t's possible" that water can get on the rubber flooring of the vehicle when it's wet outside and you step in and out of the vehicle. (T.176-177).

Eric Fowler was called to testify by the Respondent. (T.177). Mr. Fowler noted that he has worked for Paragon as a PSO for five years next month. (T.178). He stated that his job duties vary from building to building, but that the "... majority is to check ID's and screen individuals that enter Federal facilities." (T.178). He indicated that "... part of the 40-hour [training] class if you get hurt, you are supposed to report to the lieutenant or whoever is on duty that's higher." (T.179). He also noted that you can "[a]bsolutely... call the duty phone, call the on-duty supervisor no matter what. If you can't specifically get to your lieutenant, that is the on-duty supervisor for the day." (T.179). In addition, he indicated that if you are working a certain shift a phone number is always provided to you. (T.179-180).

Mr. Fowler noted that he is familiar with Petitioner, and pointed him out in the courtroom. (T.180). He testified that he knew Petitioner "[f]rom the job, I run into him from time to time on different posts." (T.180). Mr. Fowler indicated that he recalled a conversation with Petitioner in October of 2015, noting that at that time he "... came in to work, it was a Friday, and I had a minor tear in a hamstring. I'm also military. So I was training and I fell into a pothole. The post I had come into that day, that Friday evening was a 2:15 post to 6:30, but it is a standing on your feet post. I was sore that day. I'm always early for work so I had talked to the lieutenant [Gillery] and asked him if there was a possibility that I could switch to a sit down post... Lieutenant Gillery told me that he would make some calls and see what I could do, and in the meantime I had spoke[n] with the captain [Steven Abrams] as well... He had told me Officer McCoy was down at 101 Juliet which is the post that's in the basement of 230 South Dearborn, and it is a sit down post, and he had been there since 6 a.m. and was working until 6 p.m. And he would probably be the officer that would be likely to switch with me because he had been

sitting all day." (T.181-182).

Mr. Fowler indicated that he then asked Petitioner to switch with him and Mr. McCoy "... told me yes at first and that he wanted to speak to a lieutenant to make sure that it was okay to do the switch. So we got into talking, basically, while we were standing there. And then he started to talk about him being hurt himself. And I said, oh, you're hurt, and he said yes. He opened up, he had a black bag, opened up his bag and started to show me different medications that were in his bag. Two of them looked like they were prescription and one of them maybe like Tylenol or something." (T.184). Mr. Fowler stated that he then "... went to grab my bag, come back downstairs – and he, now he wants to talk to the lieutenant. So we called the lieutenant to get the approval of the lieutenant, and now he says he doesn't want to switch with me anymore because his injury was bothering him." (T.184). He noted that Petitioner did not mention which body part was affected, although he "gathered" it was the lower extremity because "... that's why he wanted to sit." (T.184). As a result, Mr. Fowler agreed that he ended up having to stand on his torn hamstring the rest of his shift. (T.186). He indicated that he has not spoken to Petitioner since that time. (T.186).

On cross, Mr. Fowler agreed that he did not like that Petitioner refused to switch with him. (T.187). He also noted that he "heard rumors" that Petitioner had hurt his right knee falling out of a vehicle sometime around Thanksgiving. (T.187). In addition, he agreed that he did not know what medications Petitioner had in his bag since he did not have an opportunity to read them. (T.188). He also agreed that most officers don't like having to stand all day and that standing in this job can be "brutal." (T.188). He stated that he was unable to talk to anybody else about switching because Petitioner "... wasted my 15 or 20 minutes that I could have found somebody else, I would have now been late for my post." (T.189).

Conclusions of Law

An employee's injury is compensable under the Workers' Compensation Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (West 2006). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill.2d 478, 483, 546 N.E.2d 603, 137 Ill.Dec. 658 (1989). Arising out of the employment refers to the origin or cause of the claimant's injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill.2d 52, 58, 541 N.E.2d 665, 133 Ill.Dec. 454 (1989). "In the course of the employment" refers to the time, place, and circumstances under which the claimant is injured. *Scheffler Greenhouses, Inc. v. Industrial Commission*, 66 Ill.2d 361, 366, 362 N.E.2d 325, 5 Ill.Dec. 854 (1977). Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill.2d at 57; *Wise v. Industrial Commission*, 54 Ill.2d 138, 142, 295 N.E.2d 459 (1973).

A "traveling employee" is one who is required to travel away from his employer's premises in order to perform his job. *Jensen v. Industrial Commission*, 305 Ill.App.3d 274, 278, 711 N.E.2d 1129, 238 Ill.Dec. 468 (1999). The determination of whether an injury to a traveling employee arose out of and in the course of employment is governed by different rules than are

applicable to other employees. *Hoffman v. Industrial Commission*, 109 Ill.2d 194, 199, 486 N.E.2d 889, 93 Ill.Dec. 356 (1985). As a general rule, a traveling employee is held to be in the course of his employment from the time that he leaves home until he returns. *Urban v. Industrial Commission*, 34 Ill.2d 159, 162-63, 214 N.E.2d 737 (1966). However, a finding that a claimant is a traveling employee does not relieve him from the burden of proving that his injury arose out of and in the course of employment. *Hoffman*, 109 Ill.2d at 199.

The test for determining whether an injury to a traveling employee arose out of and in the course of his employment is the reasonableness of the conduct in which he was engaged and whether the conduct might normally be anticipated or foreseen by the employer. *Howell Tractor & Equipment Co. v. Industrial Commission*, 78 Ill.2d 567, 573-74, 403 N.E.2d 215, 38 Ill.Dec. 127 (1980). Under such an analysis, a traveling employee may be compensated for an injury as long as the injury was sustained while he was engaged in an activity which was both reasonable and foreseeable. *Wright v. Industrial Commission*, 62 Ill.2d 65, 71, 338 N.E.2d 379 (1975).

In the present case, the Commission finds that Petitioner was a traveling employee in that his job as a protective service officer (PSO), specifically his assignment to "Delta 400" mobile patrol on the date of the alleged injury, required him to drive in a work vehicle from one location to another in order to physically inspect multiple and varied properties secured by the Respondent. Furthermore, the Commission finds that Petitioner's actions in performing these work activities – particularly exiting his work vehicle in order to access a parking a garage and come to the aid of a stranded worker – was both inherently reasonable and foreseeable under the circumstances.

Therefore, based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds, based upon the traveling employee doctrine, that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries that arose out of and in the course of his employment on 11/26/15.

The Commission also finds that Petitioner's current condition of ill-being is causally related to the accident on 11/26/15 based on the chain of events as well as the opinion of Dr. Forman as reflected in his narrative report dated 3/22/16. (PX10). Specifically, Dr. Forman stated that "...while the patient denied any previous history of injury or trauma to the right knee prior to this episode, I do feel that the patient's condition was causally connected to the work episode as reported." (PX10). He stated that this opinion was based on "[t]he medical examination including obtaining the history from the patient as well as the physical examination and review of diagnostic studies." (PX10). The Commission notes that Respondent offered no medical opinion to refute Dr. Forman on this point.

In addition, in light of the above findings as to accident and causation, the Commission finds that Petitioner is entitled to temporary total disability benefits from 12/1/15, or the date he first sought treatment and was taken off work by Dr. Mahnaz (PX4), through 4/18/16, the date of arbitration, for a period of 20 weeks (including the extra leap year day in 2016). The Commission notes that while Dr. Mahanz released Petitioner to light duty work on 12/3/15 and Dr. Forman released him to sedentary work only on 12/21/15, no such work was provided by Respondent within his restrictions. Furthermore, the evidence shows that no physician,

including Dr. Forman, has yet to release Petitioner to full-duty work as of the date of arbitration.

Furthermore, given the above findings as to accident and causation, the Commission finds that Petitioner is entitled to reasonable and necessary medical expenses totaling $2,224.00 as set forth in PX3-PX6, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

Finally, the Commission finds that Petitioner is entitled to prospective medical care and treatment in the form of right knee arthroscopic surgery to repair a torn lateral meniscus, as prescribed by Dr. Forman. This finding is based on the opinion of Dr. Forman as to the reasonableness and necessity of said treatment as well as the fact that as of the date of arbitration no medical provider has yet to find that Petitioner has reached maximum medical improvement.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated August 1, 2016 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $471.04 per week for a period of 20 weeks, from 12/1/15 through 4/18/16, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $2,224.00 as set forth in PX3-PX6, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the current treatment recommendations of Dr. Forman, including right knee arthroscopic surgery, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, 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 pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 2 1 2018
o:11/5/18
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Misuraca,
Petitioner,

vs.

No. 07 WC 57365

City of Chicago,
Dept. of Transportation,
Respondent.

18IWCC0787

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 maintenance, benefit rates 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, a 35-year-old asphalt laborer with a high school education, injured her left shoulder while raking asphalt on August 21, 2007. She underwent a series of five shoulder surgeries; the last, on April 2, 2015, being a total shoulder replacement. Petitioner was found to be at maximum medical improvement by surgeon Dr. Romeo on October 28, 2015 and was given sedentary work restrictions. Dr. Romeo revised those restrictions on April 7, 2016, allowing Petitioner to lift up to 10 lbs., but with no overhead or repetitive left arm work. On September 22, 2017, Dr. Anderson revised her restrictions further, allowing Petitioner to lift 15-20 lbs. on a frequent basis.

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Following her final surgery, Petitioner commenced a vocational rehabilitation program with MedVoc Rehabilitation in April 2016. The positions she sought included receptionist, front office person, administrative assistant and hostess.

Maintenance Benefits

Petitioner claims the Arbitrator erred by denying her maintenance benefits between June 24, 2016 and November 10, 2017. The Arbitrator found that between June 24, 2016 and April 11, 2017, Petitioner did not participate in good faith with her vocational rehabilitation program, nor did she with a self-directed job search thereafter. The Arbitrator found Petitioner did not want to work and considered herself unemployable, and that she offered up a never-ending "litany of excuses" why her job search tasks were incomplete or not performed.

Petitioner claims she was very diligent and motivated in her job searches, both self-directed and in conjunction with MedVoc Rehabilitation. Petitioner contends she fully cooperated with her vocational rehabilitation counselors and testified she did everything they asked of her. As proof, Petitioner points to MedVoc's Progress Reports and her 1,500-plus pages of job search logs. Petitioner claims she contacted over 1,000 companies in her years-long job search, applying for jobs online and in person, sending resumes and references, going on interviews, taking computer classes, meeting with vocational counselors and attending job fairs. Despite those efforts, Petitioner did not receive one job offer or one request for an interview.

The Commission notes that a claimant has an obligation to make good faith effort to cooperate in rehabilitation efforts. *Archer Daniels Midland Co. v Industrial Commission,* 138 Ill.2d 107, 561 NE2d 623, 149 Ill.Dec. 253 (1990). When there is a lack of good faith cooperation, termination of maintenance benefits is justified. *Hayden v Industrial Commission,* 214 Ill.App.3d 749, 575 NE2d 99, 158 Ill.Dec. 305 (1st Dist. 1991).

The Commission agrees with the Arbitrator that, contrary to Petitioner's claims, her job search efforts were lackadaisical. During the April 2016 to April 2017 period in which she worked with MedVoc, Petitioner showed resistance to applying for work when given numerous job leads, her voluminous job logs notwithstanding. She admitted there were instances where she did not contact the job leads provided to her by MedVoc. She admitted telling MedVoc that she thought it would be better for her to apply for jobs elsewhere than where they wanted her to look. She accused MedVoc of lying for suggesting she had customer service experience because she worked as a receptionist for a corporation. She admitted complaining to her attorney and getting him involved.

On June 24, 2016, Petitioner refused to apply for a job as a Guest Service Representative which would have required her to, "move, lift carry, push, pull and place objects less than or equal to 10 lbs." Although Petitioner claimed that job was not within her restrictions, the Commission notes that her restrictions then in effect permitted her to lift 10 lb. items; further, Petitioner had no disability or weight restrictions precluding her from lifting with her dominant right arm.

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Petitioner refused to apply for jobs requiring computer experience, claiming she had none. Although Petitioner was never given a specific restriction to not type, she claimed that typing was against her doctor's restrictions because her shoulder affects everything in her arm and hand. Petitioner self-limited her job search by avoiding sedentary jobs for which she was otherwise qualified because they involved typing. The Commission finds Petitioner's alleged typing "restriction" and claimed lack of computer experience belied by her admission that she spent three to four hours per day using a computer and keyboard at home. Petitioner spent that time sending emails, uploading and downloading documents, completing job applications and searching for jobs on multiple online internet sites.

Petitioner further self-limited her job search by refusing to consider jobs in certain geographical areas such as the north side of Chicago, less than 17 miles from her home, claiming as reasons her unfamiliarity or dislike of the neighborhoods. Given that Petitioner informed her attorney that for her, working in "bad" neighborhoods was "not a big deal," and that she, "used to work in a lot worse" neighborhoods, the Commission finds those excuses arbitrary and disingenuous.

The Commission finds Petitioner was not a credible witness. She denied many statements made to and by her voc counselors. Petitioner denied telling Ms. Warren that she should twist or word Petitioner's receptionist experience any way she liked. Petitioner denied having to be reminded to not bring her son with her when she applied for jobs. She denied that her MedVoc counselor informed her that her duties at prior employment at Smurfit could legitimately be considered customer service experience. Yet those statements and conversations were each documented in detail in MedVoc's Progress Reports dated May 16, 2016 and July 15, 2016.

Other examples of Petitioner's lack of credibility are in the record. When Petitioner was asked at arbitration whether she cancelled three meetings specifically scheduled for her to apply for a position at Robert Jeffrey Salon, she testified, *"Other than my parents being sick, I've never cancelled anything, no."* That testimony was contradicted by the July 15, 2016 MedVoc report which confirmed Petitioner did cancel multiple meetings at that salon – but not because her parents were sick. MedVoc counselor Warren wrote that Petitioner cancelled the initial appointment to complete an application at Robert Jeffrey Salon because her car was, *"still in the shop."* When MedVoc was able to reschedule the meeting for June 27, 2016, Petitioner declined to attend that one, too. Ms. Warren documented Petitioner's stated reason: *"she has some personal problems. Ms. Warren asked Ms. Misuraca if they could meet the following day. Ms. Misuraca indicated that she would have her son with her as he is too young to be left at home alone... Ms. Misuraca indicated that she would have to bring her son to the meeting. Ms. Warren recommended that Ms. Misuraca not do so when meeting at a prospective employer."*

Notwithstanding the above, the Commission does agree with Petitioner that the MedVoc Progress Reports show a minimal level of cooperation on her part with their vocational rehabilitation program. MedVoc's Progress Reports through April 2017 document that Petitioner did put forth some effort at seeking employment. The June 14, 2016 report acknowledged Petitioner had complied with MedVoc's job placement requests, "for the most part." The July 15, 2016, Progress Report acknowledged Petitioner met their requirements of making 10 employer

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contacts per week, with 5 of those in person. The Progress Reports between August and December 2016 documented similar compliance by Petitioner.

The Commission also acknowledges that emergencies can and did arise; and that some of Petitioner's excuses for missing appointments were legitimate. At times she was ill; her parents were hospitalized and her mother did pass away. For these reasons, the Commission finds Petitioner's nominal level of cooperation with her vocational rehabilitation program to be sufficient enough to entitle her to maintenance benefits during the period she worked with MedVoc Rehabilitation: from April 30, 2016 through April 11, 2017. The Commission finds maintenance benefits to Petitioner shall end on April 11, 2017; by that date it became apparent that Petitioner's job search efforts were substandard. The Commission does not believe Respondent terminated Petitioner's vocational rehabilitation program on April 11, 2017 because Respondent was "clearly satisfied" that she would conduct a productive self-directed job search on her own, as Petitioner suggests; but rather, because Respondent concluded that spending further resources on Petitioner would be fruitless.

Nature and Extent (PPD)

Petitioner claims the Arbitrator erred by finding her entitled to only a §8(d)1 permanency award and not an odd-lot permanent total disability ("PTD") award under §8(f) of the Act. Petitioner claims her unsuccessful job search efforts prove there is no stable job market for her: she made over 1,000 employer contacts; she attended all meetings with vocational rehabilitation counselors, completed a computer course, and complied with all aspects of her vocational rehabilitation program. The Commission finds Petitioner had not proven entitlement to a permanency award under §8(f).

An injured employee can establish entitlement to PTD benefits in one of three ways: by a preponderance of medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of their age, training, education, experience and condition, there are no available jobs for persons in their circumstance. *Professional Transportation, Inc. v. Illinois Workers' Comp. Comm'n,* 2012 IL App (3d) 100783WC, 966 N.E.2d 40.

Petitioner does not claim to be a medical permanent total. Instead, she claims her efforts at seeking employment prove that she completed a diligent but unsuccessful job search.

The Commission disagrees. It finds a pattern emerged which strongly suggested Petitioner was not motivated to find a job. Petitioner had to be told repeatedly by her counselors to be more aggressive in seeking employment. She dressed inappropriately for job interviews, showing up for one hostess job interview dressed in a T-shirt, baggy leggings and flip-flops. She brought her adolescent son with her when applying for jobs. She refused to provide her driver's license to a prospective employer who requested it. She persisted in telling prospective employers that she had no customer service experience. She self-limited her job search by

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applying to employers who were not hiring, by ruling out jobs which required typing, and by refusing to consider jobs in certain geographical areas. While a few of these actions might have been necessary, all of them were not.

The Commission finds Petitioner was not honest in her relationship with her MedVoc counselors. While Petitioner professed to be unwilling to lie and be totally honest with prospective employers, she lied to her MedVoc counselor. Petitioner promised her counselor that she would make a follow-up contact with a particular prospective employer, but then admitted to her attorney that she never had any intention of doing so.[1]

MedVoc Rehabilitation assisted Petitioner in revising her resume by suggesting language intended to make her a more attractive job candidate. Petitioner rejected MedVoc's suggestions and prohibited them from sending out the resumes they revised, purportedly because they were, "not honest." Instead, Petitioner sent prospective employers her own resume. Petitioner never offered into evidence the resume she sent to employers for the Commission to determine if it was prepared in good faith.

The Commission concludes Petitioner worked hardest at giving the appearance of an earnest job search by filling out numerous job logs, while simultaneously invoking a plethora of reasons to claim her job leads were unacceptable. The Commission questions whether Petitioner's words, actions and body language to prospective employers were the reason she was so often dismissed as a job candidate. For these reasons, the Commission does not find Petitioner's alleged one-thousand plus employer contacts and 1,500 pages of job search logs support her claim of being permanently and totally disabled.

The Commission also finds Petitioner failed to prove she could not find work based upon her age, training, education, experience and condition. Petitioner was only 46 years old at arbitration. She has a high school diploma. She has prior work experience as a receptionist, front desk clerk and a restaurant hostess – all jobs she could perform with her current restrictions. She has a driver's license and knows how to operate a computer. Her work restrictions are limited to her left arm. Petitioner's surgeon found her able to perform sedentary employment. Respondent's vocational rehabilitation counselor found Petitioner was able to be gainfully employed. Petitioner offered no contrary expert opinion that based upon her age, training education and condition, no work was available.

For the above reasons, the Commission finds Petitioner is not permanently and totally disabled under §8(f) of the Act and affirms the Arbitrator's §8(d)1 wage differential award.

§8(d)1 Benefit Rate

Section 8(d)1 of the Act mandates how wage differential awards are to be calculated. Such awards should be, "equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1.*

[1] PX7, 1115.

The Arbitrator calculated Petitioner's wage differential award by first finding Petitioner capable of earning a mean entry level wage of $11.65/hour, or $466.00 for a 40-hour week, based upon Respondent's Labor Market Survey (RX-1). The Arbitrator then subtracted that figure, $466.00, from Petitioner's stipulated average weekly wage of $1,262.52 (Arb. Ex. #1). Two-thirds of that figure is $531.01.

The $11.65/hour figure used by the Arbitrator represents the mean average of the entry level positions of: front desk, receptionist and customer service representative. The Commission agrees that the Arbitrator did not expressly identify those to be the occupations he found Petitioner now able and qualified to perform, a requirement which Petitioner argues was necessary, pursuant to *Crittenden v. Ill. Workers' Comp. Comm'n,* 2017 IL App (1st) 160002WC, 2017 Ill. App. LEXIS 104, 411 Ill.Dec.570. However, the Commission finds it obvious and apparent that the Arbitrator was referring to those occupations. Accordingly, the Commission finds Petitioner able and qualified to perform work as a front desk person, receptionist and customer service representative, and concurs that $11.65 per hour is the mean average starting wage for those occupations based upon Respondent's Labor Market Survey.

Petitioner argues the Arbitrator erred by using her stipulated average weekly wage, $1,262.52, as, "the average amount which she would be able to earn in the full performance of her duties in the occupation in which she was engaged at the time of the accident." Petitioner claims the Arbitrator wrongly denied her the opportunity to present evidence showing what a union asphalt laborer performing the same work as Petitioner did on the day of her accident would currently earn. Because that evidence was not put into the record, Petitioner now urges the Commission remand this matter to the Arbitrator to allow Petitioner the opportunity to offer that evidence.

The Commission declines to remand this claim to the Arbitrator solely to give Petitioner another opportunity to present evidence which was available but not offered at the time of arbitration. Without such evidence in the record, the Arbitrator did not err by using the stipulated average weekly wage in his §8(d)1 calculation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 18, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $841.68 per week for a total of 263-5/7 weeks for the periods: August 22, 2007 through June 30, 2008; September 16, 2008 through September 22, 2008; October 1, 2008 through February 15, 2010, and July 13, 2013 through April 29, 2016, those being the periods of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary partial disability benefits of $546.40 per week for a total of 11 weeks for the period commencing July 1, 2008 through September 15, 2008, that being the period for which Petitioner is entitled to temporary partial disability benefits under §8(a) of the Act.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $841.68 per week for a total of 227-1/7 weeks for the periods February 16, 2010 through July 12, 2013, and April 30, 2016 through April 11, 2017, those being the periods for which Petitioner is entitled to maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's Order that Respondent is entitled to a credit back for maintenance benefits paid from June 24, 2016 through November 10, 2017 is vacated. In its place, the Commission Orders that Respondent shall have credit for all amounts paid to or on behalf of Petitioner on account of said accidental injury, including amounts paid for temporary total disability, temporary partial disability and maintenance.

IT IS FURTHER ORDERED BY THE COMMISSION that the commencement date of Petitioner's §8(d)1 award is modified. Respondent shall pay Petitioner permanent partial disability benefits of $531.01 per week commencing April 12, 2017 for the duration of her disability, because the injuries sustained caused a loss of earnings as provided in §8(d)1 of the Act. The Commission affirms the Arbitrator's finding that Petitioner is capable of earning $11.65 per hour, or $466.00 per week, and affirms the Arbitrator's calculation of the §8(d)1 rate to be $531.01.

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: DEC 2 1 2018

o-10/24/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MISURACA, MICHELLE
Employee/Petitioner

Case# **07WC057365**

CITY OF CHICAGO
Employer/Respondent

18IWCC0787

On 12/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0010 CITY OF CHICAGO DEPT OF LAW
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michelle Misuraca
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 07 WC 57365

Consolidated cases: _____

18IWCC0787

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Cronin, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **11-07-17**. 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 Credit for maintenance to Respondent

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FINDINGS

On **August 21, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **65,641.04**; the average weekly wage was $**1,262.52.**

On the date of accident, Petitioner was **35** years of age, **single** with **1** dependent children.

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

Respondent shall be given a credit of $ **227,477.12** for TTD, $ **6,010.45** for TPD, $ **211,263.31** for maintenance, and $**0** for other benefits, for a total credit of **$ 444,750.88.**

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

ORDER

With respect to Petitioner's claims of injuries to her left arm, Respondent shall pay Petitioner permanent partial disability benefits of $ 531.01/week for the duration of disability, because the injuries sustained caused a loss of earnings, as provided in Section under Section 8(d)(1) of the Act. Petitioner is capable of earning $ 11.65/hour.

The Respondent is entitled to a credit back for maintenance benefits paid from June 24, 2016, through November 10, 2017, as Petitioner failed to meet her burden for entitlement to maintenance 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.

Arbitrator Kurt Carlson — 12-17-17 Date

DEC 18 2017

MICHELLE MISURACA V. CITY OF CHICAGO

07 WC 57365

FINDINGS OF FACT

The parties stipulate that the City of Chicago ("Respondent") was operating under the Illinois Workers' Compensation Act on August 21, 2017. On said date Michelle Misuraca ("Petitioner") sustained accidental injuries that arose out of and in the course of her employment with the Respondent. On this date she was working as an asphalt laborer for the City of Chicago. Petitioner was 35 years old on the date of this incident.

Parties proceeded to hearing on November 7, 2017, with disputed issues as to causation, nature and extent, and credit to Respondent for maintenance payments made from April 30, 2016 through November 10, 2017.

Medical History and Treatment

Petitioner testified that on August 21, 2007, she was using a "lute" to push a pile of asphalt, and she injured her left shoulder. Petitioner reported the incident to her supervisor and sought treatment that day at Mercy Works. X-rays were taken that day, which were negative for fracture or dislocation. (PX #1, p. 303). She was diagnosed at that time with left shoulder and left upper arm strain. (PX #1, p. 342). Petitioner was placed off work at this time. She underwent a MRI on August 30, 2007, which showed (1) small glenohumeral joint effusion, (2) questionable tiny bone contusion in the superolateral humeral head versus normal versus normal variation cellular type marrow, and (3) AC joint spurring indenting the supraspinatus should be correlated for any clinical signs of impingement. However, no rotator cuff tears were seen. (PX #1, p. 305).

Petitioner underwent surgery with Dr. Brian Cole on December 5, 2007, which was extensive glenohumeral debridement, microfracture of glenoid defect, and subacromial bursectomy. (PX #2, p.33). The post-operative diagnosis was left shoulder glenoid grade 4 articular cartilage defect, extensive glenohumeral articular synovitis, and subacromial bursectomy.(PX #2, p. 33). Petitioner underwent physical therapy following surgery. She received an injection to the subacromial space of her left shoulder on March 17, 2008. Petitioner returned to work light duty temporarily in a different department within the City of Chicago from July 1, 2008 through September 15, 2008. She then returned to off work status and received TTD benefits while treating.

Petitioner underwent a second operative procedure in the form of a glenoid osteochondral allograft with Dr. Cole on April 16, 2009, with post-operative diagnosis of left shoulder glenoid defect, articular cartilage and bony attrition anterior third. (PX #2, p. 112-113). Petitioner continued to follow up treatment with Dr. Cole, Mercy Works, and physical therapy.

Petitioner underwent a FCE on February 1, 2010 at Novacare, which found Petitioner in the medium physical demand level, with the ability to lift up to 30 lbs. occasionally. (PX #5, p. 10). Dr. Cole placed Petitioner at MMI with restrictions per the FCE on February 18, 2010. (PX #1, p. 184). On February 19, 2010, Petitioner was placed at MMI by Dr. Diadula at Mercy Works with restrictions of no lifting more than 30 lbs. floor to waist, occasionally and no more than 20 lbs. frequently; no lifting floor to shoulder more than 25 lbs., occasionally and 15 lbs. frequently; lift floor to shoulder no more than 20 lbs., occasionally and 15 lbs. frequently; carry (bimanual) no more than 25 lbs. occasionally, push no more than 35 lbs occasionally; and pull no more than 37 lbs. occasionally. (PX #1, p. 184)

Petitioner returned to Dr. Cole for treatment and Petitioner underwent a new MRI of the left shoulder on January 10, 2011, which showed the following impressions: (1) limited examination due to post-surgical metal artifact, (2) no evidence of full-thickness rotator cuff tear, (3) mild acromioclavicular degenerative changes, and (4) apparent fatty atrophy of the subscapularis muscle. (PX #2, p. 326)

A CT scan of the left shoulder took place on April 11, 2011, with the following impression: "mature fusion of the osseous glenoid in this patient with mild-moderate osteo-arthrosis of the glenohumeral compartment." (PX #2, p. 324)

Petitioner underwent further injections and physical therapy for her left shoulder. She ultimately was recommended for a third surgical procedure with Dr. Cole, which took place on August 14, 2013, in the form of a left shoulder arthroscopy, distal clavicle excision and biceps tenodesis. (PX #1, p. 40)

Petitioner continued to treat with Dr. Cole, and on July 22, 2014, Petitioner underwent a 4th procedure with Dr. Cole, in the form of a left shoulder pectoralis transfer, with the post-operative diagnosis as left shoulder moderate osteoarthritis, with subscapularis deficiency, chronic. (PX #2, 435). Petitioner underwent physical therapy following this procedure.

On April 2, 2015, Petitioner underwent a fifth procedure with Dr. Romeo, who she was referred to by Dr. Cole. Dr. Romeo performed a left reverse total shoulder arthroplasty; she underwent therapy following this procedure. (PX #2, p. 565)

On October 28, 2016, Dr. Romeo placed Petitioner with restrictions of sedentary duty, with no lifting greater than 10 pounds and no overhead work with left arm. (PX #2, p. 573). On April 7, 2016, Dr. Romeo gave the following permanent restrictions, "sedentary work" with "lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. No work at or above shoulder level. No repetitive use of the left arm." (PX #2, p. 574)

Petitioner is right hand dominant. Petitioner's injury is to her left arm.

Petitioner was in TTD status for the following periods: August 22, 2007 through June 30, 2008; September 16, 2008-September 22, 2008; October 1, 2008 through February 2010, and July 13, 2013 through April 29, 2016. (Arb. Ex. #1).

Petitioner was in maintenance status from February 16, 2010 through July 12, 2013; and April 30, 2016 through November 7, 2017. (Arb. Ex. #1). There was a brief TPD period agreed to by parties from July 1, 2008 through September 15, 2008, and September 23, 2008 through September 30, 2008. (Arb. Ex. #1).

At the time of hearing, Petitioner testified she was receiving pension disability checks as well. (T. 44).

The Respondent paid all claimed benefits to the Petitioner, but seeks a credit back for maintenance paid from April 30, 2016, through November 10, 2017. (Arb. Ex. #1).

Job Search and Formal Vocational Rehabilitation History

Petitioner testified she had been looking for work since 2012. (T. 64). But on cross examination she admitted she had been treating continuously through 2016. (T. 64). Petitioner admitted she did not search for work continuously throughout this entire time. (T. 65).

Petitioner testified that she was MMI and her final restrictions were given on April 7, 2016. (T. 66). Prior to that point, other meetings that she testified to such as her annual pension meetings or City of Chicago meeting were not vocational training meetings. (T. 66).

After formally beginning MedVoc in April 2016, Petitioner initially did resume work and then formal computer training. (T. 67-68). Petitioner was also advised by MedVoc on how to present herself for interviews, including with mock interview training. (T. 69). She testified she knows how to dress properly for an interview. (T. 69).

Petitioner began formal vocational rehabilitation with Medvoc Rehab in March 2016. Prior to that point, Petitioner had met with MedVoc once in 2013, but vocational rehab did not proceed at that point. Petitioner testified she conducted her own independent job search prior to starting with MedVoc, with the initial in-person meeting taking place on April 4, 2016. (PX #7, p. 360, 377).

The jobs targeted were hostess, cashier, and customer service, which were jobs within her restrictions. (T. 68).

MedVoc documented in its May 16, 2016 report that Petitioner accused MedVoc of giving false information about her abilities and/or experiences to prospective employers. (PX #7, p. 335). Ms. Diamond Warren of MedVoc advised she was unsure what she was referring to. MedVoc's Ms. Warren advised Petitioner that they "previously spoke about her experience as a receptionist at Smurfit Container" and Petitioner "was reminded that she agreed that it was ok to put that on her resume." This report also documents that "in addition, [Petitioner] had a few other years as a receptionist at previous employers where she did answer phones and greet customers, which would be considered customer service." Petitioner replied "Twist it or word it anyway you like". (PX #7, p. 335). When asked about this encounter on cross-examination, Petitioner recalled telling Medvoc they were "lying" and did not recall MedVoc explaining that her experiences qualify as customer service. (Tr. 76-77).

On July 7, 2016, MedVoc met with Petitioner at Hawk Chevrolet in Bridgeview, Illinois to apply for a scanning clerk position. Petitioner arrived 16 minutes late due a train. (PX #7, p. 221). While walking into the establishment, Petitioner advised Ms. Warren of MedVoc that "the area is bad."

MedVoc's July 15, 2016 report documents that MedVoc Rehabilitation attempted to meet with Petitioner at Robert Jeffrey Salon to apply for a front desk position. Petitioner cancelled this application completion on several occasions. (PX #7, p. 218). This report notes that as a result, before Petitioner was able to apply, the position was filled. (PX #7, p. 218). This report also notes Ms. Misuraca indicated "that she was not comfortable going to the north side." (Id.). MedVoc targeted office service clerk, host, guest service representative, receptionist, and customer service postisions. (PX #7, p. 219).

MedVoc's October 13, 2016 report notes Petitioner "is meeting the minimum required contacts each week. However, it should be noted that Ms. Misuraca's in-person job search has not been very thorough." (PX #7, p. 181). This report notes, she did not complete any in-person applications during that reporting period. She had been advised in the past that she should contact prospective employers via telephone prior to applying in person as well to be more productive in her in-person job search. (PX #7, p. 181).

Petitioner met with Ms. Diamond Warren of MedVoc Rehabilitation at Pinstripes on October 11, 2016. Petitioner did not dress professionally. (PX #7, p. 181). She advised it was because she "was not feeling well." (Id.). Petitioner was wearing a t-shirt, baggy leggings, and flip-flops." She advised it was because she was having "stomach issues." (PX #7, p. 181, 183). Ms. Warren of MedVoc reminded her to dress business causal. (PX #7, p. 183). When questioned about this incident on direct examination, Petitioner's testified "my mother had just passed away, and I was sick." (T. 70). She denied that MedVoc advised her that was not appropriate dress. (T. 70).

Petitioner testified she recalled MedVoc advising her she needed to pursue a more aggressive job search "on a couple occasions." (T. 70). She confirmed this was numerous occasions. (T. 71). Petitioner also testified she was advised she needed to pursue in-person applications. (T. 71).

On cross-examination, Petitioner testified she refused to apply to a position she called a "halfway house" and testified, she's not going to work in a halfway house. It is unclear what position this was and she did not state the name of the business when testifying. (T. 72).

Petitioner testified since formal vocational rehabilitation ended with MedVoc in April 2017, she has been spending 3-4 hours a day "on the computer" and then additional time for "paperwork and then the follow ups." (T. 59-60). She testified she does this every day. (T. 60). Her job efforts resulted in 12-15 applications a week. (T. 60). She testified she looked for jobs "within her restrictions, sedentary, office, answering the phone." (Tr. 61). She testified she does not have any restrictions answering phones. (T. 61). Petitioner testified she does not look for any "repetitive typing" jobs. (T. 62-63). On cross-examination, Petitioner admitted her restrictions are not to her left hand, but stated, "but my shoulder affects everything in my hand and my arm." (T. 63).

Formal vocational rehabilitation ended April 2017, and Petitioner began a self-directed job search.

The Respondent entered into evidence a Labor Market Survey on April 22, 2016. MedVoc used updated work restrictions of no lifting over ten pounds maximum with no overhead or repetitive work with the non-dominant arm, and Petitioner's past work history as an asphalt helper with the City of Chicago and receptionist to conduct this survey. Based on Petitioner's work history and physical capabilities, positions such as front desk, receptionist and customer service were targeted. It was found Petitioner could anticipate earning a mean entry-level wage of $11.65/hr. (RX # 1).

On cross-examination, Petitioner was asked if she believes she can work at the jobs she was applying to. She testified, "I would have been willing to try." She also confirmed she refused to apply to positions she felt she was not qualified for or able to do. (T. 78-79). Petitioner did not apply to a job within the City of Chicago since reaching maintenance in April 2016. (T. 96).

Petitioner has a high school diploma. (T. 79). She currently takes over-the-counter medications and does not have any current doctor's appointments scheduled.

CONCLUSION OF LAW

In regards to (F), "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds:

The Arbitrator finds that based upon the evidence presented that the Petitioner's current condition of ill-being as it relates to her left shoulder is causally related to the injury sustained on August 21, 2007. As a result of the work incident of August 21, 2007, Petitioner ultimately underwent 5 procedures to her non-dominant left shoulder, which resulted permanent restrictions of "sedentary work" with "lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. No work at or above shoulder level. No repetitive use of the left arm." The injury is to the Petitioner's non-dominant arm.

In regards to (L), "What is the nature and extent of the injury?", the Arbitrator finds:

The Arbitrator finds that Petitioner did not meet her burden to establish that she is permanently and totally disabled under the Act. There is no medical evidence to establish that Petitioner is medically permanently and totally disabled. Stated another way, no doctor has stated that they Petitioner in unable to return to the work force. Petitioner's injury, while significant, is to her non-dominate arm. Therefore, the Petitioner would have to establish that she classifies as an "odd-lot" perm total. She has failed to do so.

In order to be considered permanently and totally disabled under the "odd-lot" category of the Illinois Workers' Compensation Act, the Petitioner must conduct a "diligent but unsuccessful job search" or establish by a preponderance of the evidence that he is "so handicapped that he will not be employed regularly in any well-known branch of the labor market." *Professional Transportation Inc. v. IWCC*, 358 Ill.Dec. 855 (3rd Dist. 2012). Petitioner's job search has been previously addressed above and found lackadaisical. Petitioner's job self-directed job search prior to April 2016 was scattered and interrupted by periods of treatment in between. Her final, MMI placement with restrictions did not occur until April 2016. At that point, Petitioner was already enrolled in formal vocational efforts with MedVoc Rehabilitation.

Petitioner's overall work history is disappointing. Her only significant employment prior to working for the City of Chicago was a six months' stint as a receptionist at Smurfit-Stone. From the age of 18 to 28 she seemed to be unemployed, living at home with her parents. (T. 85)

It is noted Petitioner appeared resistant and less than willing to put forth a good faith effort from the beginning, where she accused MedVoc of mischaracterizing her work experience, but she had actually agreed to at an earlier date. Further, Petitioner was made aware of the importance of in-person applications, canceled numerous meeting to apply in-person with MedVoc, and also showed up to an in-person application dressed inappropriately. For instance, she arrived at an interview for a hostess position wearing flip flops, baggy leggings and a T-shirt.

Petitioner made a disparaging comment about the area while walking into another location to apply, and reported to MedVoc she does not want to be employed anywhere on Northside of Chicago.

Petitioner put forth some effort, in searching for work within her restrictions, but certainly did not put forth a consistent, valid good faith effort to support her claim she is so handicapped that she will not be employed regularly in any well-known branch of the labor market. By Petitioner's own admission, she applied to jobs within her restrictions and did not apply to jobs she felt she was incapable of doing.

However, Petitioner has shown what she was earning in her former position, $1,262.52. (Arb. Exh. 1). Per the Labor Market Survey Report of MedVoc, she is capable of a mean entry level wage of $11.65/hr (for a weekly wage of $466.00). This is based on Petitioner's work history and physical capabilities, for positions such as front desk, receptionist and customer service. Petitioner thus has met her burden that she is an 8(d)(1) wage differential under the Act.

Thus, Petitioner is entitled to have and receive weekly wage differential benefits as follows: $1,262.52 (former average weekly earnings) - $466.00 (current weekly earning capacity) = $796.52 x 2/3 = $531.01 per week, for life.

The Arbitrator notes that this case is an "old" Act claim as the date Petitioner filed her application for adjustment of claim before the legislative amendments were made in 2011. The effective date of limiting wage loss claims is September 1, 2011. Petitioner's claim was filed on December 27, 2007, nearly four year beforehand. As a result, her 8(d)(1) award is for her lifetime.

In regards to (K), "What temporary benefits are in dispute? Maintenance?"; In regard to (O) Credit for Maintenance to Respondent, the Arbitrator finds:

Typically an employee's entitlement to maintenance begins when her medical condition has stabilized, she has reached maximum medical improvement and the period of vocational rehabilitation has begun. It is a benefit that is separate from TTD, even though it is paid at the same rate. Maintenance falls under section 8(a) of the Act in conjunction with vocational rehabilitation. To be entitled to maintenance the petitioner must make a good faith effort in her job search and vocational rehabilitation program.

When there is a lack of "good-faith" cooperation with vocational rehabilitation efforts, the termination of benefits is justified. *Hayden v Industrial Commission, 214 Ill. App.3d 749, 575 NE2d 99, 158 Ill.Dec 305(1st Dist. 1991).* It is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort." *Archer Daniels Midland Co. v Industrial Commission, 138 Ill2d 107, 561, NE2d 623, 149 Ill.Dec. 253 (1990)*

In *Johnson v City of Chicago* (*17 IWCC 0035, 13 WC 9875*; Commission Decision was reviewed and decision entered at Circuit Court Level in 17 L 50173, with Commission Decision upheld), the IWCC denied *Johnson* his maintenance because "he demonstrated a lack of good faith". His "obligation to act in good faith throughout the course of his medical care and during

the pendency of his claim, yet failed to do so" was not only stressed but cost the petitioner his maintenance benefits. In the case at hand, the petitioner is held to the same standard; Petitioner must act in good faith throughout her claim.

The Respondent seeks a credit back for maintenance paid for period April 30, 2016, through November 10, 2017, a period of nearly 19 months. This is the period after Petitioner's final MMI date and when her most current restrictions were placed, allowing for formal vocational rehabilitation efforts to begin.

In reviewing the job search documents in their entirety (PX #7), the Arbitrator makes the following three observations. First, on June 14, 2016, the certified vocational expert stated in her report that the Petitioner was "mostly compliant with vocational placement." (PX #7 p. 234) and Respondent paid maintenance benefits.

However, on June 24 2016, the Petitioner refused to apply for an associate customer service representative position, absurdly stating that she was unqualified because she did not have a college degree and had no prior customer service experience. (RX #7 p.788) In fact, the job did not require a college degree, it was only preferred. (RX #7 p.242) Additionally, the record clearly supports Petitioner did, in fact, have customer relations experience in her employment background. Ironically, the only job experience she had prior to working for the City of Chicago was in customer service. (T. 84-85) And despite arguing about it with attorney and vocational counselors, Petitioner stubbornly persisted in telling prospective employers that she had no customer relations experience a year later (Id. p. 1290-1). In the Arbitrator's judgement, this not compliance under the Act.

Second, it seems clear to the Arbitrator that the Petitioner does not want to work and considers herself unemployable. The litany of excuses about why a job search task was incomplete or not performed correctly was never-ending. Problems with her health, car, personal problems, other transportation issues, family issues, vacations, sick parents, day care issues, personal inconveniences and concerns showed up too frequently in the job search documentation. For instance, Petitioner showed up to a job interview dressed in flip flops, baggy leggings and a T-shirt. Her excuse for doing so was that "she was not feeling well." (PX # 7 p. 181) She did not want to work on the Northside of the City. A large percentage of self-directed job search was targeted towards employers who were not looking to hire. (PX #7) Despite being told to focus on employers who are currently hiring, Petitioner persisted in applying to companies whom were not hiring.

Third, the Petitioner presents well in interviews and her written and communication skills are good. (RX #7 p. 745-748). Her vocational counselors further stated that she has good interview skills. She completed her Microsoft Word computer training. She able to spend hours filling out employment applications on-line and at home, but she won't apply for a job that involves typing

because she believes it is against her doctor's restrictions because her hand is connected to her arm (T. 63). Petitioner is employable, she's simply underestimating her own skills and experience.

As a result of the above, Respondent is due a credit of maintenance paid from June 24, 2016 to November 10, 2017. From that day forward, she is entitled to wage differential under 8(d)(1) benefit for life.

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

William McCarthy,
Petitioner,

vs.

City Water, Light and Power,
Respondent.

18IWCC0788

NO: 14 WC 39420

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 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: DEC 21 2018
o11/1/19
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0788

McCARTHY, WILLIAM
Employee/Petitioner

Case# **14WC039420**

14WC035167

CITY WATER LIGHT & POWER
Employer/Respondent

On 12/12/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% 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:

0000 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62705

18IWCC0788

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 McCarthy
Employee/Petitioner

v.

City, Water, Light & Power
Employer/Respondent

Case # **14** WC **39420**

Consolidated cases: **14 WC 35167**

An *Application for Adjustment 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 **10/25/17**. 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 **11/03/14**, 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.

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

In the year preceding the alleged injury, Petitioner earned **$79,859.12**; the average weekly wage was **$1,535.75**.

On the date of the alleged accident, Petitioner was **55** years of age, **married**, with **0** dependent children.

ORDER

The Petitioner did sustain an accidental injury as alleged, but said accident is not causally related to his current state of ill being. The claim for compensation is denied. (See 14 WC 35167).

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

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

Signature of Arbitrator

12/8/2017
Date

DEC 12 2017

FINDINGS OF FACT

Petitioner testified that he was given permanent restrictions by Dr. Wottowa as of September 17, 2014. This was based upon the functional capacity evaluation and involved no lifting over 20 pounds. He was allowed to drive a snow plow. He returned to work with restrictions and was doing his job. It was not right at the time but he was okay. When Dr. Wottowa saw Petitioner on September 17, 2014, he noted Petitioner continued to have the same discomfort over the anterior aspect of the shoulder. He had difficulty lifting up over his head and reaching away from his body. He noted quite a bit of discomfort in the arm in the forwardly flexed position, especially when working from waist level to above head level.

Petitioner then described an incident which took place on November 3, 2014 when he was at a meeting. One of the security guards he knew came up behind him and hit him with a flat hand on the shoulder saying what's going on buddy. Petitioner noted a lot of pain in the shoulder again. It was not moving or doing anything. He did finish the meeting. Petitioner noted that he went back to see Dr. Wottowa with the pain he was in. The pain had increased and never went back down. He saw Dr. Wottowa on November 17, 2014. Petitioner indicated he was worse and miserable on a daily basis. Dr. Wottowa sent Petitioner to Dr. Greatting for a second opinion, which took place on December 18, 2014. On the health history form filled out by Petitioner on that date, he does not mention the incident on November 3, 2014. In Dr. Greatting's office note from that date, there is no mention of the November 3, 2014 incident. When Dr. Wottowa saw Petitioner on 1/07/2015 with regard to performing a reverse total shoulder arthroplasty, Petitioner asked the doctor if this was related to his previous workers' compensation claim and the doctor said of course it was because it was a continuation of the problem from his rotator cuff injury to the right shoulder (PX4).

Petitioner was seen by Dr. Aaron Chamberlain for the first time on December 7, 2015. As part of the history, there is no mention of an incident on November 3, 2014 (PX9). Petitioner saw Dr. Cole for an independent medical evaluation on March 30, 2015. Dr. Cole's report indicates that Petitioner advised him that the November 3, 2014 incident changed things significantly from a subjective standpoint. Dr. Cole did not believe things changed structurally or anatomically just because he was slapped on the shoulder. Dr. Cole indicated he did not see evidence of a change in pathology or anything that represented a new separate injury (RX1).

CONCLUSIONS OF LAW

With regard to (C) accident and (F) causal relationship, the Arbitrator finds that an accident did occur on November 3, 2014 when Petitioner's right shoulder was slapped by a co-employee. He saw Dr. Wottowa two weeks later. The medical records do not reflect any evidence that any of the doctors thought that the slap on the shoulder caused the need for further medical treatment. Dr. Cole specifically noted that there was no change in pathology and that this did not represent a separate injury. Therefore, the Arbitrator finds that the accident occurring on November 3, 2014 represented a temporary aggravation of the Petitioner's shoulder injury. The accident is not causally related to his current condition of ill being.

See further discussion in the decision in 14 WC 35167.

In light of the above conclusions, all other issues become moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT L. WING,

Petitioner,

vs. NO: 01 WC 20623
02 WC 60941

UNITED STATES COLD STORAGE CO.,

Respondent.

ORDER

This cause comes before the Commission on Petitioner's Motion for Medical Care, Costs, and Penalties, filed on March 12, 2018. The Notice of Motion and Order, filed with Petitioner's motion, indicated that the motion would be presented on April 20, 2018, in New Lenox, Illinois. On April 19, 2018, Petitioner's attorney requested, via e-mail, a continuance to the next call date, which was granted. This matter was continued again on June 18, 2018 and October 1, 2018. On December 3, 2018, Respondent's attorney appeared but Petitioner's attorney did not.

IT IS THEREFORE ORDERED that Petitioner's Motion for Medical Care, Costs, and Penalties, filed on March 12, 2018, is hereby dismissed for want of prosecution.

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

DATED: DEC 27 2018

Charles J. DeVriendt

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maxine Harrison,
Petitioner,

18IWCC0789

vs.

NO 00 WC 27314
00 WC 48185

State of Illinois,
Dept. of Employment Security.
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 Arbitrator's Decision to not reinstate the case and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 7, 2017, is hereby affirmed and adopted.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: DEC 27 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-12/19/18
jdl/wj
68

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maxine Harrison,
Employee/Petitioner

Case # 00 WC 27314
00 WC 48185

v.
IDES,
Employer/Respondent

18IWCC0789

ORDER

This matter came before Arbitrator Glaub for Hearing on May 9, 2017 on Petitioner's Motion to Reinstate the above cases, IT IS HEREBY ORDERED:

Petitioner's Motion to Reinstate these cases is denied for the reasons set forth below.

These matters were most recently dismissed by Arbitrator Simpson on January 11, 2017. Petitioner's attorney received written notice of said dismissal on January 18, 2017 and filed a Motion to Reinstate on January 27, 2017. A hearing date was set on February 8, 2017 but apparently petitioner's attorney was out of town and his associate continued the Hearing until April 11, 2017. On March 6, 2017, Arbitrator Simpson was appointed to be a Commissioner for the Illinois Workers' Compensation Commission. On April 11, 2017, petitioner's attorney apparently was out of town again and his associate requested another continuance. An Arbitrator assigned to the trial call did not rule on the Motion to reinstate and apparently requested petitioner's attorney to file a new Motion to Reinstate according to the parties as there no Arbitrator permanently assigned to these cases. The parties could not recall the name of the Arbitrator sitting on April 11, 2017. Petitioner's attorney did file another Motion to Reinstate pursuant to the Arbitrator's instructions on April 11, 2017. The new Motion was presented at the May 4, 2017 status call and was set for a full Hearing on May 9, 2017. Arbitrator Glaub was assigned to hear cases set for trial or Hearing on May 9, 2017. Based on the above, the Arbitrator does find petitioner's Motion to Reinstate was timely filed or within 60 days of their written receipt of the dismissal notice(s).

The Arbitrator notes that these matters had been previously dismissed on multiple occasions by various Arbitrators through the years. Specifically, the claims were dismissed by the Commission on August 29, 2003, April 29, 2004, March 24, 2005, April 17, 2008 and February 14, 2013 in addition to January 11, 2017.

At the hearing, counsel for the respondent stated the efforts of their office to proceed to trial on these matters or at least to meet with petitioner's attorney to review and exchange each other's exhibits and determine which issues could be stipulated and which would be

disputed. Despite the efforts of respondent's counsel, the parties never met for this purpose. Respondent's counsel also represented that this matter received several "final" trial dates in 2016 which were eventually continued. Prior to the most recent trial date of January 11, 2017, respondent attorney advised petitioner's attorney that she would not agree to any additional continuances unless petitioner's attorney provided her with his exhibits. Respondent counsel represented that petitioner's attorney was not present on January 11, 2017 and Arbitrator Simpson granted Respondent's Oral Motion to dismiss these claims. Respondent's counsel continued to request petitioner's attorney to provide her with copies of his exhibits since the initial Motion to reinstate was filed. Respondent counsel also represented that she told petitioner's attorney she would continue to object to his Motion to Reinstate unless she received those exhibits.

The decision to grant or deny a timely Petition to reinstate is a matter which rests within the sound discretion of the Commission, and its determination will not be disturbed on review absent an abuse of that discretion. *Banks v Industrial Commission* 345 Ill. App. 3d 1138 (2004), *Conley v Industrial Commission.* 229 Ill. App. 3d 925, 930 (1992). In the present case, the petitioner had the burden of justifying the reinstatement of these claims after they had been dismissed 6 times by multiple Arbitrators. The Arbitrator also notes the language of the Illinois Supreme Court in *Bromberg v Industrial Commission.* "The endless delays, the endless failures of attorneys to appear without excuse, either real or apparent, to inform a hearing office as to the reasons for delay has reflected for years adversely upon the effective administration of justice and continues to do and will continue to do so until the Appellate Courts start acting to see to it that lawyers fulfill their responsibilities to their clients and appear on the days and dates set for hearing that move hearings to a proper conclusion". 97 Ill. 2d 395, 400 (1983).

Based on the history listed above, the Arbitrator does not believe petitioner's attorney has met that burden. It is clear that the petitioner's attorney had repeated opportunities to proceed to trial in these matters and was advised the matters would be subject to dismissal if he did not do so, or in the alternative, to simply meet with his opponent to exchange exhibits and verify the disputed issues. Petitioner's attorney presented no evidence or argument that he had ever met with his opponent to exchange exhibits and identify the disputed issues, even by May 9, 2017, four months after this matter had been dismissed based on petitioner's attorney failure to attend the scheduled trial date. It appears respondent's counsel would have agreed to a final continuance had petitioner's attorney at least met with for this purpose. The Arbitrator also takes into consideration that on 5 separate occasions, the Commission has granted petitioner's attorney's prior Motions to Reinstate these claims.

You are further notified that unless a Petition for Review is filed with the Illinois Workers' Compensation Commission within thirty (30) days after receipt of the decision, and Review perfected in accordance with the Illinois Workers' Compensation Act and the Rules of the Workers' Compensation Commission, then the Decision of the Arbitrator shall be entered as the decision of the Illinois Workers' Compensation Commission.

Signature of arbitrator

July 7, 2017
Date

JUL 7 - 2017